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What Is the Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act

B. Jessie Hill[†]

I. INTRODUCTION

When the government decides to assume a major role in providing and paying for healthcare, the government also has to decide exactly what constitutes appropriate, reasonable, or essential healthcare under its program. Congress, of course, recognized this necessity when it passed the Patient Protection and Affordable Care Act (ACA), and the statute itself provides authority to the Secretary of Health and Human Services (HHS) to determine the “essential health benefits” that must be covered under the ACA beginning in 2014, both by insurers offering plans within governmentally sponsored exchanges and on the individual and small-employer markets outside the exchanges.¹ In a decision that was hailed as both “politically astute” and problematic for the goals that the ACA itself was supposed

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¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119, 163-64 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, §§ 1302(b)(1), 2707(a) (2010) (codified at 42 U.S.C.A. § 18022(b)(1) (West 2012)). This Article refers to the consolidated act, with amendments, as the “ACA.” See also generally John K. Iglehart, *Defining Essential Health Benefits—The View from the IOM Committee*, 365 NEW ENG. J. MED. 1461, 1461-62 (2011) (describing the “essential health benefits” requirement imposed on insurance companies within and outside the exchanges).

to accomplish,² HHS shunted off the task of defining the term “essential health benefits” to the individual states.³

The states’ authority to choose a package of essential benefits for their citizens is not totally open-ended, of course. States will be required to specify a “benchmark plan” within parameters specified by HHS, to which other approved plans must be “substantially equal.”⁴ In addition, every package of essential benefits must encompass ten different categories of benefits that have been specified in the ACA itself, and nondiscrimination norms apply.⁵ Nonetheless, states end up with considerable discretion under what appears to be a political compromise.

Needless to say, the crafters of this plan were aware of the intensely fraught nature of any attempt to define the essence of “health,” “healthcare,” or “medical necessity.”⁶ Such decisions affect the lives and choices of the individuals covered by regulated insurance plans, as well as the bottom line of the insurers themselves. The breadth and precise nature of the ACA’s requirements will directly affect the Act’s ability to meet its stated goals of providing comprehensive coverage for the vast majority of Americans and controlling healthcare costs.⁷ And in certain domains—particularly reproductive healthcare—the decision to include or exclude a particular service may carry political consequences and implicate value choices in a way that is particularly salient. In August 2011, for example, substantial controversy accompanied HHS’s decision to adopt the Institute of Medicine’s (IOM) recommendation that all new private health plans must, under the ACA, cover the full range of contraceptive options along with other preventive care for women.⁸ The debate became more heated when the Obama Administration announced its intention to maintain this requirement with only a very limited “conscience clause,” which exempts organizations that have religious objections to contraception but which is too narrow to cover some entities, such as hospitals and universities, that are operated by those religious groups.⁹ While some condemned the administration’s

² See, e.g., INST. OF MED., *ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COSTS* xi (2011) (describing the major goals of specifying essential health benefits as “balancing the comprehensiveness of benefits with their cost”); Sarah Kliff, *What Counts as ‘Essential’ Health Care? White House Tells States to Decide*, WASH. POST (Dec. 16, 2011, 2:51 PM), http://www.washingtonpost.com/blogs/ezra-klein/post/what-counts-as-essential-health-care-white-house-tells-states-to-decide/2011/12/16/gIQAzOAmyO_blog.html (describing some commentators’ concerns that comprehensiveness of coverage may be sacrificed in the interests of cutting costs).

³ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, DEP’T HEALTH & HUMAN SERVS., *ESSENTIAL HEALTH BENEFITS BULLETIN* 8 (2011), available at http://cciiio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

⁴ *Id.* at 8, 12.

⁵ *Id.* at 10; see also ACA § 1302(b)(1).

⁶ See, e.g., INST. OF MED., *supra* note 2, at 8-5.

⁷ *Id.* at xi.

⁸ See Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the ACA, 76 Fed. Reg. 46,621, 46,626 (Aug. 3, 2011) (amendments to be codified at 45 C.F.R. pt. 147) (announcing the interim final rule regarding coverage of preventive health services); *Women’s Preventive Services: Required Health Plan Coverage Guidelines*, HEALTH RESEARCH & SERVS. ADMIN., <http://www.hrsa.gov/womensguidelines/> (last visited Jan. 16, 2012); Steven Ertelt, *Pro-Life Groups, Catholic Bishops Blast Obamacare Recommendations*, LIFENEWS.COM (July 19, 2011, 5:58 PM), <http://www.lifenews.com/2011/07/19/pro-life-groups-catholic-bishops-blast-obamacare-recommendations/> (noting opposition to the pre-amended rule from groups such as Americans United for Life, the Family Research Council, and the Catholic bishops).

⁹ Press Release, A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius, U.S. DEP’T OF HEALTH & HUMAN SERVS., available at <http://www.hhs.gov/news/press/2012pres/01/20120120a.html> (last revised Feb. 2, 2012) [hereinafter Sibelius Statement]

decision as an assault on religious freedom, HHS cast its determination in terms of protecting women's health.¹⁰

This controversy highlights the extraordinarily hazy contours around the definition of health in a variety of legal and policy contexts and the significance of that definition for future debates surrounding the ACA. While acknowledging that numerous social, economic, and public health consequences may attach to the definition of medical necessity, this Article focuses primarily on the constitutional issues that may arise, depending on how broadly or narrowly the government defines concepts such as "medical necessity" and "essential health benefits." At first glance it may appear that, beyond the debate about the constitutionality of the individual mandate, a governmental benefit program like the ACA is not likely to give rise to claims that an individual constitutional right has been violated. This Article speculates, however, that the unprecedented and expansive role of the government in directing individuals' healthcare portended by the ACA may provoke a re-evaluation of some apparently settled constitutional principles. While acknowledging the wide scope of constitutional rights that may become implicated, this Article focuses on one right in particular—the so-called "negative right to health." It argues that the negative right to health may be directly and substantively affected by governmental

(announcing that HHS's final rule will remain the same as the interim rule). The rule (in both its interim final form and final form) makes available an exemption from the contraceptives coverage requirement for employers who meet the following requirements:

- (1) The inculcation of religious values is the purpose of the organization.
- (2) The organization primarily employs persons who share the religious tenets of the organizations.
- (3) The organization serves primarily persons who share the religious tenets of the organization.
- (4) The organization is a nonprofit organization as described in [those portions of the Internal Revenue Code pertaining to churches and their "integrated auxiliaries"].

Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the ACA, 76 Fed. Reg. at 46,626. Most, if not all, Catholic hospitals and Catholic colleges and universities would fail to meet all of these requirements. For example, most hospitals could not be considered to have the "inculcation of religious values" as their primary aim, and neither Catholic hospitals nor universities generally employ or serve primarily those who share their religious beliefs. As of the time of publication, the Obama Administration had announced its intent to further modify the rule so as to accommodate religious employers who would not meet the narrow requirements for exemption. According to a White House fact sheet, the new accommodation would ensure that "[r]eligious organizations will not have to provide contraceptive coverage or refer their employees to organizations that provide contraception," and they would not be "required to subsidize the cost of contraception." Press Release, White House, Office of the Press Secretary, Fact Sheet: Women's Preventive Services and Religious Institutions (Feb. 10, 2012), *available at* <http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions>. Instead, coverage for contraceptives will be offered by the employers' insurance companies directly, and without cost, requiring no involvement by those religious employers who oppose contraception.

¹⁰ Compare Amanda Terkel, *Newt Gingrich Condemns Obama Administration's Contraception Rule, Calls It a 'War Against Religion'*, HUFFINGTON POST (Jan. 30, 2012, 12:10 PM), http://www.huffingtonpost.com/2012/01/30/newt-gingrich-obama-contraception-rule_n_1241655.html (noting the view of some conservatives that the contraception coverage rule constituted an assault on religion), with Sibelius Statement, *supra* note 9 (stating that the rule "will ensure that women with health insurance coverage will have access to the full range of the Institute of Medicine's recommended preventive services" and noting that "[s]cientists have abundant evidence that birth control has significant health benefits for women and their families, is documented to significantly reduce health costs, and is the most commonly taken drug in America by young and middle-aged women").

specification of essential health benefits, particularly if those benefits are defined in a way that excludes services that may be considered medically necessary.

Part II of this Article provides background. That Part begins by describing the ways in which the Affordable Care Act, supplemented by the work of the IOM, defines concepts such as “medical,” “medical necessity,” and “essential health benefits.” Part II then provides a brief, non-exhaustive overview of the ways in which courts and commentators have struggled to define a related constellation of concepts surrounding health and healthcare in various other legal contexts. Part III then turns to the “negative right to health,” beginning with an explanation, in Part III.A, of what is meant by the “negative right to health” and arguing, succinctly, for its existence. Briefly, the negative right to health is a constitutional entitlement to protect one’s health by making medical treatment decisions without excessive government interference.¹¹ As explained in greater depth below, this right may be inferred from case-law touching on reproductive rights, the right to refuse medical treatment, and related issues. The negative right to health has been described in great depth elsewhere;¹² consequently, in this Article, both the description and the defense of the right are somewhat cursory. Part III.B then examines two significant limitations on possible arguments that the ACA infringes on the negative right to health: the state action doctrine and the subsidy/penalty distinction. Finally, Part III.C considers whether any constitutional claims pertaining to the definition of medical necessity under the ACA might survive under existing precedent. Even if no claim is likely to exist under current doctrine, this Article suggests that the eventual expansion of the government’s role in healthcare decision-making under the ACA may one day provoke a reconsideration of that precedent.

II. THE DISPUTED NATURE OF “HEALTH”

Political wrangling over the meaning of “health” recently took place in Ohio, when voters overwhelmingly passed an “anti-Obamacare” amendment to the state constitution.¹³ The ballot initiative, known as the Ohio Healthcare Freedom Amendment, sweepingly provided, with limited exceptions, that “[n]o federal, state, or local law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in a health care system,” nor “prohibit the purchase or sale of health care or health insurance,” nor “impose a penalty or fine for the sale or purchase of health care or health insurance.”¹⁴ By its terms, the amendment applied only to laws passed after March 19, 2010.¹⁵ Ironically, in light of the essentially conservative base of voters that supported the amendment, the first healthcare regulations to appear vulnerable were several abortion-related laws passed by the Ohio legislature in that same year, including a post-viability abortion ban, a ban on purchasing abortion insurance through the state-sponsored exchange to be created under the ACA, and a proposed ban on all abortions after the fetal

¹¹ B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 527 (2009) [hereinafter Hill, *Reproductive Rights*].

¹² See, e.g., sources cited *infra* note 100.

¹³ See, e.g., Aaron Marshall, *State Issue 3 Won’t Have a Big Impact on Health Care in the Short Term, Experts Say*, CLEVELAND.COM, (Nov. 10, 2011), http://www.cleveland.com/open/index.ssf/2011/11/state_issue_3_wont_impact_new.html (noting that the amendment passed by a margin of two to one).

¹⁴ OHIO CONST. art. I, § 21(A)-(C).

¹⁵ *Id.* § 21(D).

heartbeat could be detected.¹⁶ Reproductive rights advocates in Ohio pointed out that such laws prohibited the purchase and sale of healthcare and were therefore vulnerable to constitutional challenge under the new amendment.¹⁷ Supporters of the Healthcare Freedom Amendment, hoping to keep in place the sorts of abortion restrictions that were recently passed in the state, responded that the Ohio legislature could avoid this conundrum simply by making it clear that abortion does not fall within the definition of “healthcare.”¹⁸ It is unclear, of course, whether the legislature will be able to change the impact of the Ohio Constitution by defining “healthcare” in a particular way through ordinary legislation; but this anecdote demonstrates, at a minimum, the absence of a clear definition of the term, as well as the essentially political nature of the determination of what is and is not healthcare. These two facets of the definition of “health” and “healthcare” are discussed at greater length below.

A. MULTIPLE DEFINITIONS

There are multiple, but related, concepts concerning “health,” all of which are relevant to the operation of the ACA, and there is no consistent or clear set of definitions for them. In each case, attempts to define concepts such as “medical necessity” and “essential health benefits” founder on circularity, or simply refer the matter to other entities to decide. As a general matter, “medical necessity,” a key term in insurance companies’ coverage decisions, usually refers to the medical appropriateness of a particular intervention in a particular case or type of case.¹⁹ “Essential health benefits,” by contrast, is a term associated with the ACA and refers more broadly to the types of healthcare that must be covered under insurance plans, such as preventive office visits and “medically necessary” treatments for various types of conditions.²⁰ Thus, “medical necessity” is a more case- or condition-specific concept, whereas “essential health benefits” refers more generally to the categories of coverage under a benefits plan. These terms are, of course, intimately related insofar as they address the question of what constitutes the sort of healthcare to which individuals can claim some form of statutory or contractual entitlement. At the same time, they remain vague at their core.²¹

Numerous questions remain unanswered by the various attempts to define these terms. For example, how severe must the harm or pain be, before the need for medical treatment is recognized? Is the term “health” narrowly limited to physical

¹⁶ H.R. 78, 129th Gen. Assemb., Reg. Sess. (Ohio 2011) (enacted); H.R. 125, 129th Gen. Assemb., Reg. Sess. (Ohio 2011) (not yet enacted).

¹⁷ Joe Guillen, *Gov. John Kasich Signs 13 Bills into Law, Including Another Anti-Abortion Measure*, CLEVELAND.COM (Dec. 21, 2011), http://www.cleveland.com/open/index.ssf/2011/12/gov_kasich_signs_13_bills_into.html.

¹⁸ Marshall, *supra* note 13.

¹⁹ See, e.g., M. GREGG BLOCHE, *THE HIPPOCRATIC MYTH: WHY DOCTORS ARE UNDER PRESSURE TO RATION CARE, PRACTICE POLITICS, AND COMPROMISE THEIR PROMISE TO HEAL* 11 (2011) (describing “medical necessity” as “the legal standard for health insurance coverage in the United States and throughout much of the world”); INST. OF MED., *supra* note 2, at xii; *cf. id.* at 2-5 (distinguishing “medical necessity” and “essential health benefits”).

²⁰ See ACA, Pub. L. No. 111-148, § 1302(a)-(b), 124 Stat. 119, 163-65 (2010) (to be codified at 42 U.S.C. § 18022(a)-(b)); see also INST. OF MED., *supra* note 2, at 4-2 to 4-3 (discussing the meaning of “essential”).

²¹ See, e.g., BLOCHE, *supra* note 19, at 11 (characterizing the term “medical necessity” as “a malleable notion, more of a euphemism for physician habit than a scientific yardstick”).

health, or does it include mental health, emotional health, and social well-being? Is reproductive care an aspect of healthcare? And which persons or entities—doctors, patients, insurers, legislatures, regulators, or judges—are or should be empowered to make the final decision regarding medical necessity? Though an exhaustive study of the multiple contexts in which these issues arise is beyond the scope of this Article, Part II.A provides a sample of some of the ways in which courts and commentators have struggled with the various axes of defining “health,” “medical necessity,” and “essential health benefits.”

1. The ACA and the Institute of Medicine Report

Prolix though it is, the ACA itself contains very little in the way of explanation or definition of key concepts such as “medical,” “medical necessity,” and even “essential health benefits.” Section 1302 of the ACA lays out the ten categories of coverage that constitute the “essential health benefits” required for new health plans under the ACA.²² Beyond that, however, the ACA provides no more guidance and instead delegates to the Secretary of HHS the authority to define “essential health benefits.”²³ The ACA contains no explicit definition of “medical necessity,” nor does it explicitly distinguish “medical” from “nonmedical” interventions.²⁴

The task of defining key concepts thus largely falls on HHS. Prior to the HHS decision to allow states to define essential health benefits on their own, the IOM issued (at the request of HHS) a lengthy consensus report entitled *Essential Health Benefits: Balancing Coverage and Costs*, in which it attempted to grapple with some of the complexities described above.²⁵ The report noted, first, the difficulty of distinguishing “medical” from “nonmedical” interventions.²⁶ After acknowledging that “the boundaries of what is medical and nonmedical are not always distinct,” and noting the additional difficulty that the ACA requires some coverage of “habilitation” services, which often have a social or educational component,²⁷ the report simply recommended allowing the decision about the distinction between medical and non-medical to be made by individual health plans, “with oversight by state regulators and HHS.”²⁸

Similarly, the IOM report noted the multiple existing definitions of “medical necessity.” Again dispensing with the necessity of fixing one particular definition for the term, the IOM report embraced the view that “[t]he central question is whether the treatment is medical in nature and whether the individual can be expected to

²² ACA § 1302(b)(1); *see also id.* § 1301(a)(1)(b) (defining a “qualified health plan” as one that provides “essential health benefits”); *id.* § 2707 (requiring insurers on the small group and individual markets to provide “essential health benefits” as defined in the ACA). The ten required categories of coverage under the ACA are “[a]mbulatory patient services,” “[e]mergency services,” “[h]ospitalization,” “[m]aternity and newborn care,” “[m]ental health and substance use disorder services, including behavioral health treatment,” “[p]rescription drugs,” “[r]ehabilitative and habilitative services and devices,” “[l]aboratory services,” “[p]reventive and wellness services and chronic disease management,” and “[p]ediatric services, including oral and vision care.” *Id.* § 1302(b)(1)(A)-(J).

²³ *Id.* § 1302(b)(1).

²⁴ The ACA does define “emergency medical condition” for various purposes, however. *See, e.g.,* ACA §§ 2707(h)(1), 2719(b)(2)(A).

²⁵ INST. OF MED., *supra* note 2.

²⁶ *Id.* at 4-19 to 4-20.

²⁷ “Habilitation” is defined in the IOM report as “distinct from rehabilitation, in that it is designed to help a person first attain a particular function, versus restoring a function.” *Id.* at 4-4.

²⁸ *Id.*

medically benefit from it”—thus referring back to the very term (“medical”) that it had earlier declined to define.²⁹ The report essentially deferred the task to private insurers, who have substantial experience in defining medical necessity, while emphasizing the values of “individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence.”³⁰ Thus, the IOM report stated that services meeting the requirements of medical necessity will be those that are “(1) clinically appropriate for the individual patient, (2) based on the best scientific evidence, taking into account the available hierarchy of medical evidence, and (3) likely to produce incremental health benefits relative to the next best alternative that justify any added cost.”³¹ The report also noted that patients’ rights would be most fully protected through the requirement of an “independent external review” that “will begin *de novo* and will be binding on the insurer” in cases where medical necessity is disputed.³²

Of course, the IOM report’s emphasis on medical benefit, functionality, and medical purpose would seem to clearly exclude certain types of procedures—those generally denominated as cosmetic, for example. Yet, even this apparently bright line admits of some fuzziness. For example, would a procedure such as breast reconstruction after surgery for removal of a tumor,³³ or microtia repair for a child born without an outer ear³⁴—two procedures that are regularly covered by insurance—fall within this definition?³⁵

2. International Law

Of course, outside the immediate context of the ACA, there have been other attempts to define “health” and “medical necessity.” Efforts to define and delimit an international right to health, for example, have necessarily struggled with the question of what constitutes a minimum required level of healthcare for all.³⁶ Health, in the international context, is understood broadly. Thus, descriptive efforts often

²⁹ *Id.* at 5-26.

³⁰ *Id.* at 5-28.

³¹ *Id.*

³² *Id.*; see also ACA, Pub. L. No. 111-148, § 2719(a)-(b), 124 Stat. 119, 887-88 (2010) (to be codified at 42 U.S.C. § 300gg-19(a)-(b)) (requiring availability of internal and external review processes for coverage determinations).

³³ Health insurance plans under the Employee Retirement Income Security Act (ERISA) currently must cover post-mastectomy breast reconstruction. 29 U.S.C. § 1185b(a) (2006).

³⁴ Microtia is a congenital condition, in which children are born with a partial or no external ear formation. Microtia repair generally adds no functionality. See June K. Wu, *Outer Ear Construction: Is Advocacy Part of Treatment?*, 12 VIRTUAL MENTOR 367, 369-70 (2010), available at <http://virtualmentor.ama-assn.org/2010/05/pdf/ccas2-1005.pdf> (describing microtia and noting that insurance companies sometimes decline to cover one or more stages of microtia repair); *Microtia Repair*, FACIAL COSMETIC SURGERY AT THE UNIVERSITY OF VIRGINIA, <http://www.cosmeticuva.com/html/services/microtiaRepair.htm> (last visited Apr. 5, 2012) (noting that repair of the external ear does not improve any hearing loss associated with the original birth defect, and stating that insurance generally covers microtia repair).

³⁵ Cf. ACA § 9017 (defining “cosmetic surgery and medical procedure” as a procedure that is “performed by a licensed medical professional” and “not necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease”) (superseded by *id.* § 10907(b)).

³⁶ See, e.g., Virginia Leary, *The Right to Health in International Human Rights Law*, 1 HEALTH & HUM. RTS. 24, 25 (1994); Anika Rahman & Rachael N. Pine, *An International Human Right to Reproductive Health Care: Toward Definition and Accountability*, 1 HEALTH & HUM. RTS. 401, 405-06 (1998) (noting that “[i]nternational organizations and scholars have made several attempts to provide content to the right to health” and to describe its minimum “core content”).

hearken back to the World Health Organization definition of “health” as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³⁷ For example, General Comment 14 to the International Covenant on Economic, Social, and Cultural Rights defines the “right to health” as “embrac[ing] a wide range of socio-economic factors that promote conditions in which people lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.”³⁸

Such definitions may be critiqued on many grounds: for starters, they are quite vague.³⁹ More importantly, perhaps, it is wildly aspirational to suggest that any constitutional, statutory, or human rights-based right to health could encompass the swath of services that would be required to achieve such a state of health in any enforceable way.⁴⁰ Consequently, although a number of constitutions that were adopted after the mid-twentieth century, under the influence of human rights law, recognize a right to health, the content of that right often remains undefined. For this reason, the definitional struggle may shift to determining when a minimum core of required health services has been provided, or on whether a government is moving sufficiently toward the progressive realization of such a state of health for all citizens.⁴¹

3. Constitutional Law—Reproductive Rights Cases

Although American law has not explicitly recognized a positive right to health, U.S. courts have had occasion to address the meaning of health and medical necessity in other contexts. In particular, significant litigation has surrounded the meaning and effect of the requirement, derived from the Supreme Court’s opinion in *Roe v. Wade*⁴² and *Stenberg v. Carhart*,⁴³ that abortion regulations must not endanger a woman’s health and that even restrictions on post-viability abortions

³⁷ Constitution of the World Health Organization, Preamble, July 22, 1946, 14 U.N.T.S. 186 [hereinafter WHO Constitution].

³⁸ U.N. Comm. on Econ., Soc. and Cultural Rights, *The Right to the Highest Attainable Standard of Health: General Comment No. 14*, ¶ 4, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000); see also Lance Gable, *Reproductive Health as a Human Right*, 60 CASE W. RES. L. REV. 957, 979-81 (2010); Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1467-68 (2001) (describing the “broad and inclusive” right to health outlined in General Comment 14).

³⁹ See, e.g., Rahman & Pine, *supra* note 36, at 406.

⁴⁰ See, e.g., Leary, *supra* note 36, at 28 (“Superficially, the ‘right to health’ seems to presume that government or international organizations or individuals must guarantee a person’s good health. This interpretation is obviously absurd and the phrase is not given such an interpretation in the context of human rights law.”).

⁴¹ See, e.g., *Soobramoney v. Minister of Health* 1998 (1) SA 765 (CC) (applying the South African right to health, but holding it did not require the state to provide dialysis treatment to the plaintiff); Mary Ann Glendon, *Rights in Twentieth-Century Constitutions*, 59 U. CHI. L. REV. 519, 527-32 (1992) (discussing the difficulties that some countries experience in implementing a right to health); cf. 241/2001 Purohit & Moore v. The Gambia, Comm’n No. 241/2001 (Afr. Comm’n on Human & Peoples’ Rights 2003) (noting the state’s obligation “to take concrete and targeted steps” to realize the right to health “while taking full advantage of its available resources”).

⁴² *Roe v. Wade*, 410 U.S. 113 (1973).

⁴³ *Stenberg v. Carhart*, 530 U.S. 914 (2000).

must give way when the woman's health is at stake.⁴⁴ Thus, it may be useful to consider how, if at all, abortion case-law has defined health and medical necessity.

Unfortunately, those concepts are never very well defined in this line of jurisprudence. One issue is whether reproductive healthcare can properly be considered an aspect of healthcare in general, or whether it must be treated as a unique category. *Doe v. Bolton*,⁴⁵ the companion case to *Roe v. Wade*, speaks of abortion itself as being, at least in part, a medical decision that should be treated like other medical decisions.⁴⁶ Indeed, those opinions have been criticized by feminist scholars for the extent to which they treat abortion as a matter of medical judgment, to be placed in the hands of the physician, even to the exclusion of the agency and judgment of the woman herself.⁴⁷ Thus, the Court in *Roe* claimed to “vindicate[] the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention.”⁴⁸ Until the point of viability, when the state's interest in the fetus becomes compelling, the Court explained, “the abortion decision in all its aspects is inherently, and primarily, a *medical* decision, and basic responsibility for it must rest with the *physician*.”⁴⁹ Similarly, the Court in *Doe* compared the abortion procedure to other surgical procedures, noting that the Georgia statute at issue in that case regulated abortion in ways that were unimaginable for other surgeries.⁵⁰ It further underlined the importance of the physician's medical judgment in determining the appropriateness of abortion in an individual case.⁵¹

In addition, the *Doe* Court addressed the scope of the concept of “health.” It considered the advisability of abortion, as medical procedure, to be a calculation that takes into account not only the woman's health concerns, but also her well-being in a more holistic sense—including “physical, emotional, psychological, [and] familial [factors], [as well as] the woman's age.”⁵² *Doe* thus views health as a broad concept, touching on not only physical health but also mental, emotional, and social factors. This definition of health may even recall the World Health Organization's definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁵³

Interestingly, moreover, the decision regarding medical need for the abortion procedure appeared to be one that should be made primarily by the doctor, rather than by parties external to the doctor-patient relationship. Indeed, this understanding of the doctor's role also seemed to play a role in the legislative debates in the 1970s over the reauthorization and scope of the Hyde Amendment, which generally prohibits the use of Federal Medicaid funds for abortions, with very limited

⁴⁴ *Roe*, 410 U.S. at 164-65; *Stenberg*, 530 U.S. at 930.

⁴⁵ *Doe v. Bolton*, 410 U.S. 179 (1973).

⁴⁶ *Id.* at 192-99.

⁴⁷ See, e.g., Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199-1200 (1992); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273-79 (1992); see also Hill, *Reproductive Rights*, *supra* note 11, at 514-17 (questioning some criticisms of the “medical model” of abortion).

⁴⁸ *Roe*, 410 U.S. at 165-66.

⁴⁹ *Id.* at 166 (emphasis added).

⁵⁰ *Doe*, 410 U.S. at 193, 197, 199.

⁵¹ *Id.* at 191-92.

⁵² *Id.* at 192.

⁵³ WHO Constitution, *supra* note 37.

exceptions.⁵⁴ While some Senators attempted to broaden the subsidy to include not only life-saving abortions but also those that were “medically necessary,” supporters of the broadening language, citing *Doe v. Bolton*, noted that the change would thus “leave it to the woman and her doctor to decide whether to terminate a pregnancy.”⁵⁵

Although *Doe*’s broad definition of “health” did not appear to carry much influence in subsequent decision-making, the concept of the maternal “health exception,” introduced in *Roe*, became a central point of contention over the definition of “medical necessity.” In particular, *Roe* held that even at the point of viability, when the state has a compelling interest in the life of the fetus, the state’s interest must give way when the woman’s life *or health* is at risk. Yet, the Court must mean something different by “health” in this context than when it talks about abortion as an aspect of healthcare in general. In other words, in the post-viability context, protecting “health” apparently refers, in a more narrow way, to something like freedom from harm—and probably significant harm. It seems to have an affiliation to the concept of self-defense, as it permits the woman, essentially, to protect herself when she is threatened by the pregnancy.⁵⁶ It is an open question whether mental health threats, as opposed to threats to the woman’s physical health, are sufficient to trigger the post-viability abortion exception.⁵⁷ Thus, this constricted definition of “health” may be contrasted with the more general concept of “healthcare,” or perhaps even interventions having a “medical purpose.” Those terms contemplate a more holistic view of health, as a state of overall well-being and the object of autonomous decision-making about how to take care of one’s body.

Gonzales v. Carhart and *Stenberg v. Carhart*,⁵⁸ the Supreme Court’s two “partial-birth abortion” cases, contain the most significant discussions of health as medical necessity in the abortion context. In both *Stenberg* and *Gonzales*, the Supreme Court considered whether laws banning a procedure referred to as “partial-birth abortion” were unconstitutional because they lacked a health exception that would allow the procedure to be performed when it is safer for the woman than other available procedures. *Gonzales* and *Stenberg* are particularly germane to the concept of medical necessity. Precisely stated, the issue before the Court in both cases was whether the state can, consistent with the Constitution, force a woman to have a

⁵⁴ The Hyde Amendment was first passed in 1976 as the Departments of Labor and Health, Education, and Welfare Appropriations Act, Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976), and it has been reauthorized by each Congress since then, although the exact scope and wording have shifted over time. For the most recent version of the Hyde Amendment, see Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, § 507, 123 Stat. 3034, 3280 (2009). A brief but useful history of the Hyde Amendment is provided in Jon F. Merz, Catherine A. Jackson & Jacob A. Klerman, *A Review of Abortion Policy: Legality, Medicaid Funding, and Parental Involvement, 1967-1994*, 17 WOMEN’S RTS. L. REP. 1, 6-8, 8 n.44 (1995).

⁵⁵ 124 CONG. REC. 31917 (Sept. 27, 1978) (remarks of Sen. Edward Brooke).

⁵⁶ See Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1824-27 (2007) (describing a constitutional right to “medical self-defense” in *Roe* and its progeny).

⁵⁷ In *Women’s Med. Prof’l Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), for example, the Sixth Circuit Court of Appeals struck down Ohio’s post-viability abortion ban due to its lack of an exception allowing the procedure to go forward when required by threats to the woman’s mental health. *Id.* at 209-10. The court further noted, however, that the exception would apply only to “severe irreversible risks of mental and emotional harm.” *Id.* at 209. Nonetheless, the Supreme Court has not decided the issue, and a number of states—including Ohio itself—have, post-*Voinovich*, enacted post-viability abortion bans with exceptions for severe threats to physical health only. See H.R. 78, 129th Gen. Assem. (Ohio 2011).

⁵⁸ *Gonzales v. Carhart*, 550 U.S. 124 (2007); *Stenberg v. Carhart*, 530 U.S. 914 (2000).

legally permissible abortion by means of a procedure that her doctor believes is riskier for her than another available procedure.⁵⁹ The Court held in *Stenberg* that this was in fact unconstitutional. In so doing, it seemed to have recognized, in part, a sort of medical self-defense right, involving an understanding of medical necessity, in the abortion context, as freedom from state-imposed harm.

Moreover, the Court arguably clung to the same concept of health in *Gonzales v. Carhart*, even though the case itself came out the other way and upheld a federal partial-birth abortion ban that lacked a health exception allowing the procedure to be performed when necessary to avoid health risks to the woman.⁶⁰ The opinion took issue neither with the notion that women have a right to avoid harm to their health resulting from a government-imposed abortion restriction, nor with the notion that this particular regulation (a ban on this particular abortion procedure) may in some circumstances impose significant health risks on a particular woman.⁶¹ Rather, the Supreme Court turned away the latter challenge, because it felt that, in light of the allegedly conflicting medical evidence before it, the existence *vel non* of those risks should be considered in the context of an as-applied challenge rather than the facial challenge that the plaintiffs had brought.⁶²

Thus, despite their differences, both *Gonzales* and *Stenberg* seemed to view the health exception as preventing harm to the woman's health in the form of significant risks; whether that includes only physical risks or possibly also mental health risks is unclear. But at the same time, the cases differ in terms of who is entitled to determine how best to avoid harm to the woman's health. The *Stenberg* Court, having determined the possibility of health risks, appeared content to leave it largely to the woman and her doctor to decide whether and when the procedure is medically necessary and appropriate.⁶³ The *Gonzales* Court, to say the least, was more skeptical: it seemed to see some role for the legislature in defining what procedures may and may not be medically necessary, and it was unwilling to adopt an across-the-board health exception that would essentially delegate decisions about medical necessity to the individual physician.⁶⁴ Instead, the *Gonzales* Court saw a need for continuing involvement by the government—including, perhaps the courts, which would be charged with further specifying when the procedure was or was not necessary to protect a woman's health.⁶⁵

4. Constitutional Law—Eighth Amendment Cases

Another area of constitutional law in which medical necessity may be implicated is case-law examining prisoners' rights to adequate medical care under the Eighth Amendment.⁶⁶ Prisoners, who are at the mercy of the state for medical care, are entitled to a certain level of healthcare provided by the state; the state's failure to provide that level of care may give rise to a claim for a violation of the

⁵⁹ *Stenberg*, 530 U.S. at 930-31 (explaining that "a State cannot subject women's health to significant risks . . . where state regulations force women to use riskier methods of abortion").

⁶⁰ *Gonzales*, 550 U.S. at 156.

⁶¹ *Id.* at 161.

⁶² *Id.* at 165-68. Presumably, the as-applied challenge would bring specific types of health conditions before the Court to be evaluated on an individual basis.

⁶³ *Stenberg*, 530 U.S. at 938.

⁶⁴ *Gonzales*, 550 U.S. at 163-67.

⁶⁵ *Id.* at 167-68 (discussing future as-applied challenges).

⁶⁶ I would like to thank Neil Siegel for suggesting this line of analysis.

Eighth Amendment right against cruel and unusual punishment.⁶⁷ The Supreme Court has made it clear that the standard under the Eighth Amendment is a demanding one, requiring that the plaintiff demonstrate the government's "deliberate indifference" to the prisoner's "serious medical needs."⁶⁸

The Ninth Circuit has interpreted this standard to mean something more serious than "routine discomfort" must be present; moreover, the failure to provide treatment must be likely to "result in further significant injury or the 'unnecessary and wanton infliction of pain.'"⁶⁹ The Ninth Circuit's standard encompasses "an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain."⁷⁰ Similarly, several other circuits define a "serious medical need" as "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."⁷¹ It seems clear that this definition includes mental health needs.⁷² This definition does not, of course, describe the level of services that must be provided in response to medical need;⁷³ it does, however, provide a description—much like that found in *Gonzales* and *Stenberg*⁷⁴—of when medical necessity exists and the right to medical treatment is triggered.

5. Summary

This brief survey of judicial and non-judicial attempts to define terms such as "health" and "medical necessity" for legal purposes has resulted in a widely divergent set of concepts.⁷⁵ On one pole are definitions, such as those found in the Eighth Amendment and "partial-birth abortion" contexts, that are narrowly concerned with protecting an individual's physical and perhaps mental well-being from severe, state-imposed harms. Those definitions might relate most closely to the concept of medical necessity. On the other pole are definitions, such as those in the human rights context and in *Roe* and *Doe*, that recognize health as a broad concept and medicine as a holistic practice, affecting not just physical and mental well-being in the strictest sense, but also the individual's social state. Arguably, this latter

⁶⁷ *Estelle v. Gamble*, 429 U.S. 97 (1976). Of course, the claim is under the Eighth Amendment if the prisoner is in federal custody, and under the Fourteenth Amendment if the prisoner is in state custody.

⁶⁸ *Id.* at 106.

⁶⁹ *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992).

⁷⁰ *Id.* at 1059-60.

⁷¹ *Gutierrez v. Peters*, 111 F.3d 1364, 1373 (7th Cir. 1997) (quoting *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D.N.H. 1977)) (citing *Mahan v. Plymouth Cnty. House of Corr.*, 64 F.3d 14, 18 (1st Cir. 1995); *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir.1987); *Riddle v. Mondragon*, 83 F.3d 1197, 1202 (10th Cir. 1996); *Sheldon v. Pezley*, 49 F.3d 1312, 1316 (8th Cir. 1995); *Hill v. Dekalb Reg'l Youth Det. Ctr.*, 40 F.3d 1176, 1186 (11th Cir. 1994)).

⁷² *See, e.g.*, *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995).

⁷³ *Cf. id.* at 1301 (noting the government's objection that the Ninth Circuit's standard does not specify a "specific level of services" to be provided in order to avoid Eighth Amendment liability).

⁷⁴ Interestingly, however, the circuits are split on whether an elective abortion is a serious enough medical need to trigger Eighth Amendment protections. Avalon Johnson, Note, *Access to Elective Abortions for Female Prisoners Under the Eighth and Fourteenth Amendments*, 37 AM. J.L. & MED. 652, 659-67 (2011).

⁷⁵ *See also* Stephen G. Gilles, *Roe's Life-or-Health Exception: Self-Defense or Relative-Safety?*, 85 NOTRE DAME L. REV. 525, 529 (2010) (describing the Supreme Court's "vaccillat[ion]" between different definitions of the health exception in the abortion case-law).

definition plays a role in the ACA's concept of "essential health benefits" as including "habilitation," which has a clear social element. Finally, it is important to recall that medical necessity is, on the ground, often defined simply as that which is likely to bring more benefit than harm for the patient—or at least enough so to justify the cost.⁷⁶

Of course, it is not entirely surprising that decision-makers reach different definitions of the constellation of concepts such as "health," "medical necessity," and "essential health benefits," given the wide variety of contexts in which the terms are used and the multitude of different purposes for which they are mobilized. It is entirely reasonable that medical necessity might be defined more narrowly by a court deciding about women's access to a particular method of later-term abortion, but more broadly by a document that sets forth entitlements of a comprehensive government benefit program. The protean nature of the term is nonetheless noteworthy—and perhaps more importantly, as this Article argues below, it may prove to be constitutionally problematic.

B. THE POLITICS OF "HEALTH"

Commentators have acknowledged the fraught nature of this definitional undertaking. Indeed, the IOM report on essential health benefits itself states that "the determination of the EHB [essential health benefits] is a politically and socially charged endeavor."⁷⁷ The concepts of healthcare and medical necessity implicate particularly thorny debates when they are invoked in relation to volatile issues such as women's reproductive healthcare. Moreover, because of its ill-defined and inherently malleable nature, the concept of medical necessity is often a mask for decision-making that is primarily based on non-medical grounds, including moral judgments, as well as more mundane concerns about value and cost.

In a recent book, Professor Gregg Bloche argues that judgments about "medical necessity" are often a covert form of healthcare rationing by insurance companies.⁷⁸ Insurance companies, being naturally unable or unwilling to pay for all of the healthcare that may be desired by a consumer or a physician, must make judgments about what they will and will not pay for. They thus make decisions about allocation of healthcare dollars and resources based on judgments—often reasonable but not always transparent—not about the beneficial or non-beneficial nature of the treatment at issue, but rather about whether the cost is justified by the additional "quality-adjusted life years" saved.⁷⁹

In some unusual but highly salient cases, political judgments have infected medical decision-making in a very direct way. Bloche points to such examples as the Bush administration's attempts to minimize payments for mental health services to veterans suffering from post-traumatic stress disorder by influencing the frequency with which the condition was diagnosed.⁸⁰ But more generally, he argues, "[a]ll medical diagnosis is political," in that it "defines personal characteristics—signs and symptoms—as both undesirable ('pathological') and beyond the scope of one's

⁷⁶ BLOCHE, *supra* note 19, at 24; INST. OF MED., *supra* note 2, at 5-28.

⁷⁷ INST. OF MED., *supra* note 2, at 8-5.

⁷⁸ BLOCHE, *supra* note 19, at 23.

⁷⁹ *Id.* at 40. *See generally id.* at 23-40.

⁸⁰ *Id.* at 67-70.

personal responsibility.”⁸¹ Labeling something as a medically treatable pathology, Bloche explains, “mobilizes social resources (public and private insurance) . . . , and it excuses people from myriad social obligations.”⁸² Examples of the political content of medical diagnoses abound. One need only think of the appearance and disappearance of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders as an identified mental illness, or of the controversy over whether deafness should be thought of as a sometimes-treatable disability or as a cultural characteristic to be embraced.⁸³ Bloche also points to the movements to label obesity or short stature as conditions requiring medical intervention.⁸⁴ In the former case, labeling obesity as a disease rather than a sign of personal weakness or a lifestyle choice involves judgments about culture, personal responsibility, and even free will.⁸⁵ Likewise, treating short stature as a medical condition involves making certain judgments about the importance of aesthetics, the relevance of social well-being to “health,” and the role of hardship in building individual moral character.⁸⁶ It is, simply put, impossible to judge whether a symptom is unusual or pathological without some reference to what is normal, and it is impossible to determine normalcy without some reference to social, cultural, and moral values.⁸⁷

The definition of “health” is also political in the sense that, in an age of rising costs and limited funds, it unavoidably involves judgments about the proper or fair allocation of scarce resources. Indeed, one commentator has characterized as “[t]he doctor’s dilemma” the inevitable tension between defining necessary or appropriate care in terms of the “primacy of patient welfare” and ensuring the equitable allocation of healthcare resources.⁸⁸ Comparing the American healthcare system to those of countries in which healthcare is universal but supported by a limited, defined budget, Victor Fuchs argues that the latter is a superior way of ensuring physicians act as stewards of those healthcare resources.⁸⁹ “In short,” he asserts, “when physicians are collectively caring for a defined population within a fixed annual budget, it is easier for the individual physician to resolve the dilemma in

⁸¹ *Id.* at 81.

⁸² *Id.*

⁸³ See generally Charles Silverstein, *The Implications of Removing Homosexuality from the DSM as a Mental Disorder*, 38 ARCHIVES SEXUAL BEHAVIOR 161 (2009) (describing the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* and noting the “political as well as professional” issues involved); Alicia Ouellette, *Hearing the Deaf: Cochlear Implants, the Deaf Community, and Bioethical Analysis*, 45 VAL. U. L. REV. 1247 (2011).

⁸⁴ BLOCHE, *supra* note 19, at 85-88.

⁸⁵ *Id.*

⁸⁶ *Id.* (“We can’t answer these questions without rendering judgments about rival aesthetics, public values, and what we should and shouldn’t accept as fate.”).

⁸⁷ Other examples might include the distinctions among circumcision, female genital cutting, and normalizing surgery on intersex infants. Though these procedures are distinct in terms of their level of invasiveness, the medical and social understandings of them are also driven by their cultural and religious meanings. See generally Cheryl Chase, “Cultural Practice” or “Reconstructive Surgery”? *U.S. Genital Cutting, the Intersex Movement, and Medical Double Standards*, in GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD 126 (Stanlie M. James & Claire C. Robertson eds., 2002); Nancy Ehrenreich & Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of “Cultural Practices,”* 40 HARV. C.R.-C.L. L. REV. 71 (2005); Ross Povenmire, *Do Parents Have the Legal Authority to Consent to the Surgical Amputation of Normal, Healthy Tissue from Their Infant Children?: The Practice of Circumcision in the United States*, 7 AM. U. J. GENDER SOC. POL’Y & L. 87, 113-19 (1999) (comparing circumcision and female genital mutilation).

⁸⁸ Victor R. Fuchs, *The Doctor’s Dilemma—What Is “Appropriate” Care?*, 365 NEW ENG. J. MED. 585, 586 (2011).

⁸⁹ *Id.* at 587.

favor of cost-effective medicine. That becomes ‘appropriate’ care.”⁹⁰ In other words, the necessity of taking cost into account is inherent in the enterprise of medicine, and this political dimension of the undertaking cannot be avoided by simply delegating the decision-making to a multitude of private actors—namely, patients, doctors, and insurance companies.

Perhaps the most obviously politicized area of healthcare, however, is reproductive healthcare. Debates have long raged, and continue to rage, over the respective roles of patients, physicians, legislators, regulators, and judges in reproductive decision-making, and American society currently lacks consensus over the role of reproductive health services within the broader statutory and contractual entitlements to healthcare. Indeed, long before the furor erupted over the Obama administration’s recent announcement that it would require most private insurers to cover prescription contraceptives, courts and commentators debated whether contraceptives were part of healthcare and whether insurers’ refusal to cover them constituted sex discrimination.⁹¹ One Washington district court, considering an employer’s argument that contraceptives are not healthcare because pregnancy is not a disease, asserted that “the availability of affordable and effective contraceptives is of great importance to the health of women and children because it can help to prevent a litany of physical, emotional, economic, and social consequences.”⁹² Thus embracing a broad understanding of health that stretches beyond mere physical well-being, the court added: “Identifying and obtaining an effective method of contraception is a primary healthcare issue throughout much of a woman’s life and is, in many instances, of more immediate importance to her daily healthcare situation than most other medical needs.”⁹³

Similarly, debates have persisted over whether abortion constitutes a form of healthcare, and, if so, what sorts of medical or other factors may be taken into account by those making the abortion decision. In particular, there is longstanding disagreement over the nature of “therapeutic” abortion, as the political controversy over “partial-birth” abortion and the resulting divided Supreme Court opinions demonstrate.⁹⁴ Yet, one study of hospital abortion committees, which were charged with deciding when therapeutic abortions would be permitted in the decades prior to *Roe v. Wade*, indicates that the politically charged nature of the issue goes back much further than the late-1990s.⁹⁵ The debate among physicians over medical

⁹⁰ *Id.*

⁹¹ See, e.g., Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363 (1998) (arguing that Title VII requires employers to offer insurance for contraceptives); EEOC Comm’n Decision on Coverage of Contraception, Dec. 14, 2000, <http://www.eeoc.gov/policy/docs/decision-contraception.html>. Compare *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1271 (W.D. Wash. 2001) (holding that employers are required to provide insurance coverage for prescription contraceptives if they offer otherwise comprehensive coverage of preventive drugs and services), with *In re Union Pac. R.R. Emp’t Practices Litig.*, 479 F.3d 936, 944-45 (8th Cir. 2007) (holding that the refusal to cover contraceptives did not violate Title VII).

⁹² *Erickson*, 141 F. Supp. 2d at 1273.

⁹³ *Id.* at 1273-74.

⁹⁴ See *supra* notes 58 and accompanying text; see also Gail Glidewell, Note, “*Partial Birth*” *Abortion and the Health Exception: Protecting Maternal Health or Risking Abortion on Demand?*, 28 FORDHAM URB. L.J. 1089, 1089 (2001) (describing the political rhetoric surrounding the procedure and asserting that it was “one of the most contentious constitutional issues” of its time).

⁹⁵ Ricki Solinger, “*A Complete Disaster*”: *Abortion and the Politics of Hospital Abortion Committees, 1950-1970*, 19 FEMINIST STUD. 241 (1993). Historian Leslie Reagan has documented the political overtones to the debate over the legality and moral permissibility of abortion in the

indications for abortion was characterized by widespread internal disagreement and “reflect[ed] broader cultural attitudes toward women, mothers, babies, and pregnancy in the postwar era.”⁹⁶ Indeed, arguably, the permissibility of therapeutic abortion to preserve the woman’s life or health turned into a requirement imposed upon the doctor “to make sure that the woman stayed moral,” rather than that she stayed healthy, by policing the reasons that entitled the woman to an abortion.⁹⁷

III. CONSTITUTIONAL ANALYSIS AND CONSTITUTIONAL SPECULATION

Even if the project of defining medical necessity is riddled with uncertainty and contestable political judgments, however, it is not automatically entwined with constitutional concerns. It may be politically, economically, or ethically problematic to define “medical necessity” in a particular way—in general, or in an individual case—but that does not make it unconstitutional.

There are, however, several respects in which a government program regulating healthcare might implicate individuals’ constitutional rights. A governmental choice to deny certain important healthcare to individuals as medically unnecessary, without notice or an opportunity to contest the finding, might constitute a violation of procedural due process.⁹⁸ A decision to permit some individuals but not others to access a particular form of healthcare could also implicate the Equal Protection Clause.⁹⁹ In addition, a decision by the government to criminalize or otherwise take certain forms of safe and effective healthcare off the table completely may implicate substantive due process rights, or the so-called “negative right to health.” This last one is the focus of this Article.

There are two barriers to recognizing constitutional claims of individuals seeking healthcare under the ACA, however. First, it is difficult to locate state action in the context of decisions about coverage and medical necessity that will be made primarily by private insurers rather than state actors. Second, the Act is in large part a governmental spending program—a subsidy, rather than a direct regulation of individuals’ healthcare options. Existing precedent clearly establishes that the government may choose to subsidize some things and not others, and that the failure to subsidize the exercise of a constitutional right is not the same as imposing a penalty on the exercise of that right.

nineteenth century, as well. *See, e.g.*, LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973, at 1-18 (1997).

⁹⁶ Solinger, *supra* note 95, at 242.

⁹⁷ *Id.* at 264.

⁹⁸ The ACA requires insurers to provide a process for appealing coverage determinations, however. ACA, Pub. L. No. 111-148, § 2719, 124 Stat. 119 (2010) (codified at 42 U.S.C.A. § 18022(b)(1) (West 2012)).

⁹⁹ *Cf. Vacco v. Quill*, 521 U.S. 793, 807-09 (1997) (recognizing the equal protection claim that a ban on assisted suicide discriminates between those who are terminally ill but not on life support and those who are on life support and can hasten death by removing devices such as feeding tubes, but applying only rational basis review and concluding that the distinction is justified). The ACA contains anti-discrimination provisions. ACA § 1557.

A. THE NEGATIVE RIGHT TO HEALTH

Several scholars, including myself, have postulated the existence of a sort of “negative right to health.”¹⁰⁰ In a 2007 article, I suggested that there was a doctrinal thread running through the Supreme Court cases dealing with access to reproductive healthcare, refusal of medical treatment, and even mandatory vaccination suggesting that individuals have a constitutional right to protect their health.¹⁰¹ This right, moreover, may include a right both to refuse care and to access care—not at government expense, but without government interference.¹⁰² Drawing on the case law and scholarship indicating that there is a “freedom of health” that encompasses, to some extent, a right to access medical treatment without government interference, Professor Abigail Moncrieff has also argued that “[a]s an aspect of general bodily autonomy, the freedom to reject care has gained formal recognition in a handful of cases, and as a necessary element of reproductive rights, the freedom to obtain treatment has been an important, though informal, player in several cases.”¹⁰³

The requirement of a health exception for prohibitions on post-viability abortion is perhaps the most obvious example of the Supreme Court’s recognition of the negative right to health. From *Roe v. Wade* onward, the Supreme Court has made it clear that the government may regulate and even prohibit abortions after the fetus is viable, but it must make exceptions for abortions that are “necessary, in appropriate medical judgment, for the preservation of the life *or health* of the mother.”¹⁰⁴ Professor Eugene Volokh has argued that the right to a post-viability health exception represents a right that is separate from the abortion right itself—a right to “medical self-defense.”¹⁰⁵ Although this right has not yet been extended to other contexts, “the right can’t logically be limited to situations in which the defensive procedure is abortion and rejected,” for example, “when a woman needs to defend herself using experimental drugs or an organ transplant.”¹⁰⁶

Indeed, several Supreme Court cases recognizing the necessity of a “health exception” to abortion regulations seem unexplainable except by reference to such a right.¹⁰⁷ In *Thornburgh v. American College of Obstetricians & Gynecologists*,¹⁰⁸ for example, the Supreme Court emphasized that states cannot regulate abortion in such a way as to impose health risks on the woman, nor can it force a trade-off of the woman’s health against the fetus’s.¹⁰⁹ This is the case, the Court held, even if the

¹⁰⁰ I describe the right as a “negative right to health” in Hill, *Reproductive Rights*, *supra* note 11, at 503, but that article draws on an earlier article describing the same right as a “right to make medical treatment decisions.” See B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277 (2007) [hereinafter Hill, *Tale of Two Doctrines*]. For other scholarship making a similar argument, see Abigail Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2235-38 (2011); John A. Robertson, *Controversial Medical Treatment and the Right to Health Care*, 36 HASTINGS CENTER REP. 15, 15 (2006); Volokh, *supra* note 56, at 1824 (describing a constitutional right to “medical self-defense”).

¹⁰¹ Hill, *Tale of Two Doctrines*, *supra* note 100, at 324-45.

¹⁰² *Id.* at 341-45.

¹⁰³ Moncrieff, *supra* note 100, at 2226.

¹⁰⁴ *Roe v. Wade*, 410 U.S. 113, 165 (1973) (emphasis added).

¹⁰⁵ Volokh, *supra* note 56, at 1826. Volokh continues: “Postviability abortions cannot be distinguished on the ground that they involve the woman’s reproductive choice. After viability, the time for that choice has passed, and the right to get a therapeutic abortion is a consequence of the woman’s medical self-defense right, not her abortion-as-choice right.” *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 1827.

¹⁰⁸ *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986).

¹⁰⁹ *Id.* at 769.

fetus is viable—that is, even if the state’s interest in potential life is compelling.¹¹⁰ Indeed, the Court in *Stenberg v. Carhart* echoed the *Thornburgh* holding when it decided that a state ban on a particular abortion procedure was unconstitutional if the permitted procedure was riskier to the woman’s health in a given case.¹¹¹ Indeed, *Stenberg* is a particularly strong example of the negative right to health because it involves the question of whether the state can require a particular *procedure* for an abortion that will take place in any case. It is, fundamentally, not a case about the circumstances under which the state can act to protect potential life, but rather about how the state can regulate surgical procedures in ways that impact a woman’s health and bodily integrity. Moreover, although the Court in *Gonzales v. Carhart* cut back in several respects on the scope and enforceability of the right at issue in *Stenberg*, the *Gonzales* Court nonetheless preserved the essential holding that government regulations of abortion methods—and, presumably, *a fortiori* of any other surgical techniques—are unconstitutional if they impose substantial health risks on the woman.¹¹²

Outside the abortion context, the Supreme Court has recognized a related right to refuse medical treatment.¹¹³ In addition, it implied in *Jacobson v. Massachusetts* that, while the government may impose compulsory vaccination requirements, that requirement, too, must be subject to a health exception if it would be harmful to the health of a particular individual.¹¹⁴ And lower courts have occasionally drawn on substantive due process doctrine to find that individuals possess a right to access particular forms of healthcare, such as acupuncture¹¹⁵ and experimental cancer drugs.¹¹⁶ At the same time, numerous courts have also denied the existence of a constitutional right to access particular medical interventions.¹¹⁷ As several commentators (including myself) have argued, however, there is a logical and doctrinal basis for asserting that substantive due process protects, at least to some extent, the right of individuals to access medical care to protect their health.¹¹⁸ There is, in other words, a negative right to health.

Of course, “[t]o recognize that individuals possess a constitutional right to protect their health by making autonomous medical treatment decisions is not, by any means, to decide that the right is a trump card and that states are powerless to withhold drugs from the market, regulate the practice of medicine, or prosecute quacks;” it is simply to say that a fundamental right is implicated by regulations affecting individual healthcare choices and that such regulations must be subject to heightened scrutiny.¹¹⁹ Moreover, although there is a firm basis for suggesting that a

¹¹⁰ *Id.*

¹¹¹ *Stenberg v. Carhart*, 530 U.S. 914, 931 (2000); see also Hill, *Reproductive Rights*, *supra* note 11, at 532-33.

¹¹² *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007). This argument is made as well in Hill, *Reproductive Rights*, *supra* note 11, at 532-33.

¹¹³ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278-79 (1990).

¹¹⁴ *Jacobson v. Massachusetts*, 197 U.S. 11, 38-39 (1905).

¹¹⁵ *Andrews v. Ballard*, 498 F. Supp. 1038, 1048 (S.D. Tex. 1980).

¹¹⁶ *Abigail Alliance for Better Access to Dev. Drugs v. von Eschenbach*, 445 F.3d 470, 472 (D.C. Cir. 2006), *rev’d en banc*, 495 F.3d 695 (D.C. Cir. 2007).

¹¹⁷ See, e.g., *Carnohan v. United States*, 616 F.2d 1120 (9th Cir. 1980); *Rutherford v. United States*, 616 F.2d 455 (10th Cir. 1980); *Kuromiya v. United States*, 37 F. Supp. 2d 717 (E.D. Pa. 1999).

¹¹⁸ See *Volokh*, *supra* note 56, at 1826; Hill, *Reproductive Rights*, *supra* note 11, at 531; John A. Robertson, *Embryo Culture and the “Culture of Life”*: *Constitutional Issues in the Embryonic Stem Cell Debate*, 2006 U. CHI. LEGAL F. 1.

¹¹⁹ Hill, *Tale of Two Doctrines*, *supra* note 100, at 331-32.

negative right to health has been recognized within abortion jurisprudence, and that that right logically extends to other contexts, there is no clear basis for delineating the scope of that right. The negative right to health, which has not even been recognized as such by the Supreme Court, has no clear contours. It is therefore difficult to say what sort of state-imposed harm or what degree of state-imposed harm is likely to violate that right. “Health,” in this context too, lacks a clear definition.

To summarize, there is arguably a negative right to health that has been recognized in American constitutional jurisprudence—though perhaps not consistently or explicitly so—that subjects government action to heightened scrutiny when it takes certain healthcare options off the table. Such constitutionally problematic regulations may include not only those that force individuals into unwanted medical treatment but also those that interfere with individuals’ access to safe and appropriate medical treatment. Those precedents do not, however, suggest that the government is constitutionally required to subsidize individuals’ medical care. Nor have they drawn a clear line as to what sorts of health risks are problematic.¹²⁰ In other words, they have not, as illustrated in Part II, given a clear interpretation of the meaning of “health” or “medical necessity” for a particular treatment.

B. PENALTIES, SUBSIDIES, AND THE STATE ACTION DOCTRINE

The ACA, of course, famously requires individuals to carry health insurance.¹²¹ It also imposes certain mandates on private employers and insurance companies that almost indisputably benefit individual consumers. Further, the Act expands Medicaid eligibility, thus increasing the number of Americans whose healthcare will be provided by the government.¹²² It does not, however, directly regulate individuals’ healthcare options. Most individuals will continue to carry private insurance provided by their employers, or purchased on the open market or through state-sponsored insurance exchanges.¹²³ Given that the government is not directly involved in the contractual relationship between individuals and their private insurers or physicians, and therefore that state action is lacking, it may, at first glance, be difficult to see how constitutional claims could arise for those individuals. The government’s regulation does not prevent anyone from accessing the healthcare that they may need or desire if they can pay for it with their own funds, nor does it

¹²⁰ See, e.g., Mark S. Stein, *Necessity, Not Autonomy*, 86 TEXAS L. REV. 15, 16-17 (2007) (discussing the content of the negative right to health).

¹²¹ ACA, Pub. L. No. 111-148, § 1501, 124 Stat. 119 (2010) (to be codified at 42 U.S.C. § 18022(b)(1)).

¹²² According to the Congressional Budget Office, the ACA will result in approximately thirty-four million additional insured Americans by 2021. This number includes roughly twenty-four million who will purchase insurance on the exchanges and approximately seventeen million new insureds under Medicaid and the Children’s Health Insurance Program. The total number of forty-one million gaining insurance in these ways is expected to be offset, however, by approximately six million fewer Americans purchasing insurance directly on the individual market and about one million fewer Americans receiving coverage through their employers. CONG. BUDGET OFFICE, CBO’S ANALYSIS OF THE MAJOR HEALTH CARE LEGISLATION ENACTED IN MARCH 2010, at 17 (2011) [hereinafter CBO ANALYSIS] (testimony of Douglas W. Elmendorf, Dir., Cong. Budget Office, before the U.S. H. Comm. on Energy and Commerce, Subcomm. on Health), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf>.

¹²³ *Id.* at 18 tbl.3.

prevent insurance companies from offering benefits above and beyond the minimum essential health benefits, for those consumers who wish to purchase additional coverage.

Even for those individuals who carry Medicaid, constitutional arguments are difficult to come by. As the Supreme Court held decades ago—in cases involving access to abortion, a form of healthcare—there is a difference between a failure to subsidize a constitutional right, which does not constitute a violation of that right, and a penalty on the exercise of a constitutional right, which may constitute a violation. As the Court held in *Maher v. Roe*¹²⁴ and *Harris v. McRae*,¹²⁵ when the government chooses to subsidize childbirth but not abortion—even “medically necessary” abortions—with Medicaid funds, neither the woman’s right to equal protection nor her substantive due process right to choose abortion is violated.¹²⁶

The woman’s right to choose abortion, and possibly her negative right to health, would be implicated if the government had instituted a total prohibition on therapeutic abortion, rather than a simple funding ban. Thus, as the Court explained in *Maher*, “[t]here is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State’s power to encourage actions deemed to be in the public interest is necessarily far broader.”¹²⁷ Analogizing to another constitutional right—the right to direct the education of one’s children—the Court explained that it had never held that the Constitution “established a ‘right of private or parochial schools to share with public schools in state largesse,’” and observed that “[i]t is one thing to say that a State may not prohibit the maintenance of private schools and quite another to say that such schools must, as a matter of equal protection, receive state aid.”¹²⁸ Thus, even assuming—as argued above—that direct regulation of individuals’ healthcare choices may implicate constitutional substantive due process, the failure to subsidize certain healthcare choices through a federal spending program generally does not rise to the level of a constitutional violation.¹²⁹

For those Americans whose insurance will be regulated by the ACA but not directly provided by the government, it appears equally difficult to argue that constitutional rights may be implicated by the government’s decision-making regarding essential health benefits and medical necessity, for at least three reasons. First, the ACA’s decisions regarding medical necessity and essential health benefits impose mandates on insurers, not on individuals. The individual mandate aside, the ACA does very little to direct or constrain individual citizens’ healthcare choices. Second, the ACA acts primarily to impose mandates—in the form of *minimum* requirements—on insurers. These mandates, unlike restrictions on care, tend to benefit consumers by requiring that they have access to a certain level of healthcare

¹²⁴ *Maher v. Roe*, 432 U.S. 464 (1977).

¹²⁵ *Harris v. McRae*, 448 U.S. 297 (1980).

¹²⁶ *Maher*, 432 U.S. at 474, 480; *McRae*, 448 U.S. at 310-11.

¹²⁷ *Maher*, 432 U.S. at 475-76 (footnote omitted).

¹²⁸ *Id.* at 477 (quoting *Norwood v. Harrison*, 413 U.S. 455, 462 (1973)) (internal quotation marks omitted).

¹²⁹ In addition, further difficulties may accompany a challenge to the administration of the Medicaid statute by state entities, such as the requirement of showing that a private cause of action exists. See, e.g., Abigail R. Moncrieff, *The Supreme Court’s Assault on Litigation: Why (and How) it Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2332-34 (2010).

services, while leaving insurers free to cover a broader range of services if they wish. Finally, and relatedly, the ACA does not purport to dictate which forms of healthcare individuals may purchase with their own funds. There is little evidence, therefore, of the sort of governmental coercion or entanglement in individual healthcare decisions that would be required to invoke constitutional protections.

Professor Abigail Moncrieff has nonetheless offered an innovative analysis that suggests one way in which constitutional questions may well arise. In her article, *The Freedom of Health*, she raises the question of whether the ACA's individual mandate might violate the negative right to health found guaranteed by the right to substantive due process.¹³⁰ Although this Article does not focus specifically on the individual mandate, Moncrieff's analysis and conclusion are relevant to the argument presented in this Article.

Considering the implications of the individual mandate for the freedom of health (or in my terminology, the negative right to health), Moncrieff astutely observes:

[Insurance] contracts give insurers . . . discretion under "medical necessity" review to decide whether their insured can buy various kinds of health care with the pool's money. That is, insurance companies today use their contracts to steer individuals towards certain health care consumption decisions, often refusing to cover treatments that they deem ineffective, unnecessary, or even just inordinately costly. . . . If she is required to buy into such a contract, a patient will give up some degree of freedom and autonomy to choose her own care; at a minimum, she will lose some freedom to direct the care that she purchases with the dollars that she has set aside in insurance.¹³¹

Thus, Professor Moncrieff concludes, the requirement of submitting oneself to this sort of medical necessity review—and the reality that most individuals will not be able to access healthcare if their insurance will not pay for it—means that the government is, at the very least, burdening consumers' rights to choose the care they deem appropriate or necessary to protect their own health.¹³² This could (but according to Professor Moncrieff, is not likely to) rise to the level of a violation of the constitutional freedom of health.¹³³

Though my analysis diverges from Professor Moncrieff's somewhat, I agree with her approach in finding the potential for state action through the ACA's subjection of individual healthcare choices to government-sponsored medical necessity review. Indeed, the point can be made even more strongly: though conducted by individual insurers, the medical necessity review under the ACA is *required by* and *governed by* the federal law. The ACA incorporates, in a sense, the private insurers' decision-making and thereby arguably requires those decisions to conform to constitutional norms and requirements.

Still, several critiques may apply to this line of analysis. First, even recognizing that the medical necessity decision-making by private insurers is guided by and required by the ACA, it is not entirely clear that this level of governmental involvement is sufficient to constitute state action for constitutional purposes.

¹³⁰ Moncrieff, *supra* note 100.

¹³¹ *Id.* at 2248.

¹³² *Id.* at 2249-50.

¹³³ *Id.* at 2250.

Indeed, the state action inquiry is notoriously amorphous.¹³⁴ Thus, the Supreme Court has held that simply operating pursuant to a state license and in compliance with a state regulatory scheme does not constitute state action.¹³⁵ Instead, for a private individual or entity to become a state actor, his conduct must be entwined with the state or his business in symbiotic relation with the state.¹³⁶ The mere fact of government regulation—even admittedly extensive government regulation—of private insurers most likely does not transform those insurers into state actors, according to current state action doctrine.

Moreover, even in the absence of the ACA's individual mandate requirement, individuals' healthcare choices are subject to their ability to pay or to locate private insurance. There is no indication, as of yet, that the ACA imposes on private insurers any stricter "medical necessity" limitations than they already impose on their own consumers—and indeed, so far the Obama Administration has demonstrated an intent to maintain the status quo by embracing the existing system of private decision-making. It is difficult to see how replication of the status quo can suddenly constitute a burden on a fundamental right.

Additionally, individuals remain free to purchase healthcare with their own money. The ACA's mandates thus do not restrict individuals' healthcare choices, just as the Hyde Amendment's prohibition on using Medicaid funds for abortions theoretically leaves Medicaid recipients free to access the procedure on their own.¹³⁷ It is true that individuals generally cannot access medical care that their insurance chooses not to cover, and therefore that their negative constitutional right to access care may be, in practical terms, nonexistent. But again, this is true whether or not the government requires individuals to carry insurance. As the Court emphasized in *Maher*, the Constitution is not implicated when the individual's own indigence, rather than government-imposed *obstacles*, prevent her from accessing care.¹³⁸

C. THE POSSIBILITY OF A CONSTITUTIONAL VIOLATION OF THE NEGATIVE RIGHT TO HEALTH UNDER THE ACA

This Article proposes a way in which constitutional requirements may still come to play a role in the future under the ACA. Over the long term, the new role assumed by the federal government in healthcare will likely have two specific effects. First, there will eventually be a massive expansion of the number of individuals who are covered by government healthcare plans.¹³⁹ Second, there will be an increased regulatory role for the federal government in private insurance plans, as the state-sponsored exchanges take on greater and greater significance vis-à-vis healthcare coverage that is obtained in other ways, such as through private employers.¹⁴⁰

¹³⁴ See, e.g., Erwin Chemerinsky, *Rethinking State Action*, 80 NW. U. L. REV. 503, 503-04 (1985) ("There still are no clear principles for determining whether state action exists.").

¹³⁵ *Moose Lodge No. 107 v. Irvin*, 407 U.S. 163 (1972).

¹³⁶ See, e.g., *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 725 (1961).

¹³⁷ *Maher v. Roe*, 432 U.S. 464, 474-75 (1977).

¹³⁸ See *id.* at 480.

¹³⁹ CBO ANALYSIS, *supra* note 122, at 17-18; cf. Richard Kronick & Todd Gilmer, *Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?*, 21 HEALTH AFF. 225, 235-37 (2002) (concluding, with some uncertainty, based on evidence from four states, that expansion of public health insurance programs may result in "crowding out" of private insurance, meaning that some of those newly insured individuals would have otherwise been covered by private insurance but for the public programs).

¹⁴⁰ CBO ANALYSIS, *supra* note 122, at 17-18.

Though not certain to occur, there is reason to believe that both outcomes are likely, and possibly intended, long-term effects of the healthcare reform.

As the government's role as both provider and regulator of healthcare becomes more important and extensive, there will be less room for private insurers to make their own decisions about coverage and medical necessity. Even in the absence of direct federal mandates pertaining to coverage, private insurers will most likely come to offer, almost exclusively, plans that meet the requirements of the exchanges, and it would not be surprising if determinations about medical necessity, made under standards set forth by the government and subject to external review, become somewhat uniform on a national level. Indeed, many would see such a result as desirable.¹⁴¹ The government's definition of essential health benefits may thus become both a floor and a ceiling.¹⁴² Indeed, as some health policy analysts have argued in a similar context, "if certain types of products are excluded in certain large markets,"—such as Medicaid or even simply the exchange-approved plans, which may exclude certain benefits because they are not required to offer them—"over time the market as a whole for a product can be expected to shift, as manufacturers move to accommodate their product to reflect the regulated design."¹⁴³ It may, for example, be more efficient for insurers to design all insurance plans so that they meet the minimum requirements—and only the minimum requirements—of a particular state's definition of essential health benefits. In addition, since essential health benefits are defined in part by what certain large, "benchmark" plans choose to cover,¹⁴⁴ insurers may well end up dictating the content of those essential benefits across states.

It may be reasonable to believe that at some point, the government's role in the healthcare marketplace will become so significant that the government cannot be treated as one actor among many private actors, free to subsidize or deny subsidies to various activities as it chooses. Instead, the government's role as healthcare provider and regulator may be analogized to that of a government speaker who so dominates the marketplace with its own message that it crowds out almost all private speech. At such a point, many commentators agree, constitutional guarantees of freedom of speech would be implicated by the actions of the government speaker.¹⁴⁵ So, too, might the negative right to health become implicated if the government so dominates the healthcare market that private decision-making about medical necessity becomes essentially impossible. In other words, at such a point in time,

¹⁴¹ Jennifer Prah Ruger, *Fair Enough? Inviting Inequities in State Health Benefits*, 366 NEW ENG. J. MED. 681, 682 (2012) (arguing that differences in state-mandated health benefits will result in inequalities and that, instead, everyone should "have access to the same high-quality goods and services" in accordance with principles of medical necessity, "within the scope of national standards").

¹⁴² See, e.g., Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 266 (2010) (suggesting that "[t]he general rule of 'federal floor, not state ceiling' may be tested in the area of health benefits").

¹⁴³ SARA ROSENBAUM ET AL., AN ANALYSIS OF THE IMPLICATIONS OF THE STUPAK/PITTS AMENDMENT FOR COVERAGE OF MEDICALLY INDICATED ABORTIONS 5 (2009), available at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_FED314C4-5056-9D20-3DBE77EF6ABF0FED.pdf.

¹⁴⁴ See *supra* note 4 and accompanying text.

¹⁴⁵ MARK YUDOF, WHEN GOVERNMENT SPEAKS 158-73 (1983); Steven Shiffrin, *Government Speech*, 27 UCLA L. REV. 565, 595 (1979).

one might wonder whether the distinction between government subsidy and government burden remains tenable and meaningful.

Thus, as Mark Yudof has suggested in the government speech context, although the government may have particular interests in speaking in various contexts, a functional First Amendment analysis would have to consider the possibility that government will distort the marketplace of ideas (and hence individuals' thinking about an issue), as well as "the degree to which the government has captured the audience," among other factors.¹⁴⁶ In the healthcare context, advocates might one day argue that the government has imposed a distorted set of healthcare options on an essentially captive audience.

Indeed, a similar issue arose in Canada, in the case of *Chaoulli v. Québec*.¹⁴⁷ In *Chaoulli*, the plaintiff challenged a Québec law prohibiting private insurance and requiring individuals to carry only public insurance. The law meant that individuals were forbidden to pay out-of-pocket for health care they desired. In a 4-3 decision, the Canadian Supreme Court held that this legislation was unconstitutional. Though there was no majority rationale, the two majority opinions saw the regulation as impermissibly interfering with individuals' right to seek healthcare to protect themselves from bodily harm.¹⁴⁸ Though such a scenario—a prohibition on all private insurance—is certainly not contemplated by the ACA,¹⁴⁹ the extensive degree of government involvement in providing and regulating health insurance that may eventually occur due to the ACA could have greatly similar effects.

Finally, this theory is connected to the problem of defining health and medical necessity—and in particular, for defining those terms for constitutional purposes. As noted above, although the Supreme Court has had occasion to consider the meaning of "health" and "medical necessity" in the abortion context, in cases that appear to implicate the negative right to health to a greater or lesser degree, it has not arrived at a settled definition. It has drawn on broader and narrower definitions, suggesting sometimes that the right to make medical treatment decisions broadly includes the right of patients to decide autonomously and in consultation with their physicians on appropriate treatment, and at other times intimating that the only right at issue is a narrow one to avoid significant state-imposed health risks or serious state-imposed physical harm.¹⁵⁰ To date, the Supreme Court has not decided a substantive due process case relying on an explicit and general negative right to health. Its strongest and most detailed discussions of the issue appear in the abortion jurisprudence. As the ACA expands the role of the government in providing and regulating individuals' healthcare, however, and as the negative right to health may come to take on more prominence for a wider swath of Americans, the definition of health will take on more significance.

Though many medical interventions may remain uncontroversial, some will certainly raise political concerns, and some decision-making might implicate the right to protect one's health. For example, a decision not to cover bariatric surgery for obese individuals may implicate the right to health. Such a claim obviously

¹⁴⁶ YUDOF, *supra* note 145, at 168-69.

¹⁴⁷ *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791 (Can.).

¹⁴⁸ See generally Hill, *Reproductive Rights*, *supra* note 11, at 522-24.

¹⁴⁹ In fact, some estimates find that the number of individuals insured through their employers will remain roughly the same after the ACA comes into full effect. See, e.g., MATTHEW BUETTGENS, BOWEN GARRETT & JOHN HOLAHAN, AMERICA UNDER THE AFFORDABLE CARE ACT 10 (2010), available at <http://www.rwjf.org/files/research/71555.pdf>.

¹⁵⁰ See generally *supra* Part III.

depends on viewing obesity as a disease rather than a lifestyle choice, and on showing that bariatric surgery is “medically necessary.” It immediately becomes clear, therefore, that the definitions of “health” and “illness,” as well as “medical necessity,” with all their cultural and political dimensions, will be implicated in such a claim. Similarly, coverage for arguably cosmetic procedures such as microtia repair may become another flashpoint.

While it appears that the ACA will not extend coverage requirements to therapeutic abortion, in any form, any time soon,¹⁵¹ the theory set out in this Article may well give reproductive rights advocates new ammunition for attacking this sort of line-drawing. If the ACA’s regulatory impact is so extensive that it essentially terminates the market for private insurance for medically necessary abortions, plaintiffs may well have an argument that this new burden is more substantial and more constitutionally significant than the burden of Medicaid non-subsidy, which the Supreme Court dismissed in *Maher v. Roe* and *Harris v. McRae*.¹⁵²

Other issues may arise in the reproductive health context as well. For example, it is conceivable that states could outlaw coverage for prenatal genetic testing or counseling, on the theory that it is likely to lead to abortion.¹⁵³ Another imaginable scenario is that insurance companies will decline to provide coverage for vaginal birth after a first child is born through caesarean section.¹⁵⁴ If governmental regulations end up making these safe and legal medical services unavailable for all intents and purposes, courts may one day decide that women’s rights to procreative autonomy and bodily integrity are implicated.

Finally, medical marijuana may also become the subject of negative right to health claims. Several states have legalized its use, when sanctioned by a doctor’s diagnosis and supervision.¹⁵⁵ Though cannabis is not currently approved by the FDA, and therefore is not generally covered by insurers, it is plausible to suggest that constitutional issues might be raised, eventually, if the federal regulations either forbid coverage for cannabis, or result in private insurers’ refusal to cover it.¹⁵⁶

¹⁵¹ The ACA explicitly excludes abortion from the definition of “essential health benefits.” ACA, Pub. L. No. 111-148, § 1303(b), 124 Stat. 119 (2010) (to be codified at 42 U.S.C. § 18022(b)(1)). In addition, states may prohibit insurance companies that offer plans on state-sponsored exchanges from covering abortion. *Id.* § 1303(a).

¹⁵² The ACA contains a provision allowing states to prohibit the sale of insurance for abortions on state-sponsored exchanges and excluding abortion from the definition of essential health benefits. *Id.* § 1303(a), 1303(b)(1)(A). In addition, it imposes extremely stringent requirements regarding the segregation of funds by any qualified health plan seeking to offer insurance for abortions other than those for which federal funding is permitted under the Hyde Amendment (such as lifesaving abortions). *Id.* § 1303(b).

¹⁵³ See, e.g., John A. Robertson, *Abortion and Technology: Sonograms, Fetal Pain, Viability, and Early Prenatal Diagnosis*, 14 U. PA. J. CONST. L. 327, 377 (2011).

¹⁵⁴ See generally Jamie R. Abrams, *From “Barbarity” to Regularity: A Case Study of “Unnecesarean” Malpractice Claims*, 63 S.C. L. REV. 191, 227-34 (2011).

¹⁵⁵ Sixteen states and the District of Columbia have legalized medical marijuana. *Medical Marijuana*, PROCON.ORG, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881> (last visited Feb. 15, 2012).

¹⁵⁶ *But cf.* *United States v. Cannabis Cultivator’s Club*, No. C 98-0085 CRB, 1999 WL 111893, at *2-3 (N.D. Cal. Feb. 25, 1999) (rejecting the plaintiffs’ claims of a substantive due process right to access medical marijuana).

IV. CONCLUSION

This Article has not aimed to define the term “health,” of course, but simply to sketch out some of the important constitutional questions that may turn on such a definition. The nature and extent of individuals’ right to protect their health under the Constitution may pertain to a wide variety of healthcare choices and, particularly, whether individuals have a right to a wide range of healthcare options, or only to resist governmental decisions that take the safest and most efficient options off the table. It will impact whether social and cultural factors may be taken into account, or only narrowly defined “medical” ones.

At a minimum, the possibility of a new constitutional claim for violation of the negative right to health may have one positive effect. The existence of such a claim may force the debate about the meaning of “health” out of the shadows and into a more deliberative forum. That forum would of course be the courts, which may or may not, however, be the ideal place for it.¹⁵⁷ Indeed, though little is certain about where the debate will end up, it seems clear that the government will not be able to avoid the issue forever.

¹⁵⁷ One might argue, for example, that legislatures are more competent than judges at making sensitive, fact-intensive decisions such as those that may be required in the context of healthcare policy and allocation of healthcare resources. At the same time, there is an argument to be made that judges are better suited to make decisions about individual healthcare entitlements. I discuss this issue at greater length in Hill, *Tale of Two Doctrines*, *supra* note 100, at 332-41.