

# STATE CONSTITUTIONALISM AND THE RIGHT TO HEALTH CARE

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## ABSTRACT

*This Article examines state constitutions and health care rights. Notably, close to a third of states' constitutions recognize health while the U.S. Constitution contains no reference. Ample scholarly commentary exists on the absence of a right to health care under the U.S. Constitution but little attention has been paid to state constitutional law. This Article begins by explaining the absence of a federal right and the rationale for looking to state constitutional protections for health. The Article then provides a comprehensive survey of state constitutional provisions and judicial decisions enforcing or interpreting them. The survey reveals certain common themes and limits, which the Article catalogues and analyzes. The conclusion is that state constitutions, although providing stronger textual support for health than the U.S. Constitution, do not, when applied, provide significantly greater guarantees. Nevertheless, state constitutional recognition of health, as well as proposed state constitutional amendments that would expressly recognize health rights, serve as important catalysts for federal and state legislation.*

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## INTRODUCTION

Health care policymaking is currently focused on federal reform. In crafting the legislation, lawmakers are considering a wide range of proposals to address myriad shortcomings of the current United States health care system, including rising numbers of uninsured patients, rising health care costs, lack of access, and limited accountability. The merits and detriments of the current system stem from the particular public-private combination of health care delivery. On the public side, large government programs, at both the state and federal level, provide health care to significant segments of the population. On the private side, commercial health insurers sell policies to groups and individuals who elect to purchase them. Competitive for-profit and non-profit health care providers deliver the bulk of health care services, including to government program beneficiaries through contractual arrangements. The system is grounded in underlying core American principles of free enterprise and individual rights as well as moral commitment to protect the less fortunate, themes expressed in the U.S. Constitution and separate states' constitutions.

Most everyone agrees that the system needs to be fixed, but there is sharp disagreement about the best approach. The debates inevitably evoke fundamental values and priorities. One issue is whether health care is a right or entitlement that government should provide to citizens, or whether health care should be distributed like any other market-based good or service, based on private choice and ability to pay. Another central theme is federalism and the respective roles of states and the federal government in health care delivery. Previous attempts to enact broad, federal health care reforms met opposition on both fronts. Private industry feared heavy-handed government regulation, and states feared one-size-fits-all solutions.

Adding an essential and previously unheard voice to the health care conversation, this Article examines state constitutional law. Nearly one-third of states recognize “health” explicitly or implicitly in their constitutions. It is instructive to consider the constitutional weight that states give to health, whether elevating health to the status of a fundamental right, assigning state responsibility to guarantee health care to individuals, or merely identifying health as a public concern. Constitutions are charter documents of sovereign states, expressing fundamental, organizing principles and political norms of a wide range of constituents. Therefore, these texts should be carefully considered to inform the health care debate.

Part I of the Article briefly explains the well-settled conclusion that there is no federal right to health and draws support for that conclusion from the constitutional design and federalism policies. Part II provides a comprehensive survey of state constitutional law, identifying thirteen state constitutional provisions expressly mentioning health, as well as additional states that give constitutional weight to health. Part III identifies trends in the state constitutions and suggests reasons underlying the inclusion and exclusion of certain persons and services, and the nature of any health right recognized. Finally, Part IV evaluates state constitutionalism on health, drawing lessons for federal and state health reform.

#### I. ABSENCE OF U.S. CONSTITUTIONAL RECOGNITION OF HEALTH

Proponents of the view that health is a fundamental right that the government should provide to all would need to identify a source of law supporting the claim. The first place to look for such a guarantee would be the highest law in the land, the U.S. Constitution. This Part affirms the conclusion of courts and other scholars that the U.S. Constitution does not explicitly or implicitly recognize health as a right. Several reasons justify that conclusion and point toward state constitutions as more likely sources of fundamental guarantees of health. First, the U.S. Constitution is primarily concerned with protecting individual liberties and freedom from

government intrusion, not specifying governmental duties or obligations. Second, protection of health, safety, and welfare falls squarely in states' Tenth Amendment reserved powers. Finally, states are better suited to address diverse health care needs and competing priorities of their residents.

### A. Absence of Textual Support

The U.S. Constitution contains no express textual reference and has never been interpreted to provide any specific protection for health,<sup>1</sup> despite President Franklin D. Roosevelt's impassioned "Second Bill of Rights" State of the Union Address<sup>2</sup> and recently proposed amendments by Representatives Jesse L. Jackson, Jr. and Pete Stark.<sup>3</sup> The Preamble, a precatory, non-binding provision, lists among the Nation's goals, "promot[ing] the general welfare."<sup>4</sup> Under Article I, Congress is empowered to tax and spend for "the general welfare,"<sup>5</sup> but not health, specifically. The Fifth and Fourteenth Amendments provide that the state shall not deprive persons of "life, liberty, or property, without due process of law."<sup>6</sup> By contrast to several state constitutions, the federal constitution

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<sup>1</sup> See, e.g., TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 24 (2003); George France, *The Form And Content of Federalism: Meanings for Health Care Financing*, 33 J. HEALTH POL. POL'Y & L. 649, 672 (2008) ("There is no generalized right to health care in either the U.S. Constitution or in federal law."); Elinor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 353 (2008) ("The Federal Constitution is silent on the matters of health and health care."); Tom Stacy, *The Courts, the Constitution, and a Just Distribution of Health Care*, 3 KAN. J.L. & PUB. POL'Y 77, 77 (Winter 1993 – 94) ("the Constitution, as interpreted and enforced by the judiciary, has virtually nothing to say" about distribution of health care); Kenneth R. Wing, *The Right to Health Care in the United States*, 2 ANNALS HEALTH L. 161, 161 (1993) ("There is nothing that can be characterized – at least in any general sense – as a constitutional right to health care in the United States.").

<sup>2</sup> President's Message to Congress on the State of the Union, 12 Pub. Papers 41 (Jan. 11, 1944); 90 Cong. Rec. 1, 55, 57 (1944) (expressly including the "right to adequate medical care and the opportunity to achieve and enjoy good health"); see generally CASS R. SUNSTEIN, *THE SECOND BILL OF RIGHTS* (2004); Cass R. Sunstein & Randy E. Barnett, *Constitutive Commitments and Roosevelt's Second Bill of Rights: A Dialogue*, 53 DRAKE L. REV. 205 (2005); see also Kinney, *supra* note 1, at 346 (discussing Roosevelt's Second Bill of Rights).

<sup>3</sup> H.R.J. Res. 30, 110th Cong. (2007) (§ 1: "All persons shall enjoy the right to health care of equal high quality." § 2: "The Congress shall have the power to enforce and implement this article by appropriate legislation."), available at <http://thomas.loc.gov/cgi-bin/query/z?c111:H.J.RES.30>.

<sup>4</sup> U.S. CONST. pmbl.

<sup>5</sup> U.S. CONST. art. 1, § 8, cl. 1 (granting Congress powers to "provide...for the general welfare").

<sup>6</sup> U.S. CONST. amends. V, XIV.

does not expressly reference the word “health” in any provision. Setting aside well-meaning proposals, the likelihood of a federal constitutional amendment identifying health as a right is all but unimaginable.<sup>7</sup>

In other contexts, the U.S. Supreme Court has found implicit constitutional rights, most notoriously, privacy, in the “penumbras” and “emanations” of the Constitution.<sup>8</sup> One might suggest that the right to health is implicitly and necessarily subsumed within the right to life. But no court has been willing to read the Constitution so broadly. Rather, the Court has expressly declined to recognize other asserted fundamental welfare rights, including financial assistance,<sup>9</sup> housing<sup>10</sup> and education.<sup>11</sup> Federal courts have been increasingly reluctant to recognize new fundamental constitutional rights bearing on individual health, such as the right of terminally ill patients to assisted suicide<sup>12</sup> or access unapproved drugs to prolong their lives.<sup>13</sup> Scholars made an intriguing but unavailing

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<sup>7</sup> See Frank I. Michelman, *Socioeconomic Rights in Constitutional Law: Explaining America Away*, 6 INT’L J. CONST. L. 663, 670 (2008) (discussing unlikelihood of “a welfare-state amendment”).

<sup>8</sup> *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965).

<sup>9</sup> *Dandridge v. Williams*, 397 U.S. 471, 487 (1970) (declining to find welfare right in the Constitution); see generally Robert H. Bork, *Impossibility of Finding Welfare Rights in the Constitution*, 1979 WASH. U. L.Q. 659; Lawrence G. Sager, *Justice in Plain Clothes: Reflections on the Thinness of Constitutional Law*, 88 NW. U. L. REV. 410, 411 (1993) (“constitutional claims pointing toward minimum welfare rights have been systematically rebuffed”).

<sup>10</sup> *Lindsey v. Normet*, 405 U.S. 56, 74 (1972) (no fundamental right to housing).

<sup>11</sup> *Rodriguez v. San Antonio Indep. Sch. Dist.*, 411 U.S. 1, 24 (1973) (declining to recognize federal right to public education); see also *Plyer v. Doe*, 457 U.S. 202, 221 (1982) (“Public education is not a ‘right’ granted to individuals by the Constitution. But neither is it merely some governmental ‘benefit’ indistinguishable from other forms of social welfare legislation.” (citing *Rodriguez*)); *Kadrmas v. Dickinson Pub. Schs.*, 478 U.S. 450 (1988) (“Nor have we accepted the proposition that education is a ‘fundamental right,’... which should trigger strict scrutiny when government interferes with an individual’s access to it.” (citing *Plyer* and *Rodriguez*)); Susan H. Bitensky, *Theoretical Foundations for a Right to Education Under the U.S. Constitution: A Beginning to the End of the National Education Crisis*, 86 NW. U.L. REV. 550, 564 – 73 (1992) (discussing U.S. Supreme Court cases on public education); Daniel S. Greenspahn, *A Constitutional Right to Learn: The Uncertain Allure of Making a Federal Case Out of Education*, 59 S.C. L. REV. 755, 768 (2008) (“*Rodriguez* has been broadly viewed as denying a right to an education under the Constitution”); Kimberly Jenkins Robinson, *The Case for a Collaborative Enforcement Model for a Federal Right to Education*, 40 U.C. DAVIS L. REV. 1653, 1659 (2007) (describing Court’s holding in *Rodriguez* and citing scholarship advocating federal right to public education).

<sup>12</sup> *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997); cf. *Cruzan v. Missouri Dep’t of Health*, 497 U.S. 261 (1990) (finding Due Process liberty interest in patient’s right to refuse life-sustaining treatment but upholding state law requiring clear and convincing evidence of patient’s wishes).

<sup>13</sup> See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach*,

case for a property right to health care as a “public good,” based on the public’s considerable investment in medical education, research, and government health care programs.<sup>14</sup> Several reasons explain the U.S. Constitution’s absence of textual recognition of health and, by contrast, several states’ inclusion of health in their constitutions.

### *B. Charter of Negative Rights*

The U.S. Constitution traditionally is considered a charter of negative rights whereas state constitutions may embody a broader view.<sup>15</sup> The federal document limits governmental interference with individual rights but does not affirmatively grant rights to individuals or establish mandatory duties on the government.<sup>16</sup> Under the Constitution, we have negative rights to be free from government interference but not affirmative rights to government services or protection.<sup>17</sup> Other countries, by contrast, do

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495 F.3d 697 (2007) (no constitutional right to access experimental drugs); Raich v. Gonzales, 545 U.S. 1 (2005) (no fundamental right to preserve one’s life by taking medical marijuana); *see generally* Randy E. Barnett, *Scrutiny Land*, 106 MICH. L. REV. 1479 (2008) (regarding courts’ reluctance to recognize new fundamental rights).

<sup>14</sup> Mark Earnest & Dayna Bowen Matthew, *A Property Right to Medical Care*, 29 J. LEGAL MED. 65, 67 (2008) (“although American law has not directly created a right to health care, Americans’ public investment in the medical industry has”).

<sup>15</sup> Robert F. Williams, *Rights, in State Constitutions for the Twenty-First Century: The Agenda of State Constitutional Reform*, vol. 3, 25 - 26 (G. Alan Tarr & Robert F. Williams, eds., 2006) (discussing absence of positive rights in federal constitution and noting presence in some state constitutions).

<sup>16</sup> *See* *Barksy v. Board of Regents*, 347 U.S. 442, 472 – 73 (1954) (Douglas, J.) (“The Bill of Rights does not say ... what government must give, but rather what it may not take away”); *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983) (Posner, J.) (“the Constitution is a charter of negative rather than positive liberties,” and that “[t]he men who wrote the Bill of Rights were not concerned that government might do too little for the people but that it might do too much to them”).

<sup>17</sup> *See* Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271, 2273 (1990); Frank B. Cross, *The Error of Positive Rights*, 48 UCLA L. REV. 857 (2001); Currie, *supra*, note 30, at 886; Helen Hershkoff, *Positive Rights and State Constitutions: The Limits of Federal Rationality Review*, 112 HARV. L. REV. 1131, 1133 (1999) (describing Supreme Court’s view of federal constitution as “charter of negative rather than positive liberties”); Mark Tushnet, *Civil Rights and Social Rights: The Future of the Reconstruction Amendments*, 25 LOY. L.A. L. REV. 1207, 1213 (1992) (“Affirmative governmental action seems to be required to promote social rights,” whereas “civil rights seem to be largely negative,” merely requiring government “to stand aside [and] not interfere”). *But see* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 271 – 77 (1992) (rebutting conventional assumptions about negative and positive rights and framers’ view of government’s role in health care).

provide affirmative rights in their constitutions;<sup>18</sup> ours is viewed as exceptional.<sup>19</sup> Rationales for declining to recognize affirmative constitutional rights include the cost of guaranteeing government services,<sup>20</sup> the inappropriateness of courts' adjudicating disputes over policy and budget,<sup>21</sup> and a heritage of free enterprise and economic liberties.<sup>22</sup>

Accordingly, the U.S. Supreme Court has repeatedly rejected suggestions to recognize affirmative rights to various public benefits, basic subsistence, or services.<sup>23</sup> The government has no constitutional obligation

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<sup>18</sup> See Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees*, 56 SYRACUSE L. REV. 1, 4, 8 (2005) (listing Switzerland, South Africa, India, Norway, Russia, and other examples); Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285 (2004); see also Lisa Forman, *Justice and Justiciability: Advancing Solidarity and Justice through South Africans' Right to Health Jurisprudence*, 27 MED. & L. 661 (2008); Puneet K. Sandhu, Comment, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151 (2007);

<sup>19</sup> See SUNSTEIN, *supra* note 2, at 127 – 38 (chapter on constitutional exceptionalism); Stephen Gardbaum, *The Myth and Reality of American Constitutional Exceptionalism*, 107 MICH. L. REV. 391, 444 – 53 (2008) (reframing issue of positive versus negative rights and surveying other countries' constitutional recognition of social and economic rights); Judith Resnik, *Law's Migration: American Exceptionalism, Silent Dialogues, and Federalism's Multiple Ports of Entry*, 115 YALE L.J. 1564, 1582 – 83 (2006) (defending American Exceptionalism and unwillingness to conform to international norms, as part of "a special and unique destiny to lead the rest of the world to freedom and democracy").

<sup>20</sup> But see STEPHEN HOLMES & CASS R. SUNSTEIN, *THE COST OF RIGHTS: WHY LIBERTY DEPENDS ON TAXES* 37 – 52 (1999) (suggesting that it may be just as, if not more, expensive for courts to guarantee contract, tort, and property rights as affirmative social welfare rights); SUNSTEIN, *supra* note 4, at 6 – 7 (suggesting that costs of ensuring fair trials under Fifth, Sixth, Seventh, and Eighth Amendments are much more costly and time consuming than implementation of social programs); Tushnet, *supra* note 17, at 1214 – 15 (noting that positive governmental action is required as much for protection of civil rights to vote, free exercise, or free speech as social rights to adequate housing, food, or employment).

<sup>21</sup> See Bandes, *supra* note 17, at 2327 – 30 (discussing institutional competence argument); Michelman, *supra* note 7, at 668 – 71 (discussing argument "that courts are ill-equipped for fine-tuned appraisals of government efforts in this field"); Sager, *supra* note 9, at 420 ("immensely complex questions of social strategy and social responsibility" are "far better addressed by the legislative and executive branches of government" and "seem out of the reach of the judiciary absent special circumstances"); Sunstein, *supra* note 18, at 16 ("American courts have been reluctant to recognize social and economic rights, in part because of a belief that enforcement and protection of such rights would strain judicial capacities.").

<sup>22</sup> Bandes, *supra* note 17, at 2305 – 06 (explaining "penalty/subsidy distinction" for Court's abortion funding decisions); Sunstein, *supra* note 18, at 17 – 18 (describing "cultural explanation" that social and economic rights are "correlated with the strength of socialist or left-wing elements").

<sup>23</sup> See *supra* notes 9 – 11 (citing cases).

to protect individuals from circumstances that endanger their health or well-being, as the Court famously held in *DeShaney v. Winnebago County Department of Social Services*,<sup>24</sup> denying a claim against the state by a severely abused child for failing to protect him from his own father.<sup>25</sup> The government also is not required to provide or pay for medical services even if a person's constitutionally protected rights to life or privacy are implicated.<sup>26</sup> For example, in *Harris v. McRae* the Court squarely held that states have no constitutional obligation to pay for abortions, even when the woman's life is at risk.<sup>27</sup> A woman has a constitutional right to choose an abortion, but the right is not unduly burdened just because she cannot pay.<sup>28</sup> States may voluntarily decide to provide certain government benefits, but

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<sup>24</sup> 489 U.S. 189 (1989).

<sup>25</sup> See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 87 (2d ed. 2008) (discussing *DeShaney* as example of Supreme Court's "remain[ing] faithful to a negative conception of the Constitution, even in the face of dire personal circumstances"); Hershkoff, *supra* note 17, at 1155 (describing *DeShaney* as "notorious example" of "baseline assumption that the U.S. Constitution does not guarantee positive rights against the government").

<sup>26</sup> See *DeShaney*, 489 U.S. at 196 ("Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual"); see also *Youngberg v. Romeo*, 457 U. S. 307, 317 (1982) ("As a general matter, a State is under no constitutional duty to provide substantive services for those within its border").

<sup>27</sup> 448 U. S. 297, 316 (1980) ("[A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls into the latter category...."); see also *Maher v. Roe*, 432 U.S. 464, 469 (1977) ("Constitution imposes no obligation on the States to pay for the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents").

<sup>28</sup> *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 507 (1989) (rejecting challenge to state ban on using state facilities for abortions, noting that "Due Process Clause generally confers no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests"); *Maher*, 432 U.S. at 473 – 74 (noting that right to abortion "protects the woman from unduly burdensome interference with her freedom whether to terminate her pregnancy" but imposes "no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds"); *Beal v. Doe*, 432 U.S. 438 (1977) (no Equal Protection violation in state Medicaid program funding childbirth and therapeutic abortions but not non-therapeutic abortions); see also *Rust v. Sullivan*, 500 U.S. 173, 192 – 93 (1991) (upholding federal regulation prohibiting federal funding to family planning facilities that provide abortion counseling); James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1378 – 80 (1981) (discussing abortion cases and concluding that "government apparently is free to allocate its scarce medical resources in accordance with its own sense of priorities"); Wing, *supra* note 1, at 164 – 66 (discussing abortion cases in context of asserted right to health care).

nothing requires states to give services away for free.<sup>29</sup> With respect to health care, the Court has recognized only a narrow right to medical care for prisoners and others in custody.<sup>30</sup>

Beyond those exceptions, the only federal constitutional protections for health derive from the Equal Protection and Due Process clauses. But those provisions are implicated only when the government voluntarily assumes a role in providing health care services, as it has under federal programs like Medicare and Medicaid. For Equal Protection purposes, there is a fairly strong case that any government health care services, whether federal or state, must be provided on a nondiscriminatory basis.<sup>31</sup> The chances of an Equal Protection claim succeeding, however, turn largely on the level of scrutiny applied. Claims alleging discriminatory provision of services would likely receive the lowest level, rational basis scrutiny unless racial discrimination or other suspect classes were involved.<sup>32</sup> Thus, almost any governmental justification for drawing lines among individuals is likely to

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<sup>29</sup> See *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 462 (1988) (“The Constitution does not require that such service be provided at all, and it is difficult to imagine why choosing to offer the service should entail a constitutional obligation to offer it for free.”).

<sup>30</sup> See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (“deliberate indifference to serious medical needs of prisoners” violates 8th Amendment but finding no violation where prisoner was seen 17 times over 3 months); *Youngberg*, 457 U.S. at 322 (involuntarily confined mentally disabled individual had a right to minimally adequate training to avoid placement in physical restraints but not broad right to care and treatment); David W. Burgett, *Substantive Due Process Limits on the Duration of Civil Commitment for the Treatment of Mental Illness*, 16 HARV. C.R.-C.L. L. REV. 205, 213 n.32 (“right to treatment” does not suggest affirmative right to state services, but rather condition on state’s rights to confine its citizens).

<sup>31</sup> See Blumstein, *supra* note 28, 1381 – 85; David P. Currie, *Positive and Negative Constitutional Rights*, 53 U. CHI. L. REV. 864, 881 – 82 (1986) (“The only requirement being equality, in theory the state could have corrected the constitutional flaw by abolishing its entire welfare program.”); Stacy, *supra* note 1, at 82 (“But once government chooses to devote resources to health care, it must do so in a way that promotes rough equality of access”); Wing, *supra* note 1, at 164 (“If the term right to health care has any relevance in describing constitutional doctrine in the United States, it is in reference to those constraints imposed on the government once it has exercised broadly defined powers to provide or finance health or health-related benefits.”).

<sup>32</sup> See, e.g., *Kadrmas*, 487 U.S. at 462 – 63 (no Equal Protection violation in state school bus fee applied only to nonreorganized school districts); *Schweiker v. Wilson*, 450 U.S. 221 (1981) (upholding state Medicaid benefits classification based on mental illness under rational basis scrutiny); *Jefferson v. Hackney*, 406 U.S. 535 (1972) (finding no Fourteenth Amendment violation in state’s system for allocating fixed pool of welfare money); *Dandridge v. Williams*, 397 U.S. 471 (1970) (applying rational basis scrutiny to review state’s allocation of welfare benefits disproportionately to large and small families); see Wing, *supra* note 3, at 173 – 74 (discussing Equal Protection claim and unlikelihood of court identifying an implicated suspect class).

pass the courts' constitutional muster.<sup>33</sup> One area of successful Equal Protection challenges is states' denial of public benefits to new residents.<sup>34</sup> Nevertheless, Equal Protection does not get to the root of the issue: Whether government is obligated to provide health care in the first place.

Constitutional claims to health theoretically also could be brought under the Due Process clause.<sup>35</sup> Accepting that health is not a constitutionally protected right, any Due Process claim, like the Equal Protection claim, would be viable only if the government voluntarily undertakes to provide health care. Moreover, the statute or regulation establishing the government service would have to create a legitimate claim of entitlement.<sup>36</sup> Even then, the government would be liable under Due Process only if it unjustly deprived individuals.<sup>37</sup> Courts have been reluctant to find enforceable, individual rights in broad legislative schemes or administrative regulations.<sup>38</sup> Nor are lawmakers anxious to ascribe entitlement status to

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<sup>33</sup> See Barnett, *supra* note 13, at 1480 (suggesting that claimant “needs a ticket into ‘Scrutiny Land’ where the government must justify its restriction” by demonstrating a fundamental right, “[o]therwise, she automatically loses”); Hershkoff, *supra* note 17, at 1153 (describing “prevalent understanding of rationality review” is that it “is not review at all” and “signals the Court’s view that a claim does not merit its institutional attention”). *But see* U.S. Dep’t of Agric. v. Moreno, 413 U.S. 528, 534 (1973) (striking down amendment to Food Stamp Act intended to exclude “hippies” and “hippie communes” from eligibility); Shapiro v. Thompson, 394 U.S. 618, 627 (1969) (holding unconstitutional state welfare program’s exclusion of individuals who had not lived in the state for a year because no basis for distinguishing old and new residents for this purpose).

<sup>34</sup> See, e.g., Saenz v. Roe, 526 U.S. 489, 511 (1999) (California durational residency requirement for Temporary Assistance to Needy Families (TANF) benefits violated Fourteenth Amendment right to travel); Memorial Hosp. v. Maricopa Co., 415 U.S. 250, 269 (1974) (Arizona one-year residency requirement for free medical care to indigents violated Equal Protection and right to travel); Shapiro, 394 U.S. at 641 – 42 (one-year residency requirement for Aid to Families with Dependent Children (AFDC) violated Equal Protection and right to travel).

<sup>35</sup> Matthews v. Eldridge, 424 U.S. 319 (1975) (holding that adequate due process was provided to person whose Social Security disability benefits were terminated); Goldberg v. Kelly, 397 U.S. 254 (1970) (requiring due process before termination of benefits); see also Goss v. Lopez, 419 U.S. 565 (1975) (requiring hearing before suspension or expulsion of public school students).

<sup>36</sup> See Board of Regents v. Roth, 408 U.S. 564, 577 – 78 (1972) (requiring “legitimate claim of entitlement” to create property interest in continued employment after expiration of contract).

<sup>37</sup> See Goldberg, 397 U.S. at 261.

<sup>38</sup> See Gonzaga v. Doe, 536 U.S. 273 (2002) (narrowing availability of § 1983 action under federal statutes); compare United States v. Erika, 456 U.S. 201 (1982) (barring judicial review of administrative “amount of benefits” determination under Medicare) with Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986) (allowing judicial review based on challenge to validity of Medicare regulations but not benefits calculation); Blumstein, *supra* note 28, at 1375 (noting limits on judicial review of benefits claims); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and*

government services provided under federal statutes and allow remedies to individuals who are denied or lose government services.<sup>39</sup> For example, no one can claim a right to pension or health insurance benefits upon reaching retirement age, despite paying mandatory payroll taxes to the Social Security trust fund,<sup>40</sup> even if Congress repeals the Social Security Act.<sup>41</sup> The narrow Equal Protection and Due Process challenges to government health care services do not create a federal constitutional right to health.

### C. Constitutional Allocation of Powers

The federal structure of the U.S. Constitution provides additional support for turning to state constitutional provisions on health. Article I assigns certain enumerated powers to the federal government. All

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*Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 416 - 17 (2008) (suggesting *Gonzaga* endangers fragile Medicaid entitlement); Kinney, *supra* note 1, at 360 – 61, n.172 (noting “diminished status of benefits in government entitlement programs due to their statutory definition” and citing cases).

<sup>39</sup> See, e.g., *Colson v. Silman*, 35 F.3d 106 (2d Cir. 1994) (holding that applicants for county’s physically handicapped children’s program had no “legally cognizable property-type interest in a government benefit” or “claim of entitlement” to state services); *White v. Moses Taylor Hosp.*, 763 F. Supp. 776 (M.D. Penn. 1991) (denying uninsured patient’s claimed right to treatment based on defendant hospital’s acceptance of federal funds); JOST, *supra* note 1, at 24 – 51; Hershkoff, *supra* note 17, at 1173 (noting Congress’s decision in 1996 to eliminate Aid to Families with Dependent Children (AFDC) program, “devolving” instead block grants to states and statute’s “purport[ing] to eliminate public assistance as a federal entitlement”); Kinney *supra* note 1, at 360, n.173 (citing statutes affirmatively stating that benefits are not entitlements); see also Sidney A. Shapiro & Richard E. Levy, *Government Benefits and the Rule of Law: Toward a Standards-Based Theory of Due Process*, 57 ADMIN. L. REV. 107 (2005).

<sup>40</sup> See Social Security Act Amendment of 1939, Pub. L. No. 76-379, § 1432, 53 Stat. 1360, 1387 (codified as amended at 26 U.S.C. §§ 3101-3128 (2002)) (program funding federal insurance for disabled and elderly persons); 26 U.S.C. § 3101(a) (tax to fund national old-age, survivors, and disability insurance); 26 U.S.C. § 3101(b); IRC §§ 3101-28 (2000) (FICA); JOST, *supra* note 3, at 64 – 65 (observing common perception of Social Security and Medicare as earned pensions or social insurance trust funds but noting that “in fact, the relationship between contributions made and pensions withdrawn from social insurance funds is quite tenuous”); Benjamin A. Templin, *The Public Trust in Private Hands: Social Security and the Politics of Government Investment*, 96 KY. L.J. 369, 369 n.2 (2008) (“most of the monies collected from the FICA payroll tax immediately go out to pay benefits to current retirees. What is not immediately paid out as benefits is invested in government bonds in a Trust Fund[,] ... but it’s not nearly enough to fund the expected benefits of future retirees”).

<sup>41</sup> See *Flemming v. Nestor*, 363 U.S. 603 (1960) (upholding Social Security Act amendment terminating benefits of aliens who are deported on certain grounds); JOST, *supra* note 1, at 30 – 33 (noting use of word “entitlement” in Medicare and Medicaid statutes and Internal Revenue Code but lack of meaningful, enforceable rights).

remaining powers are reserved to the states under the Tenth Amendment.<sup>42</sup> That allocation of power is constitutionally grounded and part of the Framers' design to facilitate centralized coordination at the federal level, on the one hand, and diffusion of power and respect for state sovereignty, on the other.<sup>43</sup> While the Constitution allows both federal and state governments to address health, the responsibility falls more squarely within states reserved powers.

Federal enumerated powers include the power to tax and spend for the general welfare, commerce power, national security powers, and the catch-all necessary and proper clause.<sup>44</sup> Most federal health legislation is enacted under the spending or commerce powers, including Social Security and Medicare for the elderly and disabled, Medicaid for needy individuals, Children's Health Insurance Program (CHIP), and Veterans Health Administration.<sup>45</sup> Congress can also use spending power to entice states to enact laws or implement programs by conditioning federal funds on states' compliance with broad federal program mandates.<sup>46</sup> Medicaid and CHIP

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<sup>42</sup> *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 203 (1824) (describing state police powers as "immense mass of legislation, which embraces everything within the territory of a state, not surrendered to the general government"); Daniel B. Rodriguez, *State Constitutional Theory and Its Prospects*, 28 N.M. L. REV. 271, 277 (1998) (describing federal Constitution as document of grants and state constitutions as documents of limits).

<sup>43</sup> See, e.g., *Printz v. United States*, 521 U.S. 898, 918 (1997) ("It is incontestable that the Constitution established a system of 'dual sovereignty.'"); *South Carolina v. Baker*, 485 U.S. 505, 533 (1988) (O'Connor, J., dissenting) ("If there is any danger, it lies in the tyranny of small decisions--in the prospect that Congress will nibble away at state sovereignty, bit by bit, until someday essentially nothing is left but a gutted shell", quoting LAURENCE TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 5-20, at 381 (2d. ed. 1988)); Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't*, 96 MICH. L. REV. 813, 816 (1998) ("The national government has unique needs in maintaining the supremacy of federal law and an orderly federal system, yet there must be a limit to federal power and a corresponding reservoir of state power if federalism is to have any meaning at all.").

<sup>44</sup> U.S. CONST. art. I, § 8 (listing the federal powers).

<sup>45</sup> U.S. CONST. art. I, § 8, cl. 1, 3; *Gonzaga*, 536 U.S. at 280 (recognizing Medicaid as spending power legislation); *Atkins v. Rivera*, 477 U.S. 154, 156 – 57 (1986) (describing Medicaid legislation); *Helvering v. Davis*, 301 U.S. 619 (1937) (recognizing Social Security Act as valid exercise of spending power); Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334, 336, 342 (1970); Robert F. Rich & William D. White, *Federalism and Health Care Policy*, 1998 U. ILL. L. REV. 861, 872 ("With the enactment of Medicare in 1965, the federal government assumed responsibility for acute care of the elderly."); *id.*, at 864 – 656 (describing Veteran's Administration programs).

<sup>46</sup> See, e.g., *South Dakota v. Dole*, 483 U.S. 203 (1987) (conditioning federal highway funds on states enacting laws limiting alcohol sales to minors and introducing limits on conditional spending power).

are prime examples of that sort of cooperative federalism.<sup>47</sup> States with approved programs receive a percentage-on-the-dollar match from the federal government for every state dollar spent.<sup>48</sup> Accordingly, states are incentivized to provide generous public benefits, while the federal government shifts a portion of the funding burden to states.<sup>49</sup> The prominence of cooperative federalism in government health care programs demonstrates states' central role in that arena.

States retain vast powers and broad discretion to carry out state policy objectives.<sup>50</sup> The Framers recognized that states bear primary responsibility for people's lives, liberties, and property.<sup>51</sup> Health, welfare, and safety fall

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<sup>47</sup> 42 U.S.C. § 1396 (Medicaid); 42 U.S.C. § 1397aa (CHIP); *see Atkins*, 477 U.S. at 157 (describing Medicaid as joint-federal state partnership); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36 – 37 (1981) (same); *Harris v. McRae*, 448 U.S. 297 (1980) (describing Medicaid as a “cooperative endeavor in which the Federal Government provides financial assistance to participating states to aid them in furnishing health care to needy persons.”); Huberfeld, *supra* note 38, at 419 (“Medicaid is a classic example of cooperative federalism”); Sara Rosenbaum et al., *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMEDICAL L. 1, 10 (2004) (“Medicaid followed the tradition of federal grant-in-aid programs, enacted pursuant to Congress’s spending clause powers, which condition the receipt of federal funds by states that elect to participate on compliance with a series of structural and operational conditions of participation.”); *see also* William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1550 (2007) (“cooperative federalism” programs “typically involve a federal statute that regulates a risk or addresses a social need” but “do not depend solely on federal actors for their implementation and enforcement”); Frank R. Strong, *Cooperative Federalism*, 23 IOWA L. REV. 459, 479 – 82 (1938) (symposium introduction).

<sup>48</sup> Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 860 – 61 (1990) (program overview); Elizabeth A. Weeks, *Cooperative Federalism and Health Care Reform: The Medicare Part D “Clawback” Example*, 1 ST. LOUIS UNIV. J. HEALTH L. & POL’Y 79, 94 – 96 (2007) (describing Medicaid program). As one of his first acts in office, President Obama signed legislation expanding (and renaming, as CHIP) SCHIP. Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111-3, *available at* <http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/content-detail.html>.

<sup>49</sup> *See Weeks, supra* note 48, at 95 & n.132 (citing sources).

<sup>50</sup> *See Rodriguez, supra* note 42, at 278.

<sup>51</sup> THE FEDERALIST NO. 45, at (Book I) 319 (J. Madison); THE FEDERALIST NO. 17, at (Book I) 113 (A. Hamilton); Stanley Mosk, *State Constitutionalism: Both Liberal and Conservative*, 63 TEX. L. REV. 1081, 1082 – 83 (1985) (citing same); *see also* Erwin Chemerinsky, *The Values of Federalism*, 47 FLA. L. REV. 499, 525 (1995) (“The Framers envisioned that the vast majority of governance would be at the state and local levels and that federal actions would be relatively rare and limited.”); Hershkoff, *supra* note 17, at 1166 (noting “assumption that states and localities are normatively superior to the national government in dealing with the everyday stuff of life: family relations, public schooling, and the like”).

squarely within states' traditional reserved police powers.<sup>52</sup> In addition, states' *parens patriae* powers encompass vulnerable members of society, including the mentally ill, children, and poor, who may have special health care needs.<sup>53</sup> States may also act within the sphere of enumerated federal powers as long as their actions are not prohibited by federal law and do not conflict with, impede the purpose of, or intrude upon an area of exclusive federal regulation, as a matter of preemption.<sup>54</sup>

Most states have broadly exercised their reserved powers, enacting a wide range of regulations governing the practice of medicine and other health professions,<sup>55</sup> licensing and operation of medical facilities,<sup>56</sup> and the business of health insurance.<sup>57</sup> States establish public health departments

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<sup>52</sup> See *United States v. Lopez*, 514 U.S. 549, 564 (1995) (“In addition to criminal law enforcement and education, health care regulation is an area where states historically have been sovereign.”).

The authority of the state to enact this [mandatory vaccination] statute is to be referred to what is commonly called the police power, -a power which the state did not surrender when becoming a member of the Union under the Constitution. Although this court has refrained from any attempt to define the limits of that power, yet it has distinctly recognized the authority of a state to enact quarantine laws and ‘health laws of every description;’ indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other states.

*Jackobson v. Massachusetts*, 197 U.S. 11, 24 – 25 (1905).

<sup>53</sup> See *infra* notes 225 – 28 and accompanying text (describing *parens patriae* power).

<sup>54</sup> See *Champion v. Ames*, 188 U.S. 321, 347 – 53 (1903) (describing coexisting federal Commerce Power and state police powers to regulate commerce); *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 436 (1819) (declaring as invalid state laws that “retard, impede, burden, or in any manner control[] the operations” of federal laws); Caleb Nelson, *Preemption*, 86 VA. L. REV. 225 (2000) (“Although the Constitution makes a few of the federal government’s powers exclusive, the states retain concurrent authority over most of the areas in which the federal government can act.”); see generally Stephen A. Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767 (1994); Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727 (2008).

<sup>55</sup> See *Williamson v. Lee Optical*, 348 U.S. 483 (1955) (upholding Oklahoma statute restricting performance of eye examinations and prescription to licensed optometrists and ophthalmologists); *Dent v. West Virginia*, 129 U.S. 114 (1889) (upholding state physician licensure requirements).

<sup>56</sup> See Clark C. Havighurst, *Regulation of Health Facilities and Services by “Certificate of Need,”* 59 VA. L. REV. 1143, 1144 – 47 (1973) (surveying state certificate-of-need (CON) laws); Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws In a “Managed Competition” System*, 23 FLA. ST. U. L. REV. 141, 144 – 47 (1995) (describing history and operation of state CON laws).

<sup>57</sup> See McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1012(a) (“The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”). The McCarran Ferguson Act was Congress’s explicit reaffirmation of the primary role of states in insurance regulation, following the Supreme Court’s decision in *United States v. South-*

and agencies dedicated to protecting the health and welfare of residents.<sup>58</sup> In addition, most states accept the conditional spending carrot and provide health care in cooperation with the federal government.<sup>59</sup> Many states enact their own initiatives funded and administered solely at the state level.<sup>60</sup>

States' reserved powers offer unique opportunities for states to address social welfare concerns.<sup>61</sup> Federal constitutional law establishes a floor, requiring states to recognize at least that level of protection to individual rights. But states may go above the federal floor and accord even greater protection.<sup>62</sup> While federal constitutional jurisprudence has rejected the

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*East Underwriters Association*, 322 U.S. 533 (1944), upholding application of federal antitrust laws to interstate insurance contracts. The Act made clear that “regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such businesses by the several States.” 15 U.S.C. § 1011. State health insurance regulation of employer health plans is significantly restricted by the federal Employee Retirement and Income Security Act (“ERISA”), Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified at 29 U.S.C. §§ 1001 – 1461).

<sup>58</sup> See GOSTIN, *supra* note 25, at 149 – 55 (describing history of state and local public health regulation).

<sup>59</sup> See Kinney, *supra* note 48, at 855 – 57 (describing current “magnitude of Medicaid program” and federal and state financial and administrative commitments); Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 120 (1995) (noting many existing “cooperative federalism” health care programs); Weeks, *supra* note 48, at 79 – 80 & n.5 (regarding cooperative federalism and Medicare and Medicaid)

<sup>60</sup> JOEL F. HANDLER, *THE POVERTY OF WELFARE REFORM* 62 – 75 (1995) (describing state experimentation in the 1980s, including varying work programs under federal Aid to Families with Dependent Children (AFDC) program); Rich & White, *supra* note 46, at 872 – 74 (describing state initiatives); Tammy Murray, Note, *State Innovations in Health Care: Congress' Broad Spending Power Under a National Health Care System Will Stifle State Laboratories of Democracy*, 3 IND. HEALTH L. REV. 263, 271 – 72 (2006) (describing state health care financing and other reform efforts).

<sup>61</sup> See DANIEL J. ELAZAR, *THE AMERICAN CONSTITUTIONAL TRADITION* 113 (1998) (“state constitutions are important determinants of who gets what, when, and how in America”); G. ALAN TARR, *UNDERSTANDING STATE CONSTITUTIONS* 149 (1998) (describing states' early recognition of responsibility for social welfare); Daniel Gordon, *Superconstitutions Saving the Shunned: The State Constitutions Masquerading as Weaklings*, 67 TEMP. L. REV. 965, 970 (1994) (“state constitutions serve as the predominant source of protection for individual rights in the United States”); Paul W. Kahn, *State Constitutionalism and the Problems of Fairness*, 30 VAL. U. L. REV. 459, 464 (1996) (states have the opportunity to address fairness controversies not being resolved satisfactorily at the federal level).

<sup>62</sup> See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 – 82 (1990) (recognizing that Missouri is entitled to accord stronger protection to preservation of life than federal law by requiring clear and convincing evidence to terminate life support); see Buzbee, *supra* note 47, at 1555 (“federal floors retain the benefits of multiple regulatory voices, protections, and diverse regulatory modalities”); James A. Gardner, *The “States-As-Laboratories” Metaphor in State Constitutional Law*, 30 VAL. U. L. REV. 475, 483 (1996)

notion of a constitutional right to health, states could recognize such a right under their own constitutions. Justice William Brennan in a series of articles<sup>63</sup> expressly urged that states could and should expand protection for individual rights, continuing the Warren Court's civil rights jurisprudence.<sup>64</sup> States have embraced that charge to varying degrees, as we shall see.

#### *D. Federalism Policies*

Several familiar federalism policy arguments further suggest that constitutional recognition of health is better grounded in state rather than federal law. State legislators may be more accessible and responsive to constituents' interests.<sup>65</sup> Local representatives also may represent the

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(discussing *Cruzan*); Hans A. Linde, *Without "Due Process" – Unconstitutional Law in Oregon*, 49 OR. L. REV. 125, 182 (1970) (urging states as defenders of civil rights); Justin Long, *Intermittent State Constitutionalism*, 34 PEPP. L. REV. 41, 51 (2006) (noting "truism that state courts are legally entitled to interpret their state constitutions as more protective of liberty than the Federal Constitution"); Thomas G. Saylor, *Prophylaxis in Modern State Constitutionalism: New Judicial Federalism and the Acknowledged, Prophylactic Rule*, 59 N.Y.U. ANN. SURV. AM. L. 283, 286 – 89 (2003) ("new judicial federalism" as "increased tendency of state courts to interpret state charters as sources of rights independent of the Federal Constitution and interpretations of the United States Supreme Court").

<sup>63</sup> William J. Brennan, Jr., *The Bill of Rights and the States*, 36 N.Y.U. L. REV. 761 (1961); William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977); William J. Brennan, Jr., *The Bill of Rights and the States: The Revival of State Constitutions as Guardians of Individual Rights*, 61 N.Y.U. L. REV. 535 (1986).

<sup>64</sup> See James A. Gardner, *The Failed Discourse of State Constitutionalism*, 90 MICH. L. REV. 761, 762 (1992) (noting that Brennan looked to "state constitutions as potentially more generous guarantors of individual rights than the U.S. Constitution as construed by the Burger Court" and others' characterizing Brennan's articles as "the 'Magna Carta' of state constitutionalism"); Kahn, *supra* note 61, at 464 ("[Brennan] was eager to preserve the judicial ideals of the 60s and 70s. State constitutionalism represented a kind of forum shopping for liberals."); Mosk, *supra* note 51, at 1081 ("For the liberal, there is the prospect of continued expansion of individual rights and liberties; the work of the Warren Court can be carried on at the state level."); Rodriguez, *supra* note 42, at 271 (describing Brennan's "strategic effort ... to highlight the value of plumbing the states for individual rights protections in the face of conservative retrenchment"); Robert A. Schapiro, *Identity and Interpretation in State Constitutional Law*, 84 VA. L. REV. 389, 420 (1998) ("The renewed interest in state constitutions was prompted by the desire to entrench and advance the accomplishments of the Warren Court at a time when the federal judiciary was becoming hostile to the expansion of certain claims of individual rights").

<sup>65</sup> See *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 576 n.18 (1985) (Powell, J., dissenting) ("The Framers recognized that the most effective democracy occurs at local levels of government, where people with firsthand knowledge of local problems have more ready access to public officials"); Chemerinsky, *supra* note 51, at 527 ("to the extent the electorate is small, and elected representatives are thus more immediately accountable to individuals and their concerns, government is brought closer to the people,

particular values and concerns of their communities, which may not be shared by the entire nation.<sup>66</sup> Some scholars reject the community values can be defined strictly by reference to state boundaries.<sup>67</sup> Even if not aligned with state borders, giving voice to diverse views of the separate sovereign states is a core tenet of our federal system.<sup>68</sup> Different territories may have different tastes and needs, especially on social policy matters.<sup>69</sup>

Political judgments about particular reform proposals are products of personal experience, political ideology, and local economic and social conditions. These factors change substantially as one moves about the United States. If change is to be workable and acceptable, it must take account of the real differences between New York and Idaho, Wisconsin and Louisiana.<sup>70</sup>

Accordingly, state constitutional rights and values may offer a collection of views of citizens across the country.

In addition, states serve as laboratories of democracy, experimenting and crafting solutions to problems, which can be borrowed by other states and the federal government.<sup>71</sup> One state's experience enshrining a

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and democratic ideals are more fully realized"); Betsy J. Grey, *The New Federalism Jurisprudence and National Tort Reform*, 59 WASH. & LEE L. REV. 475, 511 (2002) (noting one value of federalism is "foster[ing] governments that are more responsive than Congress to the needs of local citizens").

<sup>66</sup> See Shirley S. Abrahamson, *Reincarnation of State Courts*, 36 SW. L.J. 951, 965 (1982) (suggesting that state constitutional interpretation should consider states' "peculiarities," including "its land, its industry, its people, its history"); Peter D. Jacobson, *The Federalist Approach to Health Care and its Limitations: Introductory Remarks*, 29 HAMLIN J. PUB. L. & POL'Y vii, xiv (2007 – 2008) ("The individual states are closer to the people, and hence better equipped to reflect their plurality of values"); Schapiro, *supra* note 65, at 403 (discussing view that state constitutional interpretation "should be guided by various indicia of state distinctiveness").

<sup>67</sup> See, e.g., Gardner, *supra* note 64, at 823; James A. Gardner, *What is a State Constitution?*, 24 RUTGERS L.J. 1025, 1025 – 26 (1993); Long, *supra* note 62, at 59 – 61 (discussing Gardner's notion of "romantic subnationalism"); Schapiro, *supra* note 64, at 440 (suggesting mistake of state constitutional interpretation "is the conflation of the political unit of the state with an assumed underlying organic community").

<sup>68</sup> See Abrahamson, *supra* note 66, at 966; Judith S. Kaye, *Dual Constitutionalism in Practice and Principle*, 61 ST. JOHN'S L. REV. 399, 423 (1987); Long, *supra* note 62, at 101 ("Diversity among states also permits mobile Americans to vote with their feet.").

<sup>69</sup> See Alan R. Weil & James R. Tallon, Jr., *The States' Role in National Health Reform*, 36 J.L. MED. & ETHICS 690, 690 (2008) ("state policies can be more closely tailored to local economic conditions and can reflect local values"); cf. Gardner, *supra* note 64, at 816 – 17 (describing but later rebutting view that variations in state constitutions "reflect differences in the fundamental value choices and character of the people who made the constitutions").

<sup>70</sup> Mashaw & Marmor, *supra* note 59, at 116.

<sup>71</sup> *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous state may, if its

constitutional, enforceable right to health care may counsel for or against similar enactments in other states, or at the federal level. Massachusetts's 2006 comprehensive state health reform plan offers a recent example of a state experiment to which other states and federal policymakers are looking for ideas and lessons.<sup>72</sup> California attempted similar reforms but found the model difficult to adapt.<sup>73</sup> President Obama's campaign proposals and current congressional plans include key components of the Massachusetts health reform initiatives.<sup>74</sup> Especially on controversial issues, it may be

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citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”); see Chemerinsky, *supra* note 51, at 528 – 29 (“A final argument that is frequently made for protecting federalism is that states can serve as laboratories for experimentation.”); Gardner, *supra* note 62, at 486 – 87 (suggesting that approach promotes diversity and creates living examples of which policies succeed or fail); Grey, *supra* note 65, at 512 (noting “Justice Brandeis’s famous observation about the states as laboratories for experimentation”); Long, *supra* note 62, at 56 (summarizing “laboratories of democracy” rationale for independent judicial interpretation of state constitutions); Rich & White, *supra* note 45, at 868 (“[S]tates have amply demonstrated an ability to come up with innovative new solutions and act as ‘laboratories of democracy’ in important social policy areas like health care”). *But see* David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Anti-Poverty Law*, 157 U. PA. L. REV. 541 (2008) (arguing that decentralized policymaking and “democratic experimentalism” has failed to produce effective antipoverty law).

<sup>72</sup> An Act Providing Access to Affordable, Quality, Accountable Health Care, ch. 58, 2006 Mass. Acts (codified at Mass. Gen. Laws ch. 111M); see Christopher Lee, *Massachusetts Begins Universal Health Care*, WASH. POST, July 1, 2007, at A6 (“Massachusetts’s new grand experiment could become a model for major changes in health care across the country -- if it works.”); John E. McDonough, *A Year Later, Healthcare Experiment Has Strong Vital Signs*, BOSTON GLOBE, April 11, 2007; Kevin Sack, *Massachusetts Faces Costs of Big Health Plan*, N.Y. TIMES, March 16, 2009, at A1 (describing Massachusetts’s 2006 health reform law as “perhaps the boldest state health care experiment” and noting that “[w]ith Washington watching, the state’s leaders are again blazing new trails” with cost-containment efforts); see also Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1284 – 1294 (2008) (outlining Massachusetts plan); Robert Steinbrook, *Health Care Reform in Massachusetts – Expanding Coverage, Escalating Costs*, 385 NEW ENG. J. MED. 2752 (June 26, 2008) (same).

<sup>73</sup> Associated Press, *Arnold’s Plan to Stir Debate*, WASH. TIMES, Jan. 10, 2007; Sonya Geis & Christopher Lee, *Schwarzenegger Proposes Universal Health Coverage*, WASH. POST, Jan. 9, 2007, at A3; Lee, at A6 (“Gov. Arnold Schwarzenegger (R) is pushing a similar plan in California, and other states are watching closely”); Sara Watson Arthurs, *Health Plan Brings Praise, Concerns*, TIMES-STANDARD (Eureka, Cal.), Jan. 10, 2007; see Weeks, *supra* note 72, at 1299 – 1301 (comparing Massachusetts law and California proposal).

<sup>74</sup> See Linda J. Blumberg & John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, NEW ENG. J. MED., July 2, 2009, at 6 (noting that Massachusetts is the only state to require individuals to obtain health insurance); Ceci Connolly, *Kennedy’s Health-Care Measure to Require Employers to Chip In*, WASH. POST, May 29, 2009, available at <http://www.washingtonpost.com/wp->

beneficial to allow public sentiment and judicial deliberation slowly to percolate up from the states, rather than rushing a broad, federal pronouncement that may generate backlash or ill-fitting solutions.<sup>75</sup>

Arguments in favor of a federal approach to health reform include uniformity, universality, portability, and comprehensiveness.<sup>76</sup> If health care is a right, or at least an significant public concern, it may be important that all citizens receive the same core package of services.<sup>77</sup> The federal government can establish and enforce uniform standards. Moreover, federal benefits are portable, allowing people move from state to state without losing or having to change their health care benefits.<sup>78</sup> The federal government may also have greater administrative capacity and financial resources than states to implement broad social policies.<sup>79</sup> To the extent that health reform requires subsidies or redistribution of resources, the

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[dyn/content/article/2009/05/28/AR2009052803772\\_pf.html](http://www.nytimes.com/2009/05/28/AR2009052803772_pf.html); Robert Pear, *Sweeping Health Plan is Drafted by Kennedy*, N.Y. TIMES, June 6, 2009 (describing key components of American Health Choices Act), available at <http://www.nytimes.com/2009/06/06/health/policy/06health.html?scp=1&sq=sweeping%20helath%20plan%20drated&st=cse>; Kevin Sack, *One State's Lesson on Health Care*, N.Y. TIMES, March 29, 2009, at wk 1, 4 (side-by-side comparison of Massachusetts Plan and Obama's proposals); Kevin Sack, *Massachusetts, Model for Universal Health Care, Sees Ups and Downs in Policy*, N.Y. TIMES, May 28, 2009, available at <http://www.nytimes.com/2009/05/28/health/policy/28massachusetts.html>.

<sup>75</sup> See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (holding that constitutional right of privacy encompasses woman's decision to terminate pregnancy but that state may have compelling justifications for limiting the right); Adam Liptak, *Gay Vows, Repeated from State to State*, April 12, 2009, at wk 1 (suggesting that state-by-state recognition of same-sex marriage rights may be preferable to U.S. Supreme Court decision because Court's previous "decisions on issues like school desegregation, abortion, and same-sex marriage can raise questions about the judicial branch usurping the democratic process," shut down developments in state law, and generate lasting backlash).

<sup>76</sup> Mashaw & Marmor, *supra* note 59, at 118 (listing desirable federal standards for health reform); Rich & White, *supra* note 45, at 867 (noting that "the federal government can ensure equity through uniform national standards"); see also Robert L. Glicksman & Richard E. Levy, *A Collective Action Perspective of Ceiling Preemption by Federal Environmental Regulation: The Case of Global Climate Change*, 102 NW. U.L. REV. 579, 598 – 99 (2008) (on uniformity).

<sup>77</sup> Kinney, *supra* note 48, at 857 ("This lack of uniformity [in Medicaid] may arguably be undesirable from an equity perspective but is inevitable from Congress's decision to ... give[] states great authority to structure programs within federal constraints"); Mashaw & Marmor, *supra* note 59, at 119 – 20; Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127, 132 (1995).

<sup>78</sup> Mashaw & Marmor, *supra* note 59, at 124.

<sup>79</sup> Jacobson, *supra* note 66, at xv ("Resource availability also favors federal implementation."); Rich & White, *supra* note 45, at 867; Super, *supra* note 71, at 558 ("To the extent that state and local governments lack the resources to fund important activities, democratic experimentalism assumes Congress will fund them to pursue broadly defined purposes.").

federal government can achieve that objective on a national scale.<sup>80</sup>

Federal programs also might avoid race-to-the-bottom and in-migration problems that could occur at the state level.<sup>81</sup> The race-to-the-bottom argument suggests that if one state offers generous government benefits while neighboring states do not, people may be tempted to move to the more generous state.<sup>82</sup> As more people move, the generous states' costs rise.<sup>83</sup> The negative incentive, then, is for the state to offer minimal government benefits in the first instance, thereby avoiding the undesired in-migration and increased cost problems.<sup>84</sup> The concern is exacerbated

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<sup>80</sup> Rich & White, *supra* note 45, at 867 (“federal government can redistribute resources on a national basis, whereas the states ... are limited to internal redistribution”); Super, *supra* note 71, at 577 (“Decentralization imposes the burden of redistributing to low-income people on narrow segments of society”).

<sup>81</sup> See *Saenz v. Roe*, 526 U.S. 489, 509 (1999) (“The Solicitor General also suggests that ‘States might engage in a ‘race to the bottom’ in setting the benefit levels in their [welfare] programs’”); Charles Barrilleaux & Paul Brace, *Notes from the Laboratories of Democracy: State Government Enactments of Market-Based and State-Based Health Insurance Reforms in the 1990s*, 32 J. HEALTH POL. POL’Y & L. 655, 670 (2007); Dennis C. Mueller, *Federalist Governments and Trumps*, 83 VA. L. REV. 1419, 1426 (1997) (describing “welfare effects of mobility across communities”); Jonathan Rodden & Susan Rose-Ackerman, *Does Federalism Preserve Markets?*, 83 VA. L. REV. 1521 (1997) (“Interjurisdictional competition ... provides incentives for subnational units to produce externalities that favor local businesses and citizens and export costs onto others.”); Super, *supra* note 71, at 557 (suggesting that arguments in favor of democratic experimentalism “include externalities from one state or locality’s actions that affect another state of locality”); cf. Glicksman & Levy, *supra* note 76, at 597 – 98 (describing race to the bottom concern with state environmental regulation).

<sup>82</sup> As the Court recognized in *Memorial Hospital v. Maricopa Co.*, considering a state law denying public hospital care to new immigrants:

A person afflicted with a serious respiratory ailment, particularly an indigent whose efforts to provide a living for his family have been inhibited by his incapacitating illness, might well think of migrating to the clean dry air of Arizona, where relief from his disease could also bring relief from unemployment and poverty. But he may hesitate if he knows that he must make the move without the possibility of falling back on the State for medical care should his condition still plague him or grow more severe during his first year of residence.

415 U.S. 250, 257 (1974)

<sup>83</sup> See *Saenz*, 526 U.S. at 507 (“California has instead advanced an entirely fiscal justification for its multitiered scheme” which “will save the State approximately \$10.9 million a year”); Mueller, *supra* note 81, at 1426 (discussing example of better schools and noting that the family that moves “may impose further costs on the community it enters by overcrowding its schools”).

<sup>84</sup> See, e.g., *Plyler v. Doe*, 457 U.S. 202, 228 (1974) (recognizing that “a State might have an interest in mitigating the potentially harsh economic effects of sudden shifts in population”); *Shapiro v. Thompson*, 394 U.S. 618 (1969) (state’s justification for waiting period was that if “people can be deterred from entering the jurisdiction by denying them welfare benefits during the first year, state programs to assist long-time residents will not be impaired by a substantial influx of indigent newcomers”).

because federal Equal Protection prohibits states from imposing durational residency requirements for government benefits.<sup>85</sup> Those economic incentive arguments against state benefits should not be given undue weight, however, as various sources rebut the “welfare magnet” notion that people move simply to obtain government services. In fact, those most in need of government assistance may be the least able to relocate.<sup>86</sup>

In sum, the U.S. Constitution, in text, purpose, structure, and policy provides little support for a federal health care right. If any right to health exists, it would be more suitably identified in state constitutions. The next Part provides a comprehensive survey of relevant state constitutional provisions on health and judicial decisions construing those terms.

## II. STATE CONSTITUTIONAL PROVISIONS ON HEALTH

This Part surveys state constitutions expressly referring to health and case law relying on those provisions. Thirteen state constitutions specifically mention health.<sup>87</sup> Six of those provisions have been judicially interpreted.<sup>88</sup> Another state’s constitutional provision on “beneficent provision” for the needy has been interpreted to encompass health care.<sup>89</sup> One additional state judicially recognizes health care as a fundamental

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<sup>85</sup> See, e.g., *Saenz*, 526 U.S. at 511 (California durational residency requirement for Temporary Assistance to Needy Families (TANF) benefits violated Fourteenth Amendment right to travel); *Maricopa*, 415 U.S. at 269 (Arizona one-year residency requirement for free medical care to indigents violated Equal Protection and right to travel); *Shapiro*, 394 U.S. at 641 – 42 (one-year residency requirement for Aid to Families with Dependent Children (AFDC) violated Equal Protection and right to travel).

<sup>86</sup> See *Saenz*, 526 U.S. at 506 (“although it is reasonable to assume that some persons may be motivated to move for the purpose of obtaining higher benefits, the empirical evidence reviewed by the District Judge, which takes into account the high cost of living in California, indicates that the number of such persons is quite small”); Scott W. Allard & Sheldon Danziger, *Welfare Magnets: Myth or Reality?*, 62 J. POL. 350, 363 (2000) (concluding that single parents do not move frequently, and when they do it is for reasons other than taking advantage of a state’s welfare benefits); F.H. Buckley & Margaret F. Brinig, *Welfare Magnets: The Race for the Top*, 5 SUP. CT. ECON. REV. 141 (1997); Super, *supra* note 71, at 582 (suggesting that “research is mixed” on whether individuals “respond to differences in welfare policy”); cf. PAUL E. PETERSON & MARK C. ROM, *WELFARE MAGNETS: A NEW CASE FOR A NATIONAL STANDARD* 82 – 83 (1990) (noting that welfare policies may affect geographic residency choices in the long-term, if not the short-term).

<sup>87</sup> See ALA. CONST. art. IV, § 93.12; ALASKA CONST. art. VII, § 4; ARK. CONST. art. 19, § 19; HAW. CONST. art. IX, §§ 1, 3; ILL. CONST. pmbl.; LA. CONST. art. XII, § 8; MICH. CONST. art. 4, § 51; MISS. CONST. art. IV, § 86; MO. CONST. Art. 4, § 37; MONT. CONST. art II, § 3; N.Y. CONST. art. 17, §§ 1, 3; S.C. CONST. art. XII, § 1; WYO. CONST. art. 7, § 20.

<sup>88</sup> See *infra* Part II.B.

<sup>89</sup> N.C. CONST. art. XI § 4 (“Beneficent provisions for the poor, the unfortunate and the orphan is one of the first duties of a civilized and Christian state”); see *infra* Part II.B.3 (discussing North Carolina case law).

value, despite the absence of a constitutional statement.<sup>90</sup>

### A. Overview of State Constitutional Provisions

The year of adoption for state constitutional provisions on health varies widely.<sup>91</sup> The earliest provision dates back to 1869, along with two others enacted in the late 1800s. The last two states admitted to the Union, Alaska and Hawaii, have constitutional provisions on health. Alaska's, adopted in 1956, pre-dates its statehood by three years. Hawaii's is the most recently adopted, in 1978. Six others date to the 1970s. One state's constitutional amendments addressing health were added in the late 1930s, at the time of progressive federal reforms, including the Social Security Act, designed to promote recovery after the Great Depression.<sup>92</sup> Another state's was adopted in the early 1960s Great Society era, which brought federal programs to address poverty and social injustice, including Medicare and Medicaid.<sup>93</sup>

The text of state constitutions reveals certain trends. Some constitutions arguably create enforceable rights.<sup>94</sup> Others merely recognize health as an important value, public concern, or aspiration. Some contain mandatory language that the state or, specifically, state legislature, "shall pass suitable laws" or "shall provide" for the health of citizens. Other constitutions identify the state's power or authority over health, but not a duty. In addition to varying strength of rights-creating language, state constitutions differ in their inclusiveness. Some limit the right or duty to the indigent, insane, or other vulnerable members of society. Other constitutions specify types of services, such as public health or hospital care. All of the provisions fall well short of a broad guarantee of health.

### B. Judicial Interpretation of State Constitutions

Judicial interpretation of the relevant provisions is relatively thin. Most

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<sup>90</sup> See *infra* Part II.B.7 (discussing New Jersey cases).

<sup>91</sup> See Appendix A (chart listing text of provisions and dates of adoption).

<sup>92</sup> PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 266 – 70 (1982) (describing history of Social Security Act); Joel Handler, "Constructing the Political Spectacle": *The Interpretation of Entitlements, Legalization, and Obligations in Social Welfare History*, 56 *BROOKLYN L. REV.* 899, 912 – 20 (1990) (describing the New Deal welfare reforms).

<sup>93</sup> STARR, *supra* note 92, at 367 – 74 (describing Great Society programs and Medicare and Medicaid enactment); Peter B. Edelman, *Toward a Comprehensive Antipoverty Strategy: Getting Beyond the Silver Bullet*, 81 *GEORGETOWN L.J.* 1697, 1710 – 18 (1993) (describing Great Society programs and aftermath).

<sup>94</sup> See Appendix B (chart summarizing similarities and differences in the text of state constitutional provisions).

cases rely on the constitutional provisions pertaining to health indirectly to support a conclusion on a different question. When state courts have enforced the provisions, the holdings have been deliberately narrow, drawing careful lines to avoid broadly applicable rights to health.

### 1. Michigan

Michigan is a useful starting point because it has seen the most direct claim of a broad, enforceable right to health care. Article 1, section 51 of Michigan's constitution, provides: "The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health..."<sup>95</sup> The first sentence is largely aspirational, expressing a shared value and concern for health as primary responsibility of the state.<sup>96</sup> By its terms, the constitution recognizes "public health" and "general welfare," not individual rights. The second sentence uses mandatory language, requiring the legislature to pass public health laws.

In *Michigan Universal Health Care Action Network v. State*,<sup>97</sup> various advocacy groups brought a class action on behalf of uninsured and underinsured residents, seeking a declaratory judgment that article 1, section 51 requires the legislature to establish a state-wide health care plan.<sup>98</sup> The court of appeals' brief, unreported opinion affirmed the trial court's dismissal for lack of standing.<sup>99</sup> The appeals court noted that section 51 is not self-executing and merely empowers the legislature to enact laws.<sup>100</sup> Despite the mandatory language in the second sentence, the court concluded that the provision did not "require the state to provide state-funded health care coverage."<sup>101</sup> Accordingly, the plaintiffs could not show the requisite "causal connection between the State's alleged failure to comply with the constitution by enacting a health care plan and the plaintiff's injuries, allegedly caused by their lack of health coverage."<sup>102</sup> The case was dismissed without reaching the merits.

The few other Michigan cases referring to section 51 involved

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<sup>95</sup> MICH. CONST. ART. 4, § 51

<sup>96</sup> See Gary A. Benjamin & Shaakirrah R. Sanders, *Michigan's Duty to Provide Access to Health Care*, 6 J.L. & SOC. 1, 13 (2005).

<sup>97</sup> 2005 WL 3116595 (Mich. App. 2005).

<sup>98</sup> 2005 WL 3116595 (Mich. App. 2005); see Benjamin & Shaakirrah, *supra* note 98, at 32 – 33 (discussing case background, with appellate review pending).

<sup>99</sup> *Id.* at \*1.

<sup>100</sup> *Id.* at \*2.

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

malpractice or negligence suits against state-owned health care facilities. The defendants claimed governmental immunity based. In two of the cases, patients themselves were injured by hospital staff.<sup>103</sup> In the third case, a third-party in the community was injured by an inpatient on a grounds pass.<sup>104</sup> In all three cases, the courts held that the hospital entities and employees were immune from liability, noting that they were acting “in furtherance of the state’s constitutional mandate to protect and promote public health.”<sup>105</sup> With respect to enforceable health rights, the decisions in effect give with one hand and take away with the other. They first acknowledged the state’s duty to provide care and treatment but then held the governmental actors immune for failing to properly carry out the duty.<sup>106</sup> The relevance of the constitution was merely to establish that the defendants were carrying out a public function. As interpreted by Michigan courts, article 1, section 51 does not create, and, in fact, seems to negate, any enforceable claim over state action or inaction.

## 2. New York

Another promising venue for constitutional protection of health is New York, which has been widely acknowledged as a bastion of social and economic rights.<sup>107</sup> Two constitutional provisions could be interpreted as establishing health rights. First, the “Aid to the Needy Provision,” article 17, section 1: “The aid, care, and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time

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<sup>103</sup> *Perry v. Kalamazoo State Hospital*, 273 N.W.2d 421 (Mich. 1978) (patient placed in restraints and asphyxiated on his own vomit); *Coen v. Oakland County*, 400 N.W.2d 614 (Mich. 1987) (patient allegedly injured by prescription drugs).

<sup>104</sup> *Hamilton v. Reynolds*, 341 N.W.2d 152 (Mich. 1983) (woman killed in her home by patient released on grounds pass).

<sup>105</sup> *Id.* at 154 (citing section 51); *see also Perry*, 273 N.W.2d at 423 n.4 (quoting section 51); *Coen*, 400 N.W.2d at 615- 16 (citing section 51).

<sup>106</sup> In *Perry*, the claim was framed as a breach of the defendant hospital’s “duty to provide for the care, treatment and custody of its patients.” 273 N.W.2d at 210, n.1. *Coen* noted that “the provision of mental health services ... involves an activity impliedly mandated by the State Constitution.” 400 N.W.2d at 615.

<sup>107</sup> *See TARR*, *supra* note 61, at 149 (suggesting that New York “pioneered” state efforts, “committing itself explicitly to providing for the social welfare of its residents”); Williams, *supra* note 15, at 25 (citing New York provisions as examples of positive rights); Hershkoff, *supra* note 17, at 1144 – 45 (citing New York constitution as example of mandatory obligation on state); Alan Jenkins & Sabrineh Ardalann, *Positive Health: The Human Right to Health Care Under the New York State Constitution*, 35 FORDHAM URB. L.J. 479, 483 (2008) (“New York’s Constitution is particularly protective of [education, shelter, and health care] rights”); Sunstein, *supra* note 18, at 13 – 14 (describing New York as “exemplary” of state “constitutional declaration of social and economic rights”).

determine.”<sup>108</sup> Second, the “Public Health Provision,” article 17, section 3: “The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.”<sup>109</sup> The provisions identify “aid, care, and support” and “health” as matters of “public concern.” Both provisions use mandatory “shall” language but accord discretion to the legislature to determine “in such manner and by such means” to provide state assistance.

In 1938, New York adopted five amendments expressly recognizing welfare needs of citizens as matters of public concern, including the Aid to the Needy and Public Health Provisions. Other amendments addressed care and treatment for persons with mental illnesses<sup>110</sup> and housing for low-income citizens.<sup>111</sup> The Public Health Provision aimed primarily at address public health and hygiene concerns of the era, such as sanitation and vaccination. But reports on the Constitutional Convention suggest that lawmakers also discussed important, recent medical advances and the eventual need for universal health care.<sup>112</sup> Despite those aspirational beginnings, the New York constitutional provisions have not supported broad claims to health rights.

There is little relevant case law on the Public Health provision. Most cases merely recognize local public health departments’ authority to promulgate rules and regulations.<sup>113</sup> When plaintiffs have asserted claims

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<sup>108</sup> N.Y. CONST. art. 17, § 1.

<sup>109</sup> N.Y. CONST. art. 17, § 3.

<sup>110</sup> N.Y. CONST. art. 17, § 4 (“The care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by state and local authorities and in such manner as the legislature may from time to time determine.”).

<sup>111</sup> N.Y. CONST. art. 18, § 1 (“Subject to the provisions of this article, the legislature may provide in such manner, by such means and upon such terms and conditions as it may prescribe for low rent housing and nursing home accommodations for persons of low income as defined by law”).

<sup>112</sup> See Helen Hershkoff, *Welfare Devolution and State Constitutions*, 67 *FORDHAM L. REV.* 1403, 1415 – 25 (1999) (discussing history of Article XVII); Jenkins & Ardalann, *supra* note 108, at 483 – 95 (discussing history of amendments); Martha Davis, *Part I: The Spirit of our Times: State Constitutions and International Human Rights*, 30 *N.Y.U. REV. L. & SOC. CHANGE* 359, 392 (2006); see also STARR, *supra* note 92, at 182 – 89 (describing New York’s early public health interventions); Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 *AM. J. PUB. HEALTH* 75, 75-85 (2003); R.L. Duffus, *Shall Medicine Be Socialized? A Big Issue Is Joined*, *N.Y. TIMES*, Dec. 4, 1932, at XX7; S.J. Duncan-Clark, *Editorial, Doctors and Laity in Row over Health*, *N.Y. TIMES*, Apr. 21, 1929, at 51 (“The mounting cost of medical care has become a most serious problem for many persons of moderate means.”).

<sup>113</sup> See, e.g., *Conlon v. Marshall*, 59 *N.Y.S.2d* 52 (Sup. Ct. 1945) (regarding New York

under the Public Health Provision, courts have side-stepped the question. For example, in *Hope v. Perales*,<sup>114</sup> plaintiffs charged that a state parental assistance program that did not cover abortions as medical services violated the Public Health Provision.<sup>115</sup> The court held that the parental assistance program was not aimed at protecting the public's health; therefore, the Public Health Provision was inapplicable.<sup>116</sup> Similarly, in *Aliessa v. Novello*,<sup>117</sup> the court declined to rely on the Public Health Provision to uphold a challenge to the state's denial of Medicaid to undocumented immigrants. The court recognized a duty to provide Medicaid benefits to the plaintiffs but based its decision on the Aid to the Needy Provision instead.

Based on that provision and federal precedent, the *Aliessa* court cited the U.S. Supreme Court's then-recent decision in *Memorial Hospital v. Maricopa County*,<sup>118</sup> which identified health care as a "basic necessity of life."<sup>119</sup> *Maricopa* struck down a state durational residency requirement for publicly funded nonemergency hospitalization or medical care as violating the constitutional right of interstate travel by denying newcomers the "basic necessities of life."<sup>120</sup> The key point in both *Aliessa* and *Maricopa* was that state benefits must be available equally to both newly-arrived and longer-term residents. But the cases do not recognize any baseline right to state-provided medical care.

The Aid to the Needy Provision, while not expressly mentioning "health," has been more vigorously interpreted to create affirmative rights.<sup>121</sup> The New York court noted: "In view of this legislative history, as well as the mandatory language of the provision itself, it is clear that section 1 of article XVII imposes upon the State an affirmative duty to aid the

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City tuberculosis regulation).

<sup>114</sup> 634 N.E.2d 183 (N.Y. 1994).

<sup>115</sup> *Id.* at 188

<sup>116</sup> *Id.*

<sup>117</sup> 754 N.E.2d 1085 (N.Y. 2001)

<sup>118</sup> 415 U.S. 250 (1974).

<sup>119</sup> *Aliessa*, 754 N.E.2d at 1093 (quoting *Maricopa*, 415 U.S. at 259).

<sup>120</sup> 415 U.S. at 259 (citing *Shapiro v. Thompson*, 394 U.S. 618 (1969) (striking durational residency requirement on welfare benefits)); Department of Health, Education, and Welfare (HEW), Report to Congress on Medical Resources Available to Meet the Needs of Public Assistance Recipients; President Nixon; and Ghandi).

<sup>121</sup> See, e.g., *Tucker v. Toia*, 317 N.E.2d 449, 451 – 53 (N.Y. 1977) (finding affirmative state duty to provide home relief benefits to minor children living alone); *McCain v. Koch*, 511 N.E.2d 62, 62 – 63 (N.Y. 1987) (upholding injunction against New York City emergency homeless shelter to maintain minimum standards); *Wilkins v. Perales*, 487 N.Y.S.2d 961, 964 (Sup. Ct. 1985) (recognizing Aid to the Needy provision as individually enforceable fundamental right); *Hershkoff*, *supra* note 113, at 1425 (discussing individually enforceable right to welfare under New York constitution).

needy.”<sup>122</sup> In the Medicaid case, *Aliessa*, the New York court held that denying medical assistance based on criteria other than need, namely, immigration status, violated the letter and spirit of the Aid to the Needy Provision.<sup>123</sup> The court emphasized that “care of the needy is not a matter of ‘legislative grace,’ it is a constitutional mandate.”<sup>124</sup> Even while recognizing a constitutional duty on the state, the New York court stopped short of telling the state legislature how to carry out its duty,<sup>125</sup> allowing considerable discretion to define the scope of its obligations and flexibility to adapt to changing circumstances.<sup>126</sup> The New York Court of Appeals was similarly hesitant to spell out the contours of the state’s duty to provide mental health treatment under that constitutional provision.<sup>127</sup>

Despite some expectation that New York would recognize a broad, constitutional right to health, judicial interpretation of the 1938 amendments is more equivocal. New York courts declined the opportunity to recognize enforceable rights under the Public Health provision. Courts do recognize an affirmative duty under the Aid to the Needy provision but will not tell the legislature how to carry out the duty.

### 3. North Carolina

Similar to New York’s Aid to the Needy provision, the North Carolina constitution does not expressly mention health, but a provision on welfare has been the basis of several claims involving medical treatment. Article XI, section 4, provides: “Beneficent provisions for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and

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<sup>122</sup> *Tucker*, 317 N.E.2d at 452.

<sup>123</sup> *Id.* at 1098 – 99.

<sup>124</sup> *Id.* at 1092; *see similarly* *Lovelace v. Gross*, 605 N.E.2d 339, 342 (N.Y. 1992) (“recognizing that the Legislature may not refuse to aid the needy” (citing *Tucker*)).

<sup>125</sup> *See Lovelace*, 605 N.E.2d at 342 (New York “Constitution vests the Legislature with discretion”); *Tucker*, 317 N.E.2d at 452 (recognizing that constitution grants legislature discretion “in determining the amount of aid, and in classifying recipients and defining the term ‘needy’”).

<sup>126</sup> *See* *Hershkoff*, *supra* note 112, at 1427 – 28.

<sup>127</sup> The court recognized minors’ due process right to treatment as a consequence of being deprived of their liberty by being placed in state training facilities but declined to address the adequacy of the treatment. *Lavette v. City of New York*, 316 N.E.2d 314, 317 (N.Y. Ct. App. 1974).

We are frank to acknowledge the practical limitations upon the power of courts to determine the adequacy and effectiveness of treatment afforded [minors in need of state supervision]. By what yardstick shall we measure? Surely the role of formulating criteria to measure the effectiveness of treatment facilities is not and should not be an exclusively judicial function.

*Id.*

Christian state. Therefore the General Assembly shall provide for and define the duties of a board of public welfare.”<sup>128</sup> The provision expressly declares a state duty but limited to the “poor” and “unfortunate.”

An early North Carolina Supreme Court decision clearly turned on the indigent status of the patient. *State Hospital at Raleigh v. Security National Bank*,<sup>129</sup> involved a hospital collections action against the guardian of a deceased patient. The patient, a U.S. Army veteran, was both insane and indigent when admitted to the hospital.<sup>130</sup> During his stay, the patient became eligible for Veterans’ Bureau financial assistance, sufficient to cover the cost of care he had received.<sup>131</sup> The patient’s guardian claimed that the Veterans’ Benefits were exempt from any and all creditors and, therefore, the hospital could not collect. The Supreme Court of North Carolina observed that, “The Constitution of North Carolina empowers the General Assembly to provide that indigent insane persons shall be cared for at the charge of the state.”<sup>132</sup> The court then noted that nothing in the constitution required or authorized the legislature “to provide care, treatment, or maintenance of nonindigent insane persons at the expense of the state.”<sup>133</sup> Accordingly, once the patient became nonindigent, he had no further right to state-provided care.<sup>134</sup>

North Carolina affirmed that approach in *Graham v. Reserve Life Insurance Company*,<sup>135</sup> holding that a state-operated tuberculosis sanatorium could collect payment from a nonindigent’s health and accident insurance policy.<sup>136</sup> Rejecting the patient’s argument that providing free tuberculosis treatment to the indigent, while collecting payment at varying rates from the nonindigent and insured, violated equal protection, the court noted:

Germs attack both the affluent and the indigent. Therefore, in order to protect all its citizens, the State must – in the first instance, at least – provide treatment without cost to the indigent. It does not follow, however, that it must also furnish free treatment to those who are able to pay or who have had

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<sup>128</sup> N.C. CONST. art. XI, § 4.

<sup>129</sup> 178 S.E. 487 (N.C. 1935).

<sup>130</sup> *Id.* at 488.

<sup>131</sup> *Id.*

<sup>132</sup> *Id.* at 491; N.C. CONST. (1868) art. XI, § 10; see John L. Sanders, *Our Constitutions: A Historical Perspective, The North Carolina Constitution*, State Library of North Carolina (summarizing history of constitutional conventions and amendments), available at <http://statelibrary.ncdcr.gov/nc/STGOVT/PRECONST.HTM>.

<sup>133</sup> *Id.* at 491.

<sup>134</sup> *Id.* at 492.

<sup>135</sup> 161 S.E.2d 485 (S.C. 1968).

<sup>136</sup> *Id.* at 491.

the forethought to purchase insurance to cover the cost of hospitalization.<sup>137</sup>

The state's decision to allocate scarce resources to the indigent, while collecting payment from those who can afford to pay, did not operate as unconstitutional discrimination.<sup>138</sup>

Two more recent decisions likewise narrowly define the constitutional duty. First, *Casey v. Wake County*<sup>139</sup> considered whether a county health department family planning clinic was a governmental actor entitled to sovereign immunity. The personal injury action was brought by a sixteen-year-old plaintiff who developed complications from insertion of an intrauterine device. In upholding the health department's immunity claim, the court cited article XI, section 4, noting that "our State Constitution mandates care for those in need as a duty of the state."<sup>140</sup> The duty may be delegated to counties and local boards of health, authorized by statute to make rules and regulations "not inconsistent with law, as are necessary to protect and advance the public health."<sup>141</sup> The county family planning clinic, under such delegation, provided services "to all women, whether they can pay or not"<sup>142</sup> and as "a benefit to the general populus,"<sup>143</sup> consistent with the state's duty to provide for the "health and welfare of the citizens of the county."<sup>144</sup> Distributing free family planning and contraceptives, therefore, was a governmental function for which the hospital was entitled to immunity.<sup>145</sup> The decision did not explicitly turn on the plaintiff's lack of ability to pay or otherwise limit the definition of "need" to financial status. References to the "general populus" and suggestion of a duty "to all women," could be read to support a broader duty, not limited to the indigent. But there is no case law supporting that interpretation.

*Craven County Hospital Corporation v. Lenoir County*<sup>146</sup> suggests that North Carolina courts likely would not accept the broader reading. *Craven County* involved an action by a private hospital against a city, county, and sheriff's department to recover costs of medical care provided to an indigent, intoxicated person injured while in police custody. As a threshold matter, the court clarified that the intoxicated man was not under arrest but

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<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

<sup>139</sup> 263 S.E. 2d 360 (N.C. App. 1980).

<sup>140</sup> *Id.* at 361.

<sup>141</sup> *Id.* (citing N.C.G.S. 130-17(b)).

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Id.*

<sup>145</sup> *Id.* at 362.

<sup>146</sup> 331 S.E.2d 690 (N.C. App. 1985).

had merely been detained by the sheriff's department, as authorized by statute, until he became sober.<sup>147</sup> The court also clarified that the patient's injury resulted from his own intoxicated state, not any conduct by the officers.<sup>148</sup> Had the patient been in police custody under arrest or conviction, the case would likely have come out differently, with federal constitutional implications.<sup>149</sup>

On the issues raised, the court considered the hospital's constitutional claim that article XI, section 4 imposed a duty to provide medical care and, therefore, pay for the patient's treatment.<sup>150</sup> The court noted that article XI, section 4 makes clear that "care of the indigent sick and afflicted poor is a proper function of the Government of this State" and that the function may be delegated to local governments.<sup>151</sup> Carefully parsing the text, the court acknowledged that the state had properly delegated the "duty to provide local *public health* services" to counties but not the duty to provide hospital care or establish public hospitals.<sup>152</sup> Accordingly, the county had no duty to pay for the man's hospital care. Therefore, the hospital could not collect payment from the county, city, or sheriffs' department for the cost of the intoxicated patient's care.<sup>153</sup>

*Craven County Hospital* demonstrates the careful line that courts draw in declining to recognize an affirmative right to state-funded health care. The case carefully specified that the patient was not under arrest in police custody, which would have created a duty to provide medical care. The decision also distinguished sharply between "public health" and "hospital care." Moreover, the case recognized that the state's duty does not extend to governmental subunits absent a clear legislative delegation. The court seemed untroubled by the fact that the private hospital would be left bearing the cost of care for an indigent patient delivered to its doors by governmental authorities. Had the man wandered into the hospital on his own, the result presumably would have been the same: The hospital would have treated him and been unable to collect payment.<sup>154</sup>

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<sup>147</sup> *Id.* at 693 (citing N.C.G.S. 122-65.13).

<sup>148</sup> *Id.* at 693 – 94.

<sup>149</sup> See *infra* notes 247 – 50 and accompanying text (explaining Eighth Amendment implications).

<sup>150</sup> 331 S.E.2d at 694.

<sup>151</sup> *Id.* at 694 (citing *Martin v. Comm'rs of Wake*, 180 S.E. 777 (N.C. 1935) (interpreting 1868 constitution)).

<sup>152</sup> *Id.* at 695 (emphasis added).

<sup>153</sup> *Id.*

<sup>154</sup> *Craven County* pre-dates the federal patient "anti-dumping" law, the Emergency Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, enacted in 1986. Even had EMTALA been in effect at the time of the decision, it would not create a right to treatment for the patient or right to payment for the hospital. EMTALA requires hospitals that maintain emergency rooms and participate in the Medicare program to screen and stabilize

#### 4. Mississippi

Mississippi's provision is one of the oldest on the books, adopted in 1869, and thus could be a source of well-developed judicial interpretation. Article IV, Section 86 provides: "It shall be the duty of the legislature to provide by law for the treatment and care of the insane; and the legislature may provide for the care of the indigent sick in the hospitals in the state...."<sup>155</sup> The text is clear that the mandatory, "shall ... provide" provision applies only to mental health care for "the insane." Otherwise, the state, seemingly in its discretion, "may provide" general hospital care to "the indigent sick."

Consistent with the constitutional text, Mississippi courts have not recognized a broad right to health care under article IV, section 86. In *Craig v. Mercy Hospital-Street Memorial*,<sup>156</sup> a hospital sought to compel the state treasury to pay a requisitioned grant of state funds, which would then be matched by federal grants. The State Attorney General deemed the hospital ineligible for the state grant on two grounds: First, a state statute limited the federally matched grants to non-profit entities. Second, a different constitutional provision, section 66, prohibited the state from giving any "donation or gratuity" for "a sectarian purpose or use."<sup>157</sup>

The Mississippi Supreme Court rejected the Attorney General's first argument, concluding that the hospital was a non-profit organization.<sup>158</sup> On the second argument, the court acknowledged that the hospital was religiously affiliated but noted that it operated under a separate charter from the Sisters of Mercy and described itself as nonsectarian. Accordingly, the court held that the grant to the hospital did not violate section 66. The court also noted that section 86 of the Mississippi constitution creates an "obligation ... though not a mandatory duty" to provide hospital care for the indigent sick.<sup>159</sup> In carrying out that duty, the legislature could delegate to private entities, including those with religious affiliation.<sup>160</sup> A state "grant"

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patients regardless of their ability to pay but does not prohibit hospitals from attempting to collect payment after the fact. 42 U.S.C. §1395dd(b)(1) (2000); *see* Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,222 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489) (summarizing EMTALA requirements).

<sup>155</sup> MISS. CONST. art. IV, § 86.

<sup>156</sup> 45 So.2d 809 (Miss. 1950).

<sup>157</sup> *Id.* at 810 – 11 (citing MISS. CONST. art. IV, § 66).

<sup>158</sup> *Id.* at 814.

<sup>159</sup> *Id.* at 817 – 18.

<sup>160</sup> *Id.* at 818.

to a private entity carrying out the public purpose of providing indigent hospital care would not be considered “a donation or gratuity” violating section 66.<sup>161</sup> Accordingly, the plaintiff-hospital was eligible for the grant.

A more recent case considered the state’s constitutional duty to provide care for the mentally ill. In *Attorney General v. Interest of B.C.M.*,<sup>162</sup> the Mississippi Supreme Court considered whether a statute authorizing the facility director to refuse admission under certain circumstances violated section 86.<sup>163</sup> The case involved a minor court-ordered for treatment at a local hospital. The director of the hospital refused to admit the patient, citing lack of space. The court noted that the state’s “duty to care for the mentally ill is constitutionally mandated” but, as in *Craig*, allowed the state to delegate the public function to particular health care providers.<sup>164</sup> While the “Constitution mandates that the Legislature provide for the care of the insane, it places no restrictions on how the Legislature may allot that duty.”<sup>165</sup> The Court concluded that the state fulfilled its constitutional duty by requiring the admitting institution to assume at least temporary responsibility for court-ordered patients, even if the hospital is unable to keep the patient for longer-term treatment.<sup>166</sup> The refusal-to-admit provision, therefore, was constitutional.

The two reported Mississippi cases construing article IV, section 86 offer scant support for a general right to health care. At most, *Craig* clarifies that the state-provided hospital care for indigent patients is discretionary and can be delegated to private, religiously affiliated entities. *B.C.M.* recognizes the state’s mandatory duty to care for the insane and also allows that responsibility to be delegated. In addition, by upholding the statutory allowance for an institution to refuse admission based on lack of space, the *B.C.M.* court implicitly recognized pragmatic resource limits on the constitutional duty. Although the state “must” provide care, the duty can be satisfied by providing only temporary detention of patients.

## 5. South Carolina

South Carolina’s provision is similar to Michigan’s and New York’s in expressly recognizing health as a public concern and creating a mandatory duty on the legislature. Article XII, section 1 provides:

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<sup>161</sup> *Id.* at 822.

<sup>162</sup> 744 So.2d 299 (Miss. 1999).

<sup>163</sup> *Id.* at 299 (citing Miss. Code Ann. § 41-21-77)

<sup>164</sup> *Id.* at 302 – 03.

<sup>165</sup> *Id.* at 303.

<sup>166</sup> *Id.* at 305.

The health, welfare, and safety of the lives and property of the people of this State and the conservation of its natural resources are matters of public concern. The General Assembly shall provide appropriate agencies to function in these areas of public concern and determine the activities, powers, and duties of such agencies.<sup>167</sup>

There are no South Carolina cases interpreting the current provision, adopted in 1971, and case law on earlier versions is very limited. Although the current text does not limit any state duty to mental health as opposed to general medical care, the constitution and courts historically made that distinction.

A 1941 South Carolina Supreme Court case, *Crouch v. Benet*,<sup>168</sup> involved a taxpayer petition to enjoin a state loan to a hospital and training center for the mentally ill.<sup>169</sup> The court noted the state's long history of providing care for the "unfortunate," dating back to 1822, with "probably the oldest building now standing in the United States built by a State for the insane."<sup>170</sup> The court cited an earlier version of article XII, section 1, which provided that "institutions for the care of the insane ... and poor shall always be fostered and supported by this State,"<sup>171</sup> which the court deemed both "a wise provision of law" and "long established public policy."<sup>172</sup> Accordingly, the court recognized the state's role in assisting "helpless members of society who because of mental infirmities cannot care for themselves" as a "mandate of the Constitution of the State."<sup>173</sup> State loans to the defendant hospital comported with that duty, and the taxpayer's challenge was rejected.

*Crouch* hardly stands as a judicial declaration of an individual right to health care, providing merely that appropriations shall be made as often as necessary to carry out the purpose of article XII, section 1.<sup>174</sup> Also, the court limited to the state's duty to care for the mentally ill, even though the constitutional provision referred to "helpless members of society" more broadly.

## 6. Montana

Montana's 1972 constitution contains an express "inalienable rights"

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<sup>167</sup> S.C. CONST. art. XII, § 1

<sup>168</sup> 17 S.E.2d 320 (S.C. 1941).

<sup>169</sup> *Id.* at 321.

<sup>170</sup> *Id.* at 323.

<sup>171</sup> *Id.* at 323.

<sup>172</sup> *Id.* 323-24.

<sup>173</sup> *Id.* at 324.

<sup>174</sup> *Id.*

provision that includes “health,” suggesting a promising venue for clear judicial recognition. Article II, section 3, provides:

All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life’s basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and seeking their safety, health and happiness in all lawful ways.<sup>175</sup>

Despite the robust language, close reading and judicial interpretation of the provision limits article II, section 3 to negative rights to be free from governmental interference, not affirmative rights to government services. Specifically, “[a]ll persons” have “inalienable rights” to “seek[] their ... health ... in all lawful ways.” In other words, the state is prohibited from interfering with an individual’s lawful pursuit of health but does not have to provide health care to individuals. For the most part, Montana case law has consistently restricted the provision to that interpretation.

For example, a recent Montana Supreme Court opinion, *Simms v. Montana Eighteenth Judicial District Court*, relied on article II, section 3 in deciding a procedural issue in a medical malpractice case.<sup>176</sup> The issue was whether the trial court exercised proper supervisory control over the litigation by ordering the plaintiff-patient to undergo an invasive independent medical evaluation in Oregon at the defendant-hospital’s request. The Supreme Court held that the trial court abused its discretion in ordering the examination, noting: “When a proposed examination risks unnecessary, painful or harmful procedures, the scale must favor protecting individual rights.” Accordingly, the state, or trial court judges, cannot compel individuals to submit to unnecessary medical examinations. *Simms* identifies health as a fundamental right<sup>177</sup> but hardly establishes an affirmative, enforceable right to health care. At most, the decision recognizes the negative right to be free from burdensome, painful intrusions on individual health and bodily integrity.

The Montana Supreme Court similarly recognized the inalienable right to health as a negative right in other contexts. *Armstrong v. State*<sup>178</sup> struck down a statute providing that only physicians could lawfully perform pre-viability abortions. Non-physician health care providers challenged the statute on state constitutional grounds. The decision turned primarily on

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<sup>175</sup> MONT. CONST. art II, § 3.

<sup>176</sup> 68 P. 3d 678, 682, 683 (Mont. 2003) (citing art. II, §§ 3 (right to safety, health, and happiness), 10 (right to privacy)).

<sup>177</sup> *Id.* at 685 (concluding that trial court abused its discretion, when considering requested examination “in the context of *Simms*’ fundamental rights”).

<sup>178</sup> 989 P. 2d 364 (Mont. 1999).

Montana's constitutional privacy provision, Article II, Section 10.<sup>179</sup> But the court buttressed its holding, noting that "Article II, Section 3, guarantees each person the inalienable right to seek safety, health and happiness in all lawful ways – i.e., in the context of this case, the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference."<sup>180</sup> The decision echoes *Simms*'s recognition of individual rights of bodily integrity and medical decisionmaking. *Armstrong* specified that the fundamental right of privacy includes a "personal autonomy component" that "broadly guarantees each individual the right to make medical judgments affecting his or her bodily integrity and health in partnership with a chosen health care provider free from the interference of the government."<sup>181</sup>

Another recent case, *In the Matter of C.R.O.*,<sup>182</sup> sounds a similar note. The Supreme Court reversed a decision terminating parental rights of a father who was undergoing treatment for mental illness. The majority declined to terminate parental rights, finding the evidence lacking that the father's condition was unlikely to change within a reasonable time, which would allow him to assume the role of parent.<sup>183</sup> The holding did not turn on article II, section 3. But Justice Nelson in dissent noted that "the Court's decision trammels the inalienable constitutional rights of [the child] to pursue life's basic necessities, to enjoy a safe, healthy, and happy life" and "basic human dignity," presumably through adoption or foster care in a "permanent, stable and loving family."<sup>184</sup> Justice Nelson's passionate dissent, reminiscent of Justice Blackmun in *DeShaney*, concluded: "Once again, the biological parent wins a court case and the child loses a shot at a decent life. How sad. Indeed, how tragic."<sup>185</sup> Certainly, the constitutional provision played no role in the majority's decision to uphold parental rights. But *C.R.O.* suggests that at least one justice would give constitutional weight to certain basic necessities, including health. Moreover, Justice

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<sup>179</sup> MONT. CONST. art. II, § 10 ("The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.").

<sup>180</sup> *Id.* at 389.

<sup>181</sup> *Id.* at 384.

<sup>182</sup> 43 P. 3d 913 (Mont. 2002).

<sup>183</sup> *Id.* at 919.

<sup>184</sup> *Id.* at 921 (citing art. II, § 3), 922 (paraphrasing same).

<sup>185</sup> *Id.* at 922; *see similarly* *DeShaney v. Winnebago Co. Dep't of Soc. Services*, 489 U.S. 189, 196 (1989) (Blackmun, J., dissenting) (exclaiming, "Poor Joshua!" and noting that as a result of the Court holding no constitutional duty to protect the child from his father's abuse, "this child, Joshua DeShaney, now is assigned to live out the remainder of his life profoundly retarded").

Nelson seemed willing to recognize affirmative state action, specifically, removing the child from parental custody, might be required to protect the inalienable health right.

Even more revealing of Montana's strong preference for negative rights is its willingness to imply certain fundamental rights, bootstrapping from the express inalienable rights provision. *Wadsworth v. State*<sup>186</sup> involved state worker's claim for wrongful termination under a regulation that prohibited state employees from moonlighting. The court held that the anti-moonlighting law violated the plaintiff's fundamental right to pursue employment under article II, section 3. The court quoted the inalienable rights provision and acknowledged that employment was not one of the enumerated rights.<sup>187</sup>

[N]evertheless, we have held that rights may be 'fundamental' under Montana's constitution if the right is either found in the Declaration of Rights or is a right 'without which other constitutionally guaranteed rights would have little meaning.' The inalienable right to pursue life's necessities is stated in the Declaration of Rights and is therefore a fundamental right.<sup>188</sup>

The court further noted that employment enables the worker to obtain "the most basic of life's necessities, such as food, clothing, and shelter" and "other essentials of modern life, *including health and medical insurance, retirement, and day care.*"<sup>189</sup> Having concluded that article II, section 3, contains an implied fundamental right to employment, the court then applied strict scrutiny, requiring "the State to show a compelling state interest" and that "the legislative action is the least onerous path that can be taken to achieve the state objective."<sup>190</sup> The state failed to meet that burden; therefore, the plaintiff was wrongfully discharged.<sup>191</sup> *Wadsworth* recognizes only a negative right to be free from government intrusion in the lawful pursuit of employment as a means to obtaining health insurance, not a positive right to government-provided health care. To wit, Montana courts have declined to recognize other implied fundamental rights, in particular, to government benefits.<sup>192</sup>

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<sup>186</sup> 911 P.2d 1165

<sup>187</sup> *Id.* at 1171 – 72 ("While not specifically enumerated in the terms of Article II, section 3 ... the opportunity to pursue employment is, nonetheless, necessary to enjoy the right to pursue life's basic necessities.")

<sup>188</sup> *Id.* (citation omitted).

<sup>189</sup> *Id.* at 1172 (emphasis added)

<sup>190</sup> *Id.* at 1174.

<sup>191</sup> *Id.* at 1175.

<sup>192</sup> *See Zempel v. Uninsured Employers' Fund*, 938 P.2d 658 (Mont. 1997) (no constitutional violation in excluding businesses operating exclusively on Indian reservations from workers compensation benefits); *Butte Community Union v. Lewis*, 712

By contrast to the equivocal stance on health, Montana courts have given much stronger enforcement for environmental rights. The same inalienable rights provision that includes health also lists “a clean and healthy environment.” The environmental right is the first in the list and is not limited to an individual’s own “seeking,” “possessing,” “pursuing,” “acquiring,” or “defending,” as the other inalienable rights are. Montana courts have allowed individual claims to enforce the environmental provision and squarely hold that the right is fundamental.

In *Montana Environmental Information Center v. Dept. of Environmental Quality*, environmental groups sought to enjoin a state-issued exploration license that would have allowed discharge of groundwater containing high levels of arsenic and zinc into two river aquifers.<sup>193</sup> The constitutional challenge to the statute authorizing the license was expressly based on article II, section 3<sup>194</sup> and article IX, section 1, which expressly requires the state to “maintain and improve a clean and healthful environment,” protect “environmental life ... from degradation,” and “prevent unreasonable depletion and degradation of natural resources.”<sup>195</sup> Together, those two constitutional provisions create a judicially enforceable right.

The court first held that the environmental organizations had standing to bring the challenge.<sup>196</sup> Moreover, the constitutional right was self-executing, without any legislative enactment, in noted contrast to the *Michigan Universal Health Care Action Network* decision in Michigan, which struck the plaintiffs’ claim for lack of standing and lack of an enforceable right.<sup>197</sup> Under the two constitutional provisions, the *Montana Environmental Information Center* court recognized a fundamental right to a clean and healthful environment, any interference with which would be subject to strict scrutiny,<sup>198</sup> citing *Wadsworth*.<sup>199</sup> The decision further relied on a detailed historical record of Montana’s 1972 Constitutional Convention on state environmental protection, suggesting the drafters’ intent that “healthful” modify or set a standard for the “environment.”<sup>200</sup> Other

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P.2d 1309 (Mont. 1986) (no implied fundamental right to state general assistance).

<sup>193</sup> 988 P. 2d 1236, 1237 (Mont. 1999).

<sup>194</sup> *Id.* at 1243 (citing MONT. CONST. art.II, § 3).

<sup>195</sup> *Id.* (citing MONT. CONST. art. IX, § 1, ¶¶ (1) & (3)).

<sup>196</sup> *Id.* at 1243.

<sup>197</sup> 2005 WL 3116595 (Mich. App. 2005); *see supra* notes 97 – 102 (discussing case).

<sup>198</sup> *Id.* at 1246.

<sup>199</sup> *Id.* at 1245.

<sup>200</sup> *Id.* at 1247 – 49; *see also* John L. Horwich, *Montana’s Constitutional Environmental Quality Provisions: Self-Execution or Self-Delusion?*, 57 MONT. L. REV. 323, 323 & n.1 (1996) (describing history of Montana’s 1972 Constitution); Cameron Carter & Kyle Karinen, Note, *A Question of Intent: The Montana Constitution*,

Montana decisions have similarly recognized a fundamental right to a “healthful environment” under the state constitution.<sup>201</sup>

## 7. New Jersey

The lessons of Montana’s implied fundamental rights decisions apply more broadly to New Jersey. The New Jersey constitution contains no specific provision on health, but New Jersey courts have consistently identified “preservation of health” as an implied constitutional right.<sup>202</sup>

Beginning with *Tomlinson v. Armour & Co.*<sup>203</sup> an early products liability suit over canned ham, the New Jersey Court of Appeals maintained that “among the most fundamental of personal rights, without which man could not live in a state of society, is the right of personal security, including the preservation of a man’s health from such practices as may prejudice or annoy it.”<sup>204</sup> Accordingly, the court upheld the plaintiff’s action against the tainted meat vendor, despite the presence of a contractual agreement and absence of scienter. As described in *Tomilson*, the right suggests freedom from interference with health, rather than a right to state-provided health care, much like the Montana cases. But the *Tomlison* language has been carried forward and applied more broadly in recent New Jersey decisions, most notably, abortion cases.

In *Right to Choose v. Byrne*,<sup>205</sup> the New Jersey Supreme Court struck down a state statute on Medicaid funding for abortions. New Jersey’s Medicaid program covered abortions only when the life of the mother was

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*Environmental Rights, and the MEIC Decision*, 22 PUB. LAND & RESOURCES L. REV. 97, 98 (2001) (“MEIC is the first decision by the Montana Supreme Court to delineate the nature and scope of the environmental provisions contained in Montana’s Constitution”).

<sup>201</sup> See, e.g., *Cape-France Enter. v. Estate of Peed*, 29 P. 3d 1001, 1016 (Mont. 2001) (noting that clean environment is a “fundamental right that may be infringed, only by demonstrating a compelling state interest” and allowing plaintiff to drill a well “may cause significant degradation of uncontaminated aquifers and pose serious public health risks”).

<sup>202</sup> See Helen Hershkoff, *The New Jersey Constitution: Positive Rights, Common Law Entitlements, and State Action*, 69 ALB. L. REV. 553, 553 – 55 (2006) (lauding New Jersey Supreme Court as “a jurisprudential entrepreneur ... on decisions that involve social and economic life” and noting that “not all important social welfare rights are enumerated in the New Jersey text”); Judith S. Kaye, *Forward: The Common Law and State Constitutional Law as Full Partners in the Protection of Individual Rights*, 23 RUTGERS L.J. 727, 738 – 50 (1992) (describing examples, including New Jersey, of judicial recognition of new individual rights, outside express constitutional provisions and characterizing trend as “a common law infused with constitutional values”).

<sup>203</sup> 70 A. 314 (N. J. Ct. App. 1908), *overruled in part by* *Henningsen v. Bloomfield Motors, Inc.*, 161 A.2d 69 (1960) (no longer requiring privity of contract for implied warranty claim).

<sup>204</sup> *Id.* at 317 (citations omitted).

<sup>205</sup> 450 A. 2d 925 (N.J. 1982).

in danger. The court recognized that a woman's right to choose an abortion is a fundamental right of all residents, "including those entitled to Medicaid reimbursement for necessary medical treatment."<sup>206</sup> The decision rested on two implied rights in the New Jersey Constitution: privacy and health. The right to privacy, deemed fundamental, derived from the New Jersey constitution's express recognition of "certain natural and unalienable rights," including "life, liberty and the pursuit of safety and happiness."<sup>207</sup> The trial court also recognized an implied, fundamental right to health, but the Supreme Court did not go quite that far. The Supreme Court cited *Tomlinson* as recognition "that New Jersey accords a high priority to the preservation of health."<sup>208</sup> Then, applying strict scrutiny to the abortion-funding law, the *Byrne* court held that "[i]n balancing the protection of a woman's health and her fundamental right to privacy against the asserted state interest in protecting potential life, we conclude that the governmental interference is unreasonable."<sup>209</sup>

In another case, *Horizon Health Center v. Felicissimo*,<sup>210</sup> a family planning clinic sought to enjoin anti-abortion protesters from picketing on the public sidewalk in front of the clinic.<sup>211</sup> The court upheld the injunction even though it restricted the protestors' free speech rights as narrowly tailored to serve the state's interest.<sup>212</sup> Citing both *Tomlinson* and *Byrne*, the Court noted that "the New Jersey Constitution does not explicitly guarantee a fundamental right to health" but does place a "high priority to the preservation of health."<sup>213</sup> After recognizing that the state "has a significant interest in insuring unrestricted access to ... medical services," the Supreme Court held that the trial court did not err in issuing the injunction against interference with that interest.<sup>214</sup> *Felicissimo* thus affirms New Jersey's recognition of a significant interest, if not fundamental right, to health care. *Byrne* comes closer to saying that the state must affirmatively provide certain medically necessary treatment once it establishes a medical assistance program.<sup>215</sup> *Felicissimo* does not compel

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<sup>206</sup> *Id.* at 934; *see also* *Doe v. Bridgeton Hosp. Ass'n*, 336 A.2d 641, 647 (N.J. 1980) (holding that hospital's moral objection to abortion could not override woman's right to reproductive choice).

<sup>207</sup> *Id.* at 933 (citing N.J. CONST. art 1, ¶ 1).

<sup>208</sup> *Id.* at 934.

<sup>209</sup> *Id.* at 937; *see* Hershkoff, *supra* note 202, at 555 (discussing *Byrne*).

<sup>210</sup> 638 A. 2d 1260 (N.J. 1994).

<sup>211</sup> *Id.* at 1262.

<sup>212</sup> *Id.* at 1268 – 69.

<sup>213</sup> *Id.* at 1269.

<sup>214</sup> *Id.*

<sup>215</sup> 450 A.2d at 936 – 37 (declining to rest decision solely on equal protection or due process grounds).

government action but recognizes the state's legitimate interest ensuring access to medical services, including abortion.

The abortion decisions recognizing health care as a "high priority" were cited in a different context, prisoner health care, and for a different result, to conclude that the state is not obligated to pay for medical services. In *Mourning v. CMS of St. Louis*<sup>216</sup> inmates challenged a law requiring prison inmate copayments for medical treatment. A prisoner challenged the copayment statute as violating "his right under the New Jersey constitution to reasonable healthcare."<sup>217</sup> The court acknowledged that prison officials have "an absolute duty to provide medical care during a term of imprisonment" but that "it is up to the Legislature to determine who should bear the cost."<sup>218</sup> Citing *Byrne* for the proposition that the New Jersey Supreme Court declined to recognize health as a fundamental right, the court proceeded to consider the copayment requirement under rational relation scrutiny.<sup>219</sup> The court concluded that the state had a "legitimate interest in defraying the cost of health care provided to inmates ... and in reducing the alleged abuse of the sick-call policy."<sup>220</sup> Accordingly, the copayment law was upheld.<sup>221</sup>

*Mourning* purported to rely on *Byrne*, but the holdings are difficult to reconcile. *Mourning* suggested that the state must provide health care to prisoners but is not required to pay.<sup>222</sup> While *Byrne* suggested that in order to protect a woman's right to medical care, the state must pay. *Tomlison* and *Felicissimo* recognized the importance of health and take steps to protect that interest from interference by others. Even *Byrne*, recognizing that the state must fund all medically necessary abortions for Medicaid beneficiaries, does not establish an affirmative right for all persons to state-funded medical care. The decision is consistent with federal equal protection cases, recognizing that once the government elects to provide certain benefits it must do so even-handedly.

### III. TRENDS IN STATE CONSTITUTIONAL HEALTH LAW

The survey of state constitutions and judicial decisions law reveals common limits, exceptions, and distinctions in constitutional recognition of health. States seem generally reluctant to identify express, enforceable

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<sup>216</sup> 692 A. 2d 529 (N. J. 1997).

<sup>217</sup> *Id.* at 535.

<sup>218</sup> *Id.* at 537 – 38 (citing *Byrne*).

<sup>219</sup> *Id.* at 538 ("plaintiff forthrightly admits" there is no fundamental right to health).

<sup>220</sup> *Id.*

<sup>221</sup> *Id.* at 539 (on federal Eighth Amendment and state constitutional grounds).

<sup>222</sup> *Id.* at 230 ("Although the government must provide medical care, the Supreme Court has never held that the government must pay for it." (citing cases)).

rights to health care for all, although they extend protection to certain groups and certain types of services for various reasons explored below. The trends derive from constitutional theory, tradition and history, moral reasoning, pragmatic concerns, and social values. Identifying the limits and underlying reasoning in states' charter documents adds a new perspective on federal and state health reform debates. This discussion suggests answers to fundamental questions about the respective roles of government and individuals for health and proposed reforms should balance those interests.

State constitutions, for all of their arguable shortcomings, represent the views of a wide range of stakeholders on some of their most fundamental concerns.<sup>223</sup> It is significant that several states enshrine health explicitly in their constitutions, unlike the U.S. Constitution. Understanding the ways in which states extend greater constitutional protection to health and the reasons underlying those decisions should inform both state and federal policymakers' approaches to health care rights, duties, and responsibilities. Although attention is currently focused on federal reform, states remain central to the health care system through cooperative state-federal health care programs and regulation of health care providers and insurers operating within their borders. State political processes, including proposals to amend state constitutions to add health rights, foster the democratic process and development of novel approaches to health reform.

#### A. *Vulnerable Groups*

Of the states that identify a duty to provide or protect health, some limit the duty to certain vulnerable groups of individuals, including the mentally insane, indigent, prisoners, and others. States' willingness to recognize

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<sup>223</sup> See Gardner, *supra* note 64, at 831 (questioning noting that state constitutions represent distinct community values, defined by state boundaries, but acknowledging that state constitutions at least represent "clumpy, irregular variations of a single national character" that "the views of any subgroup of the community, such as the people of a state, might yield a profile somewhat different from the national one"); Kahn, *supra* note 61, at 1168 (American constitutionalism "is enriched whenever new voices are added to the debate over the meaning of the rule of law with in a democratic polity. It is especially enriched because fifty different courts will talk with each other, as well as with the federal courts, about the meaning of a common enterprise."); Rodriguez, *supra* note 42, at 271 (state constitutions are "intrinsically important as legal frameworks for the implementation of public policy throughout all fifty states"); Schapiro, *supra* note 64, at 393 (state constitutions represent "the collection of those particular values that various electoral supermajorities have seen fit to enshrine in the constitution"); see also Linde, *supra* note 62, at 195 ("The presence or absence of a clause in a constitutional equal rights amendment, for instance, or a right of privacy, may or may not be evidence of societal values, but it is unmistakable evidence of societal action, of the choice whether to enact an idea into law.").

affirmative duties to provide care and treatment for those groups may be explained by the tradition of states as *parens patriae*. The duty may also derive from the U.S. Constitution and common law of torts. In some instances, state law parallels federal law. In other instances, states' constitutional protections exceed the federal floor.

### 1. Mentally Ill

Mississippi, New York, and Arkansas, by constitutional text, and South Carolina, by judicial interpretation, recognize a duty to provide care and treatment for the mentally ill or insane.<sup>224</sup> In addition, several other state judicial decisions involved state-funded psychiatric hospitals. The special concern for the mentally ill may derive from the tradition of states acting as *parens patriae*, or "government as parent." *Parens patriae* is often invoked to justify government protection for the mentally insane, children, and others who are legally incompetent to manage their affairs.<sup>225</sup> Mentally ill persons, in particular, have been deemed proper objects of state *parens patriae*.<sup>226</sup> Likewise, the blind, disabled, and children may warrant special protection.<sup>227</sup> Children would seem particularly appropriate objects, but

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<sup>224</sup> See Appendices A (listing current constitutional text) & B (summarizing similarities); see also N.Y. CONST. art. 17, § 4 (regarding "care and treatment of persons suffering from mental disorder or defect").

<sup>225</sup> See 3 WILLIAM BLACKSTONE, COMMENTARIES 47 (defining *parens patriae* as state acting as "the general guardian of all infants, idiots, and lunatics"); *Addington v. Texas*, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves."); *Mormon Church v. United States*, 136 U.S. 1, 57-58 (1890) (*parens patriae* authority of Crown devolved upon the state legislatures); *Fontain v. Ravenel*, 58 U.S. 369, 384 (1854) ("The State, as a sovereign, is the *parens patriae*."); *Fontain*, 58 U.S. at 393 (Taney, C.J., concurring) ("These prerogative powers, which belong to the sovereign as *parens patriae*, remain with the States."); *State of W. Va. v. Chas. Pfizer & Co.*, 440 F.2d 1079, 1089 (2d Cir. 1971) ("*Parens patriae*, literally 'parent of the country,' refers traditionally to the role of the state as sovereign and guardian of persons under a legal disability to act for themselves such as juveniles, the insane, or the unknown."); GOSTIN, *supra* note 29, at 95 – 97 (describing state *parens patriae* powers).

<sup>226</sup> *Addington*, 441 U.S. at 426 (recognizing state's legitimate interest under *parens patriae* power in confining mentally ill persons who are unable to care for themselves); Antony B. Klapper, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 819 (1993) (listing six states with constitutional provisions recognizing affirmative rights of the mentally ill). *But see* Michael L. Perlin, *State Constitutions and Statutes as Course of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A. L. REV. 1249, 1292 – 93 (1987) (concluding that no state, save three "ambiguous" decisions, has recognized an affirmative right to treatment for mentally disabled persons).

<sup>227</sup> See, e.g., ARK. CONST. art. 19, § 19 (duties to the "deaf and dumb and the blind, and also for the treatment of the insane"); MISS. CONST. art. IV, § 86 ("treatment and care

none of the state constitutions specify health care rights or special concern for children.<sup>228</sup> One conclusion may be that people needing general medical care, as distinct from mental health care, apparently do not come under the state's paternalistic arm.<sup>229</sup>

The historically greater concern for the mentally ill in some state constitutions and case law stands in marked contrast to the practice of commercial health insurers, which tend to cover treatment for physical health problems more generously than mental health problems. Recent federal mental health parity legislation aimed to correct that disparity.<sup>230</sup> The federal statute certainly does not establish any constitutional duty or even a statutory obligation on commercial health plans, much less federal or state governments, to provide care to the mentally ill. But commercial insurance plans that cover mental health must provide coverage and terms comparable to general health care policies.<sup>231</sup> The law effectively serves as a federal statutory equal protection law for commercial insurance companies. But it creates no affirmative right to state-funded mental health care, treatment, or coverage.

State constitutions, by contrast, traditionally have been more generous to mental health needs than physical health needs of individuals. *Parens patriae* may be one justification inasmuch as the mentally ill were deemed

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of the insane"); N.C. CONST. art. XI § 4 (provision "for the poor, the unfortunate and the orphan").

<sup>228</sup> See *In re Gault*, 387 U.S. 1, 16 (1967) (describing origins of juvenile justice system, in which the idea was rehabilitation, not punishment, and the "proceedings were not adversary, but that the state was proceeding as *parens patriae*"); Gilbert T. Venable, Note, *The Parens Patriae Theory and Its Effect on the Constitutional Limits of Juvenile Court Powers*, 27 U. PITT. L. REV. 894, 895 (1966) (describing origin of *parens patriae* as English King's power to protect children and "idiots").

<sup>229</sup> See, e.g., *State v. Copeland*, 765 P.2d 1266, 1271 (Utah 1988) (noting that because *parens patriae* is premised on state caring for those who cannot care for themselves, power is implicated only when individual cannot make own evaluation of need for treatment); cf. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (holding that states' civil commitment power does not extend to "nondangerous [mentally ill] individual who is capable of surviving safely in freedom by himself").

<sup>230</sup> See Mental Health Parity and Addiction Equity Act of 2008 (signed October 3, 2008), S. 558, 110th Cong. § 712a(a), (2007); Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (2008) (codified as amended in scattered sections of 26, 29, and 42 U.S.C.); Mental Health Parity Act of 1996, Pub. L. No. 104-204, 702(a), 110 Stat. 2944 (Sept. 26, 1996), *codified at* See 29 U.S.C.A. § 1185a (2008); 42 U.S.C.A. § 300gg-5 (2008).

<sup>231</sup> See Carol M. Suzuki, *When Something Is Not Quite Right: Considerations for Advising a Client to Seek Mental Health Treatment*, 6 HASTINGS RACE & POVERTY L.J. 209, 242 (2009) (describing federal parity legislation); Stacy A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 AKRON L. REV. 469, 489 – 96 (2009) (describing federal and state mental health parity laws).

incompetent to care for themselves. But state police powers also justify civil confinement of “dangerous” mentally ill individuals.<sup>232</sup> It may be that state constitutions recognizing mandatory duties to care for the mentally ill were not motivated by progressive notions of parity or special compassion but rather the desire to incapacitate or control “the insane.” Nevertheless, states that constitutionalize a duty to provide treatment, and not merely control and confinement, for the mentally ill, exceed the federal constitutional floor. The U.S. Supreme Court has not recognized a broad right to treatment for mentally ill individuals as a constitutional requirement of civil commitment.<sup>233</sup> State constitutions that specify even a limited duty to the mentally ill, therefore, provide more than federal law.

## 2. Indigent

Indigency is another limit that appears in some state constitutions. Mississippi, for example, explicitly limits the constitutional recognition of health to the poor.<sup>234</sup> Other states, such as New York and North Carolina,

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<sup>232</sup> See *Addington v. Texas*, 441 U.S. 418, 426 (1979) (“the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill”); *Kansas v. Hendricks*, 521 U.S. 346, 363 (1996) (“The State may take measures to restrict the freedom of the dangerously mentally ill. This is a legitimate nonpunitive governmental objective and has been historically so regarded.” (citing *Allen v. Illinois*, 478 U.S. 364, 373 (1986), and *United States v. Salerno*, 481 U.S. 739, 748-49 (1987))); *State v. Post*, 541 N.W.2d 115, 133 (Wis. 1995) (stating that “the state has a compelling interest in protecting the public from dangerous mentally disordered persons”); Elizabeth A. Weeks, Note, *The Newly Found “Compassion” for Sexually Violent Predators: Civil Commitment and the Right to Treatment in the Wake of Kansas v. Hendricks*, 32 GA. L. REV. 1261, 1283 – 85 (1998) (discussing police power justification for civil commitment).

<sup>233</sup> See *Hendricks*, 521 U.S. at 365 – 66 (holding that civil confinement, without treatment, “may be a legitimate end of the civil law”); *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982) (recognizing involuntarily committed mentally disabled individual’s right to “such minimally adequate or reasonable training to ensure safety and freedom from undue restraint”); *O'Connor v. Donaldson*, 422 U.S. 563, 573 (1975) (declining to decide “whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State”); see also *Compagnie Francaise de Navigation a Vapeur v. Louisiana Bd. of Health*, 186 U.S. 380, 388 (1902) (cited by majority in *Hendricks* for proposition that state can civilly detain such persons even in the absence of treatment); Burgett, *supra* note 29, at 213 n.32 (clarifying that “right to treatment” does not suggest affirmative right to state services, but rather condition on state’s rights to confine its citizens); see generally Perlin, *supra* note 226, at 166 – 213 (discussing right to treatment). But see Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499 (1960) (advocating right to treatment for individuals confined in public institutions); Weeks, *supra* note 232, at 1276 – 83 (discussing Supreme Court precedent that could support a right to treatment).

<sup>234</sup> MISS. CONST. art. IV, § 86 (granting legislature discretion to provide “care of the indigent sick”); see also HAW. CONST. art. IX, § 3 (regarding “financial assistance, medical

do not recognize health as a distinct constitutional right but address health care as a component of constitutional provisions on welfare or aid to the needy.<sup>235</sup> States that limit the duty to provide of health care to financially needy individuals may be operating under *parens patriae* justification inasmuch as impoverished persons are considered vulnerable.<sup>236</sup> But there are myriad other justifications underlying government welfare programs, including moral,<sup>237</sup> economic,<sup>238</sup> political,<sup>239</sup> historical,<sup>240</sup> and social.<sup>241</sup>

The history of federal welfare policy does not suggest a general concern for the poor; thus, states may be more inclusive. Rather than providing broad, government assistance, federal programs elaborately distinguish between the “deserving” and “undeserving” poor.<sup>242</sup> Typically, people who

assistance and social services for persons who are found to be in need of ... such assistance and services”).

<sup>235</sup> See Appendices A (listing state constitutional provisions on health) & B (noting provisions referencing the indigent); see also Hershkoff, *supra* note 17, at 1136 (estimating that “more than a dozen state constitutions provide explicit protections for the poor”); Rory Weiner, *Universal Health Insurance under State Equal Protection Law*, 23 W. NEW ENG. L. REV. 354 & n.142 (2002) 335 – 36 (“twenty-three states that have some form of constitutional provision for assisting the poor,” suggesting that “this strategy offers more potential than relying on explicit health-related state constitutional provisions”); cf. Stacy, *supra* note 1, at 85 (suggesting judicial approaches to federal welfare right to health care).

<sup>236</sup> Edelman, *supra* note 93, at 1703 – 04 (1993) (“the blind, the deaf, and the incurably insane were treated fairly consistently as deserving – objects of state assistance not subject to discretionary judgments about their individual morality or worth”); see, e.g., Higdon v. Boning, 296 A.2d 569 (N.J. Juv. & Dom. Rel. Ct. 1972) (enforcing municipality’s duty under state statute to aid the needy to prevent “unnecessary” suffering from “sickness,” including payment for cerebral palsy patient’s physical therapy and other services).

<sup>237</sup> See generally J. Donald Moon, *The Moral Basis of the Democratic Welfare State*, in DEMOCRACY AND THE WELFARE STATE 27 – 52 (Amy Gutmann ed., 1988) (discussing various moral justifications for welfare programs).

<sup>238</sup> See, e.g., VICTOR R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 17 – 30 (Expanded ed. 1999) (discussing economic considerations underlying health care resource allocation); RICHARD A. POSNER, ECONOMIC ANALYSIS OF THE LAW 507 – 11 (1998) (“Poverty imposes costs on the nonpoor that warrant, on narrowly economic (i.e. wealth-maximizing) grounds and so without regard to ethical or political considerations, incurring some costs to reduce it.”).

<sup>239</sup> See, e.g., STARR, *supra* note 92, at 235 – 89 (describing political contours of social insurance reform movement in U.S. history); Super, *supra* note 71, at 593 – 98 (listing and describing “Political Sources of Antipoverty Law”).

<sup>240</sup> See, e.g., Goldberg v. Kelly, 397 U.S. 254, 265 (1970) (“From its founding the Nation’s basic commitment has been to foster the dignity and well-being of all persons within its borders.... This perception, against the background of our traditions, has significantly influenced the development of the contemporary public assistance system.”).

<sup>241</sup> See Handler, *supra* note 90, at 936 – 38 (“Much of welfare policy is driven by the belief that the poor pose silent, insidious threats to dominant ideologies and social order.”).

<sup>242</sup> See Edelman, *supra* note 93, at 1703 (“America has always had a regard for the ‘deserving’ among its poor, and the categories of deserving poor have broadened as time

became impoverished through conditions beyond their control are considered more deserving than those perceived to be poor simply because they failed to work hard enough to support themselves.<sup>243</sup> That view is widely reflected in federal health care programs for the elderly, disabled, and other “blameless” poor.<sup>244</sup>

By contrast, state constitutions that recognize duties to provide health care to the poor, generally, without the finer distinctions typical under federal programs, take a broader view of health rights. On the other hand, state constitutions’ indigency distinctions may simply reflect the reality of scarce resources, necessity of line-drawing, and concerns about the appearance of “socialized medicine.”<sup>245</sup> Nevertheless, at least some states expressly acknowledge that people unable to pay for health care warrant some level of government assistance. That view has begun to resonate at the federal level with serious proposals to provide subsidies or government plans to those who cannot afford commercial health insurance coverage.<sup>246</sup>

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has passed, a salutary development that must be noted positively.”); Handler, *supra* note 92, at 906 (“Thus, the heart of poverty policy centers on the question of who is excused from work. Those who are excused are the ‘deserving poor’; those who must work are the ‘undeserving.’); *see also* RAND ROSENBLATT, SYLVIA LAW & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 412 (1997) (suggesting that English and American Poor Laws “distinguished the ‘worthy’ from the ‘unworthy’ poor, i.e., those who had a socially legitimate reason for poverty and not working (such as advanced age, illness and physical disability) versus those who did not” and suggesting that Social Security Act of 1935 reflected that tradition) (citing additional sources); Moon, *supra* note 237, at 48 (suggesting that welfare programs “rely largely upon selective programs in which eligibility is determined by means-testing, rather than the principles of universality and social insurance”).

<sup>243</sup> *See Goldberg*, 397 U.S. at 265 (“We have come to recognize that forces not within the control of the poor contribute to their poverty.”); CHARLES MURRAY, LOSING GROUND: AMERICAN SOCIAL POLICY 1950 – 1980 (1984) (distinguishing between laid-off factory worker and healthy “drone,” who merely refuses to work);

<sup>244</sup> *See, e.g.*, 42 U.S.C. § 1395c (describing eligibility for Medicare, including persons over age 65, disabled, and with end-stage renal disease); 42 U.S.C. § 1396a(a)(10)(a) (listing categories of recipients eligible for Medicaid); ROSENBLATT, LAW & ROSENBAUM, *supra* note 242, at 425 (discussing market-based justifications for Medicaid categories) (citing Robert Nozick, *Anarchy, State, and Utopia* 262 – 64 (1974)); WELFARE: A DOCUMENTARY HISTORY OF U.S. POLICY AND POLITICS 1 (Gwendolyn Mink & Rickie Solinger eds., 2003); Edelman, *supra* note 93, at 1703 – 09 (summarizing U.S. welfare programs for the “deserving” poor) Handler, *supra* note 92, at 909 – 10 (describing welfare programs for “for particular categories of the poor,” including Aid for Families with Dependent Children (AFDC)).

<sup>245</sup> *See Graham v. Reserve Life Ins. Co.*, 161 S.E.2d 485 (N.C. 1968) (rejecting nonindigent patient’s equal protection argument, noting that “[s]uch a contention is least expected from those who, under other circumstances, decry the expansion of the welfare state and urge medical and hospital insurance with private corporations as a bulwark against socialized medicine”).

<sup>246</sup> *See Blumberg & Holahan*, *supra* note 74, at 7 (discussing individual mandate and

### 3. Prisoners

A few state constitutional decisions suggest that criminals and others in state custody may be entitled to health care. Those cases, for the most part, closely track federal constitutional law. The U.S. Supreme Court has held that denying medical care to prisoners constitutes cruel and unusual punishment under the Eighth Amendment.<sup>247</sup> States typically interpret their duty to provide prisoner medical care in lockstep with federal law, providing no more than the minimal requirement.<sup>248</sup> For example, New Jersey recognized prisoners' right to medical care but upheld a state law requiring them to pay a portion of their care.<sup>249</sup> North Carolina declined to impose a duty on local governments to pay for private hospital care for an individual who was in police non-arrest custody.<sup>250</sup>

Others in state custody, such as juveniles<sup>251</sup> and mentally disabled

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subsidies); Jacob S. Hacker, *Healthy Competition – The Why and How of a “Public-Plan Choice,”* NEW ENG. J. MED., July 31, 2009, at 2269; Robert Pear, *Reach of Subsidies is Critical Issue for Health Plan,* N.Y. TIMES, July 27, 2009.

<sup>247</sup> See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (plurality opinion) (holding that “deliberate indifference to serious medical needs of prisoners” violates Eighth Amendment but finding no violation where prisoner was seen 17 times over 3 months); see *Substantive Rights Retained by Prisoners*, 36 GEO. L.J. ANN. REV. CRIM. PROC. 948, 969 n.2914 (2007) (listing Supreme Court cases applying “deliberate indifference” standard); see also *West v. Atkins*, 487 U.S. 42 (1988) (contracting out prison medical care does not relieve state of its constitutional duty to provide adequate medical treatment to those in its custody); *Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244 (1983) (Due Process Clause requires responsible government or governmental agency to provide medical care to suspects in police custody who have been injured while being apprehended by the police); Blumstein, *supra* note 28, at 1381 (“The irony of *Gamble* rests on the fact that an indigent in need of medical treatment becomes constitutionally entitled to it only if he is incarcerated.”).

<sup>248</sup> See Brennan, *supra* note 63, at 550 – 51 (“Some state courts and commentators have taken umbrage at the suggestion that proceeding in lockstep with the Supreme Court is the only way to avoid irrational law enforcement.”); Gardner, *supra* note 64, at 790 (“lockstep analysis of the state constitution discourages the development of an independent state constitutional discourse”); Schapiro, *supra* note 64, at 421 (“Interpreting the state constitution to mean the same as the federal represents a kind of middle position between the duty to apply federal law and the ability to engage in independent interpretation of the state constitution.”).

<sup>249</sup> See *supra* notes 216 – 22 and accompanying text (discussing *Mourning v. CMS of St. Louis*, 692 A. 2d 529 (N. J. 1997)).

<sup>250</sup> See *supra* notes 146 – 53 and accompanying text (discussing *Craven County Hospital Corporation v. Lenoir County*, 331 S.E.2d 690 (N.C. App. 1985)).

<sup>251</sup> Compare *Santana v. Collazo*, 714 F.2d 1172, 1177 (1st Cir. 1983) (juveniles have no right to rehabilitative treatment under the Constitution) with *Nelson v. Heyne*, 491 F.2d 352 (7th Cir. 1974) (juveniles have a right to rehabilitative treatment under the Fourteenth Amendment); *Stevens v. Harper*, 213 F.R.D. 358, 375-76 (E.D. Cal. 2002) (acknowledging conflicting case law on juveniles' constitutional right to treatment); Alexander S. ex rel.

persons,<sup>252</sup> may be entitled to health care on similar grounds.<sup>253</sup> If *DeShaney's* Poor Joshua had been in state protective custody, rather than his father's care, it seems likely that the case would have been decided differently, at least as a matter of federal constitutional law.<sup>254</sup>

The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – e.g., food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.<sup>255</sup>

Under similar reasoning, federal decisions recognize states' constitutional duty to protect children placed in state foster care.<sup>256</sup>

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*Bowers v. Boyd*, 876 F. Supp. 773, 790 (D.S.C. 1995) (juveniles have a right to rehabilitative treatment under the Fourteenth Amendment); *Lavette v. City of New York*, 316 N.E.2d 314 (1974) (right to treatment for children under state custodial supervision, premised on due process liberty deprivation).

<sup>252</sup> See *Youngberg v. Romeo*, 457 U. S. 307, 317 (1982) (“When a person is institutionalized-and wholly dependent on the State[,] ... a duty to provide certain services and care does exist”); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 31-32 (1981) (declining to decide whether mentally retarded individual residing at state institution are entitled to treatment); *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (mentally handicapped patients civilly committed at state institutions have constitutional right to treatment).

<sup>253</sup> See *Wing*, *supra* note 1, at 163 (“The Supreme Court has recognized that government has some affirmative responsibility to provide for the needs, including the medical needs, of mental patients, the institutionalized retarded, prisoners, and, presumably, other wards of the state or federal governments”).

<sup>254</sup> *DeShaney v. Winnebago Co. Dep't of Soc. Services*, 489 U.S. 189, 201 (1989) (right to treatment analysis has “no applicability in the present case. Petitioners concede that the harms Joshua suffered occurred not while he was in the State's custody, but while he was in the custody of his natural father”). *But see id.* at 206 – 09 (Brennan, J., dissenting) (faulting Court for failing to consider other, non-physical ways in which the state took control over Joshua).

<sup>255</sup> *Id.* at 200; see *similarly Currie*, *supra* note 31, at 874 (suggesting that prisoner medical treatment cases do not establish affirmative right but merely demonstrate due process violation “by locking an individual up without providing such services, the government has deprived him of them in the most traditional sense”).

<sup>256</sup> See, e.g., *Berman v. Young*, 291 F.3d 976, 982 (7th Cir. 2002) (“Recognizing the ‘special relationship’ exception to the general *DeShaney* rule, we have held that once a state removes a child from her parents' custody, it has sufficiently restrained the liberty of the child and therefore assumes a duty of safekeeping.”); *Burton v. Richmond*, 276 F.3d 973, 978 – 79 (8th Cir. 2002) (distinguishing *DeShaney* because child was clearly in state custodial foster care); see also *DeShaney*, 489 U.S. at 201 n.9 (recognizing several lower courts held “that the State may be held liable under the Due Process Clause for failing to protect children in foster homes from mistreatment at the hands of their foster parents”); *Wing*, *supra* note 1, at 163 (suggesting that when Supreme Court recognized affirmative

States are bound only to the federal constitutional minimum and could extend greater protection for the health care of prisoners and others in custody.<sup>257</sup> So far, none have accepted the invitation with respect to health care rights.<sup>258</sup> By comparison, all but two states have adopted explicit constitutional provisions limiting the severity of punishment for convicted criminals, and thirty-five of those provisions differ substantially from the U.S. Constitution's Eighth Amendment.<sup>259</sup> The New Jersey and North Carolina decisions on health care rights of those in custody suggest that states acknowledge the constitutional duty but resist bearing the full financial burden of providing the care.

A duty to provide medical care to persons in state custody would also be consistent with common-law torts principles. As a general rule, there is no duty to provide affirmative care, protection, aid, or warning.<sup>260</sup> But if the defendant takes the plaintiff into custody or otherwise deprives him of access to care, then a duty arises.<sup>261</sup> Some states have recognized affirmative duties on law enforcement officers under state tort law, if not

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duty to provide medical care for “mental patients, the institutionalized retarded, prisoners,” and other wards of the state, “the Court has premised its reasoning on the fact that the protected individual was in the custody, in the most literal sense, of the government”).

<sup>257</sup> See Brennan, *supra* note 63, at 502 (“decisions of the [U.S. Supreme] Court are not, and should not be, dispositive of questions regarding rights guaranteed by counterpoint provisions of state law”).

<sup>258</sup> Cf. MICHAEL L. PERLIN, *LAW AND MENTAL DISABILITY* 195 – 96 (1994) (recognizing “virtually no case law on the question of a state constitutional right to treatment on behalf of mentally disabled persons”); Klapper, *supra* note 226, at 739 (suggesting possibilities for recognizing right to treatment under state constitutions).

<sup>259</sup> See Richard S. Frase, *Limiting Excessive Prison Sentences under Federal and State Constitutions*, 11 U. PA. J. CONST. L. 39, 64 – 69 (2008) (summarizing state constitutional provisions and defendant-favorable case law).

<sup>260</sup> See RESTATEMENT (SECOND) OF TORTS § 314; DAN B. DOBBS, *THE LAW OF TORTS* § 227, 578 – 79 (2000) (describing general “no duty” rule); see, e.g., *Harper v. Herman*, 499 N.W.2d 472, 475 (Minn. 1993) (holding private boat owner not liable for injuries to passenger who dove into shallow water); *Yania v. Bigan*, 155 A.2d 343, 346 (Pa. 1959) (“The mere fact that Bigan saw Yania in a position of peril ... imposed upon him no legal, although a moral, obligation or duty to go to his rescue”); *Union Pacific R’way v. Cappier*, 72 P.281, 283 (Kan. 1903) (denying recovery to trespasser killed by train and distinguishing cases allowing recovery, in which “the person injured was in the custody and care of those who were at fault in failing to give him proper treatment”).

<sup>261</sup> See RESTATEMENT (SECOND) OF TORTS § 314A(4); see, e.g., *People v. Wong*, 588 N.Y.S.2d 119, 124 (N.Y. App. Div. 1992) (legal duties created by a contractual babysitting agreement and the “voluntary assumption of complete and exclusive care of a helpless child”); *Mirand v. City of New York*, 84 N.Y.2d 44 (N.Y. App. Div. 1994) (school board liable for harm sustained when two sisters were assaulted by another student, recognizing “The duty owed derives from the simple fact that a school, in assuming physical custody and control over its students, effectively takes the place of parents and guardians”).

state constitutional law.<sup>262</sup>

### *B. Types of Services*

In addition to limiting constitutional protection to particular vulnerable groups, states also limit the types of that services they are obligated to provide. Several constitutions recognize public health, distinguished from individual health care or medical treatment.<sup>263</sup> Other constitutions specify environmental rights.<sup>264</sup> One state's constitution is expressly limited to hospital care.<sup>265</sup> Several states recognize constitutional rights to a particular medical procedure, abortion, but not health care more generally.

#### 1. Public Health

State police powers have long been recognized to encompass protection and promotion of public health.<sup>266</sup> Until the New Deal, the power to act in the interest of public health was exclusively the province of states.<sup>267</sup> Consistent with the historical role of states in public health, more than half of the constitutions surveyed and several judicial decisions distinguish between the states' duty with respect to the public's health, as opposed to individual health. "Health care" focuses on individual wellness or freedom from pathology, whereas "public health" is concerned with promoting

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<sup>262</sup> See, e.g., *Wilson v. Kotzebue* (Alaska 1981), 627 P.2d 623, 628-629 (intoxicated prisoners or arrestees may heighten the duty of custodial officers to see that they are protected from harming themselves or from harm by others); *Clemets v. Heston*, 485 N.E.2d 287, 291 (Ohio Ct. App. 1985) (affirmative duty on law officer to protect those the officer has arrested and has in custody).

<sup>263</sup> See Appendix B (identifying eight states' provisions).

<sup>264</sup> See, e.g., MONT. CONST. art. II, § 3 (inalienable rights include "the right to a clean and healthful environment" and "health"); S.C. CONST. art. XII, § 1 ("health" and "the conservation of its natural resources" as "matters of public concern").

<sup>265</sup> See MISS. CONST. art. IV, § 86.

<sup>266</sup> *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) ("According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety."); *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1 (1824) (regarding state powers to enact "inspection laws, quarantine laws, health laws of every description").

<sup>267</sup> James G. Hodge, *Implementing Modern Public Health Goals through Government: An Examination of the New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93, 94, 101 – 02 (1997); see also GOSTIN, *supra* note 25, at 91 ("The states and localities have had the predominant public responsibility for population-based health services since the founding of the republic."); Parmet, *supra* note 17, at 272 ("Public health regulation has long been regarded as one of the states' primary and most important 'police powers.'").

optimal health of the population as a whole.<sup>268</sup> The goal of public health is not simply improving individual health outcomes but the common good.<sup>269</sup> According to some, public health, welfare, and security were the very reasons for establishing government in the origin of society.<sup>270</sup>

By contrast, there is no long-standing tradition of state involvement in individual medical care. Consistent with the negative rights orientation and free-market tradition, individuals through their own efforts are left to secure necessary health care for themselves and their families.<sup>271</sup> Health care is

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<sup>268</sup> Nancy M. Baum et al., *Looking Ahead: Addressing Ethical Challenges in Public Health Practice*, 35 J.L. MED. & ETHICS 657, 658 – 59 (2007) (distinguishing “public health from individually oriented health care” and urging that “public health ethics is a field of inquiry in its own right”); Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 AM. J. PUB. HEALTH 1607, 1608 (1997) (defining “health” as a “personal, medical matter, a state of freedom from pathology achieved by an individual through the mediation of a doctor” and characterizing “[p]ublic health, by contrast . . . as an attribute of communities in social and physical environments”); Mason Meier & Larisa M. Mori, *The Highest Attainable Standard, Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101, 112 – 15, 121 – 24 (2005) (distinguishing “health” and “public health” rights); Andrew W. Siegel, *The Jurisprudence of Public Health: Reflections on Lawrence O. Gostin’s Public Health Law*, 18 J. CONTEMP. HEALTH L. & POL’Y 359, 361-62 (2001) (suggesting that “[p]ublic health law is concerned with the state’s role in advancing the health of the community, whereas health care law is concerned with the ‘microrelationships between health care providers and patients’” (quoting Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* 15 (2000))).

<sup>269</sup> WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 9 (2009) (“the focus of public health is on the health or well-being of people, not individuals”); Lawrence O. Gostin, *Health of the People: The Highest Law?*, 32 J.L. MED. & ETHICS 509, 510 (2004) (“The field of public health would profit from a vibrant conception of ‘the common’ that sees public interests as more than the aggregation of individual interests.”); Baum, *supra* note 268, at 657 (noting “public health’s emphasis on population health rather than issues of individual health”).

<sup>270</sup> See PARMET, *supra* note 269, at 15 (quoting maxim, *salus populi suprema lex*, “The well being of the public is the supreme law,” as meaning that attainment of public safety “was the rationale for civil society”); Richard A. Epstein, *In Defense of the “Old” Public Health*, 69 BROOK. L. REV. 1421, 1428 (2004) (quoting same maxim as having “powerful roots in the American political tradition”); James A. Tobey, *Public Health and the Police Power*, 4 N.Y.U. L. REV. 126 (1927) (suggesting that government is “organized for the express purpose, among others, of conserving the public health”).

<sup>271</sup> See DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE 7 – 9 (2000) (tracing demise of “Marcus Welby medicine” and rise of market-based health care); ROSENBLATT, LAW, & ROSENBAUM, *supra* note 242, at 32 – 33 (explaining market-competition view of health care); Jonathan Oberlander, *Who Pays? Who Benefits? Distributional Issues in Health Care*, 60 LAW & CONTEMP. PROBS. 245, 252 (2006) (noting that “American political culture values liberty over equality, cherishes markets and individual responsibility over government and social solidarity”); Arnold Relman & Uwe Reinhardt, *Debating For-Profit Health Care and the Ethics of Physicians*, 5 HEALTH AFFAIRS, 5, 12 (Summer 1986) (“If one looked for die-hard champions of free enterprise

viewed as a matter of individual, not collective, responsibility.<sup>272</sup> Individuals privately contract with health care providers and insurers, as they would for any other good or service.<sup>273</sup> That libertarian view is exemplified in Montana's decisions, recognizing a fundamental right to employment as means to obtaining individual health care but not a right to state benefits. For similar reasons, courts upheld challenges to various obstacles to obtaining individual health care.<sup>274</sup>

Public health, by contrast, largely rejects market theory.<sup>275</sup> Traditional public health objectives, including sanitation,<sup>276</sup> infectious disease control, nuisance abatement, public safety, and pure food and drinking water,<sup>277</sup> cannot be secured through individual effort and call for coordination through centralized government. Collective action and public benefit are hallmarks of public health interventions.<sup>278</sup> Public health, for example, may

and libertarian thought, one could always find them among our physicians.”).

<sup>272</sup> See, e.g., Joseph M. Boyle, Jr., *The Concept of Health and the Right to Health Care*, 3 SOC. THOUGHT 5, 5 (Summer 1977) (noting common perception that “being healthy is primarily a matter of individual responsibility”); Yvonne Denier, *On Personal Responsibility and the Human Right to Health Care*, 14 CAMBRIDGE Q. OF HEALTHCARE ETHICS, 224, 224 (2005) (discussing “role of personal responsibility in healthcare,” noting, “[o]n the one hand, it is reasonable to hold people responsible for the consequences of their actions”).

<sup>273</sup> See, e.g., *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) (rejecting patient’s personal injury claim for physician’s “refusal to enter into a contract of employment”).

<sup>274</sup> See, e.g., *Armstrong v. State*, 989 P. 2d 364 (Mont. 1999) (striking down restriction on choice of provider); *Horizon Health Center v. Felicissimo*, 638 A. 2d 1260 (N.J. 1994) (upholding injunction on abortion clinic protesters as obstructing access to medical care).

<sup>275</sup> See PARMET, *supra* note 269, at 15 – 16 (explaining but rebutting traditional market-theory view that government intervention is required only when private markets are flawed or fail); STARR, *supra* 92, at 180 – 89 (describing historical tension between medical profession and public health); Burriss, *supra* note 268, at 1608 (“to accept the rhetorical structure of market individualism is to accept a political language that has no words for public health”).

<sup>276</sup> See STARR, *supra* note 92, at 189 – 90 (“In mid-nineteenth-century America, public health was mainly concerned with sanitary reform and affiliated more closely with engineering than with medicine”); Elizabeth Fee, *The Origins and Development of Public Health in the United States*, reprinted in LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW & ETHICS: A READER, at 27, 28 (from *Oxford Textbook of Public Health*, vol. 1 (3d ed. 1997)) (“In the colonies, public health consisted of activities deemed necessary to protect the population from the spread of epidemic diseases, by the enactment of sanitary laws and regulations governing such matters as the construction of toilets, the disposal of wastes, and the disposition of dead animals.”); PARMET, *supra* note 269, at 290 (“public sanitation regulations in Massachusetts go back as far as 1634”).

<sup>277</sup> GOSTIN, *supra* note 25, at 95 (listing various state public health powers).

<sup>278</sup> INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 19 (1988) (“Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”); GOSTIN, *supra* note 29, at 9 (“no single individual or group of individuals can ensure his or her health. Meaningful protection and assurance of the population’s health require

justify a state paying to treat infectious disease because otherwise the infected individual would endanger the health and safety of all.<sup>279</sup> There is some tradition of federal public health regulation, but the federal role is not constitutionally recognized or as broad as states' authority.<sup>280</sup>

The scope of public health traditionally recognized in state constitutions is consistent with the negative rights orientation. The traditional scope of public health was limited to those collective action problems in which individual efforts cannot secure the desired outcome. The "new" public health takes a broader view, addressing seemingly individual health habits or conditions, such as obesity, smoking, domestic violence, firearms, and socioeconomic disparities.<sup>281</sup> In the traditional view, states would avoid interfering with individual rights unless necessary to protect the

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communal effort."); STARR, *supra* note 92, at 180 (defining "public health as the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts . . . and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health"); Michael Walzer, *Security and Welfare*, reprinted in GOSTIN, *supra* note 289, at 69, 75 (from *Spheres of Justice: A Defense of Pluralism and Equality* (1983)) ("Dealing with tuberculosis, cancer, or heart failure, however, requires a common effort. Medical research is expensive, and the treatment of many particular diseases lies far beyond the resources of any individual citizens. So the community steps in. . .").

<sup>279</sup> See, e.g., *Graham v. Reserve Life Ins. Co.*, 161 S.E.2d 485, 491 (N.C. 1968) (upholding provision of free tuberculosis treatment to the indigent, noting [i]t is within the police power of the State to provide treatment for infectious and contagious disease, which – if untreated – can become epidemic"); *Kirk v. Wyman*, 65 S.E. 387, 389 (S.C. 1909) (holding that it "is a reasonable exercise of the police power" to establish boards of health and pesthouses); GOSTIN, *supra* note 276, at 24 (suggesting that within the context of the industrial revolution and increased urbanization "citizens began to think of the control of disease as being properly within the sphere of government control").

<sup>280</sup> See GOSTIN, *supra* note 25, at 155 – 61 (describing and cataloging history of federal public health regulation).

<sup>281</sup> See THEODORE H. TULCHINSKY, *THE NEW PUBLIC HEALTH* 107 – 09 (2000) (citing World Health Definition of the "New Public Health (NPH)" as "a philosophy which endeavors to broaden the older understanding of public health so that, for example, it includes the health of the individual in addition to the health of populations, and seeks to address such contemporary health issues as are concerned with equitable access to health services, the environment, political governance and social and economic development"); Epstein, *supra* note 270, at 1423 (distinguishing "old" and "new" public health and listing examples of inspection, quarantine, and vaccination for the former, and tort reform, access to health care, and relieving wealth disparity for the latter); Lawrence O. Gostin & M. Gregg Bloche, *The Politics of Public Health; A Response to Epstein*, 46 PERSPECTIVES IN BIOLOGY & MED. S160, S162 (Summer 2003) (responding to Epstein's and other "conservatives" attacks on public health but agreeing that "there is a 'new' public health, broader in its reach than . . . control of infectious disease"); Meier & Mori, *supra* note 268, at 119 ("modern public health programs can be framed expansively as part of a social justice movement").

community.<sup>282</sup> If the broader, “new” public health view gains wider acceptance, the implications could be dramatic. States that constitutionally recognize a duty to protect and promote the public health may be required to intervene more directly and affirmatively in a wide range of activities.

## 2. Environmental Health

Just as there is no federal constitutional right to health, there is no federal constitutional right to a clean environment.<sup>283</sup> Montana and several other states have expressly extended protection of environmental rights above the federal floor. Some states’ constitutional provisions are framed in terms of environmental health.<sup>284</sup> The environmental provisions are supported by reasoning similar to the public health provisions and do not

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<sup>282</sup> See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (“But the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good.”); GOSTIN *supra* note 25, at xxv (summarizing “the dominant liberal position that individual freedom is by far the preferred value to guide ethical and legal analysis in matters of physical and mental health.”).

<sup>283</sup> See ROBERT L. GLICKSMAN ET AL., *ENVIRONMENTAL PROTECTION: LAW AND POLICY* 49 – 50 (5th ed. 2007) (describing courts’ resistance to recognition of federal constitutional environmental rights); J.B. Ruhl, *The Metrics of Constitutional Amendments: And Why Proposed Environmental Quality Amendments Don’t Measure Up*, 74 NOTRE DAME L. REV. 245 (1999) (evaluating proposed environmental quality amendments to U.S. Constitution).

<sup>284</sup> See, e.g., MONT. CONST. art IX, § 1, ¶ 1 (“The state and each person shall maintain and improve a clean and healthful environment in Montana for present and future generations.”); HAW. CONST. art. XI, § 9 (“Each person has the right to a clean and healthful environment.”); ILL. CONST. art XI, § 1 (“The public policy of the State and the duty of each person is to provide and maintain a healthful environment for the benefit of this and future generations”); LA. CONST. art. IX, § 1 (“The natural resources of the state, including air and water, and the healthful, scenic, historic, and esthetic quality of the environment shall be protected, conserved, and replenished insofar as possible and consistent with the health, safety, and welfare of the people.”); PENN. CONST. art. 1, § 27 (providing that “[t]he people have a right to clean air, pure water, and to the preservation of the natural, scenic, historic, and esthetic values of the environment”); see generally Barton H. Thompson Jr., *The Environment and Natural Resources in Tarr & Williams*, *supra* note 15 (chapter on state constitutional provisions protecting natural resources and the environment, suggesting that “[a] majority of state constitutions seek to protect the public’s interest in natural resources and the environment” and citing sources); Horwich, *supra* note 200, at 325 & n.13 (listing seven states, including Montana); A.E. Dick Howard, *State Constitutions and the Environment*, 58 VA. L. REV. 193 (1972) (describing then-recent trend of states’ adopting constitutional environmental provisions); Mary Ellen Cusack, Comment, *Judicial Interpretation of State Constitutional Rights to a Healthful Environment*, 20 B.C. ENVTL. AFF. L. REV. 173, 182 & n.62 (1993) (listing seven states’ environmental provisions).

provide support for an individual right to health care.

Montana's constitutional environmental rights are particularly robust, with two constitutional provisions and judicial recognition of a self-executing, individually enforceable right.<sup>285</sup> Other states' constitutional provisions on the environment or natural resources have been interpreted more narrowly.<sup>286</sup> Montana's judicial enforcement of environmental rights, like its strong negative rights orientation to health, is consistent with themes of rugged individualism and the frontier American West.<sup>287</sup> Under that view, the government generally should refrain from interfering with individual rights unless necessary to secure communal wants and needs. Clean air and water, like public health, are classic nonexcludable, nonexclusive "public goods," requiring collective action to secure, protect, and promote.

The community as a whole has a stake in environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. These collective goods, and many more, are essential conditions for health. Yet these benefits can be secured only through organized actions on behalf of the people.<sup>288</sup>

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<sup>285</sup> Montana Environmental Information Center v. Dept. of Environmental Quality, 988 P. 2d 1236, 1237 (Mont. 1999); Horwich, *supra* note 200, at 323 & n.1 (quoting public land law scholar Charles Wilkinson, describing Montana's Constitution as "the single strongest statement of conservation philosophy in the constitution of any state and, very likely, of any nation in the world").

<sup>286</sup> See, e.g., Machipongo Land & Coal Co. v. Commonwealth, 799 A.2d 751 (Pa. 2002) (allowing state to defend takings claim against coal mine by showing that proposed mine had high potential to pollute stream); Glisson v. City of Marion, 720 N.E.2d 1034 (Ill. 1999) (limiting state constitutional protection to pollution, but not biodiversity conservation); Margret J. Fried & Monique J. Van Damme, *Environmental Protection in a Constitutional Setting*, 68 TEMP. L. REV. 1369 (1995) (urging stronger recognition of environmental rights under Pennsylvania's constitution); Howard, *supra* note 284, at 202 – 04 (listing states' constitutional provisions declaring environmental "rights" and statutes allowing citizens' suits); Cusack, *supra* note 284, at 182 – 91 (discussing enforcement challenges).

<sup>287</sup> See Gardner, *supra* note 64, at 817 ("The founders of a populist frontier state with a tradition of ferocious individualism, like Washington or Orgeon, probably intended to carve out a larger sphere of rights, a larger arena of activity into which the government could not intrude" (quoting David Schuman, *Advocacy of State Constitutional Law Cases: A Report from the Provinces*, 2 EMERGING ISSUES IN ST. CONST. L. 275, 285 (1989))); Thompson, *supra* note 284, at 307 (describing new Western states' approaches to natural resources and the environment, including constitutional protections).

<sup>288</sup> See GOSTIN, *supra* note 25, at 9; John S. Harbison, *Waist Deep in the Big Muddy: Property Rights, Public Values, and Instream Waters*, 26 LAND & WATER L. REV. 535, 547 – 48 (1991); Brett M. Frischmann, *An Economic Theory of Infrastructure and Commons Management*, 89 MINN. L. REV. 917, 942 – 56, 981 – 83 (2005) (defining terms and applying to environment); see also Mancur Olson, *The Logic of Collective Action: Public*

By contrast, health insurance and medical care are typically considered private goods for which individuals are responsible for obtaining on the private market, though their own effort and resources. State constitutional provisions on environmental health provide little support for health rights.

### 3. Hospital Care

At least one state, Mississippi, expressly limits the state's constitutional authority to the indigent in hospitals.<sup>289</sup> Other states' constitutions, not surveyed above, expressly authorize the state to build public hospitals.<sup>290</sup> Those provisions reflect states' traditional, limited role in providing health care to residents through almshouses, public hospitals, pesthouses, or sanatoria.<sup>291</sup> Similarly, early private and quasi-governmental health insurance programs typically covered only the catastrophic risk of hospitalization, not a full array of routine and preventative medical care.<sup>292</sup> Often, access to state hospitals was limited to the poor.<sup>293</sup>

Thus, the hospital-only limit on state constitutional recognition of health may be simply a subset of the indigency limit.<sup>294</sup> The provisions may also

*Goods and the Theory of Groups* (1971); Ronald H. Coase, *The Lighthouse in Economics*, 17 J. LAW & ECON. 357 (1974) (defining public goods as nonexclusive, nonexcludable goods, such as a lighthouse beacon).

<sup>289</sup> MISS. CONST. art. IV, § 86.

<sup>290</sup> See, e.g., ALA. CONST. art. IV, § 93.12 (“The state ... may acquire, build, establish, own, operate and maintain hospitals, health centers, sanatoria and other health facilities. The legislature for such purposes may appropriate public funds and may authorize counties, municipalities and other political subdivisions to appropriate their funds ...”).

<sup>291</sup> STARR, *supra* note 91, at 150 (“By making the almshouse the only source of governmental aid to the poor, legislatures hoped to restrict expenditures for public assistance.”); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 26 (2006) (“Prior to 1965 of course, the bulk of local spending on indigent health care took the form of direct investments in health care facilities such as public hospitals and clinics.”)

<sup>292</sup> See ROSENBLATT, LAW & ROSENBAUM, *supra* note 242, at 10 (describing history of Blue Cross, covering hospital but not physician services); *id.* at 369 – 70 (describing political background of original Medicare program, which began as Part A, hospital insurance); STARR, *supra* note 92, at 295 – 96 (describing emergence of Blue Cross and other early insurance plans to cover hospital care).

<sup>293</sup> See, e.g., *Graham v. Reserve Life Ins. Co.*, 161 S.E.2d 485, 491 (N.C. 1968) (upholding North Carolina's provision of free tuberculosis treatment to the indigent only, noting [i]t is within the police power of the State to provide treatment for infectious and contagious disease, which – if untreated – can become epidemic”); *Kirk v. Wyman*, 65 S.E. 387, 391 (S.C. 1909) (noting deplorable conditions of city pesthouse and acknowledging that “even temporary isolation in such a place would be a serious affliction and peril to an elderly lady, enfeebled by disease, and accustomed to the comforts of life”).

<sup>294</sup> See *supra* Part III.A.2.

fall under the public health duty. To the extent that state hospitals were established to treat infectious diseases, they fall within the scope of public health, rather than individual medical care.<sup>295</sup> If nothing else, the constitutional provisions on hospitals reflect an attempt to narrowly define any state responsibility and allocate scarce resources to a specific service.

#### 4. Abortion

Several decisions construing on constitutional provisions to health arose in the context of abortion. New York declined to consider whether refusing to fund abortions under a state parental assistance program violated the Public Health provision because the program was not considered public health.<sup>296</sup> Montana struck down restrictions on abortion providers because the law violated the inalienable right to health.<sup>297</sup> New Jersey required the state Medicaid program to cover all medically necessary abortions<sup>298</sup> and upheld an injunction against abortion protesters as obstructing access to medical services.<sup>299</sup>

To the extent that any of those cases establish a right to the particular medical treatment of abortion, they provide little support for a right to health care more generally. The New York decision suggests little other than the court's reluctance to allow individual claims under the Public Health Provision and the traditional scope of public health as pertaining to community, not individual, health. The Montana provider choice and New Jersey abortion protester cases are consistent with a negative rights view, preventing interference with, but not requiring affirmative provision of, medical treatment.

The New Jersey Medicaid decision, *Right to Choose v. Byrne*, comes the closest to establishing an affirmative right to publicly funded abortions. The court declined to recognize a fundamental right to health but noted that the state places a "high priority" on health.<sup>300</sup> The decision rested primarily on the implied fundamental right to privacy and sounded in equal protection. The *Byrne* court made clear that the state is not constitutionally required to fund all abortions for all people in the state but may not "jeopardize the health and privacy of poor women by excluding medically necessary abortions for a system providing all other medically necessary

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<sup>295</sup> See *supra* Part III.B.1.

<sup>296</sup> *Hope v. Perales*, 634 N.E.2d 183 (N.Y. 1994).

<sup>297</sup> *Armstrong v. State*, 989 P. 2d 364 (Mont. 1999).

<sup>298</sup> *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982).

<sup>299</sup> *Horizon Health Center v. Felicissimo*, 638 A.2d 1260 (N.J. 1994).

<sup>300</sup> *Byrne*, 450 A.2d at 934.

care for the indigent.”<sup>301</sup>

By contrast, the U.S. Supreme Court had held two years earlier that states are not constitutionally obligated to fund abortions at all under Medicaid.<sup>302</sup> Federal abortion funding cases, even while recognizing a fundamental privacy right in the decision to terminate an abortion,<sup>303</sup> did not limit states’ authority “to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.”<sup>304</sup> The Court subsequently backed down from the fundamental rights approach, replacing “close scrutiny” with the “undue burden” test for government regulation of a woman’s interest in abortion.<sup>305</sup>

But even under the more rigorous standard of review, lack of government funding was not considered to interfere with a woman’s right to an abortion.<sup>306</sup> Denial of state funding or access to public facilities leaves a woman “no worse off” than if the state had done nothing at all.<sup>307</sup> Moreover, poverty is not a suspect class that warrants heightened scrutiny for equal protection purposes.<sup>308</sup> Thus, states are not required to pay for abortions, even though some women’s lives may be at risk.<sup>309</sup> The federal abortion funding cases express the same negative rights view as *DeShaney*: the state’s failure to intervene to protect the child from his abusive father left him no worse off.<sup>310</sup> Likewise, a state’s failure to intervene to protect a

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<sup>301</sup> *Id.*

<sup>302</sup> *Harris v. McRae*, 448 U.S. 297, 325 – 26 (1980).

<sup>303</sup> *Roe v. Wade*, 410 U.S. 113, 153 – 55 (1973).

<sup>304</sup> *Maher v. Roe*, 432 U.S. 464, 473 – 74 (1977).

<sup>305</sup> *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 876 – 77 (1992)

<sup>306</sup> *Harris*, 448 U.S. at 314 – 15, 322 – 23; *Maher*, 432 U.S. at 473 – 78; Wiener, *supra* note 235, at 353 – 54 (explaining Court’s decisions that restrictions on state funding for abortions does not constitute government interference with the right to abortion); Wing, *supra* note 1, at 168 – 69 (explaining that exclusions or limitations on government health programs are not subject to heightened review).

<sup>307</sup> *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 509 (1989) (upholding state law that prohibits use of state employees or facilities to perform abortions not necessary to save the mother’s life); *see also* *Rust v. Sullivan*, 500 U.S. 173, 198 (1991) (extending rationale to uphold federal statute prohibiting public funding to health care facilities that counsel abortions); *Harris*, 448 U.S. at 316 – 17 (a state “may not place obstacles in the path of a woman’s exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls into the latter category....”)

<sup>308</sup> *Maher*, 432 U.S. at 470 – 71.

<sup>309</sup> *Id.* at 316 -18; Blumstein, *supra* note 28, at 1378 – 79 (noting that Court distinguished a woman’s interest in protecting her own health from claimed constitutional entitlement to public funds for abortions); Wing, *supra* note 1, at 169 – 70 (discussing *Harris*).

<sup>310</sup> Blumstein, *supra* note 28, at 1379 (“Freedom from government intrusion in a privacy realm does not automatically establish ‘an entitlement to such funds as may be necessary to realize all the advantages of that freedom.’” (quoting *Harris*, 448 U.S. at

woman whose health or life is in danger if she cannot obtain an abortion leaves her no worse off.

Federal law, although recognizing abortion rights, requires no affirmative state action to protect the right. States may, of course, give greater protection to individual rights than federal law.<sup>311</sup> *Byrne* establishes New Jersey's decision to elevate women's abortion rights above the constitutionally mandated federal floor.<sup>312</sup> Montana and New Jersey while also seem to recognize a broader notion of "interference" than federal precedents by striking down restrictions on choice of medical provider and limiting free speech of abortion protesters.

But the enhanced protection that some states accord to abortion does not extend to health care, more broadly defined. Abortion is a singular, ideologically charged issue that encompasses much more than a medical procedure.<sup>313</sup> There is no basis for assuming that state courts would apply the same principles in the same way to other, less controversial health care services or government-funded medical care. The state abortion cases tell more about the state constituencies' religious beliefs, moral values, political ideologies, and medical standards than the value they place on health.

### C. State Constitutional Amendments

In assessing state constitutional provisions on health, it is useful to consider, at least briefly, not only what state constitutions include but also what amendments they have rejected. Several states recently considered constitutional amendments expressly recognizing broad, individually

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318)); Wing, *supra* note 1, at 168 (drawing similar comparison to *DeShaney*).

<sup>311</sup> See *Byrne*, 450 A. 2d at 931 – 32 (noting that "the individual states may accord greater respect than the federal government to certain fundamental rights" (citing U.S. Supreme Court cases); *supra* notes 62 – 64 (discussing Justice Brennan's articles and "new federalism").

<sup>312</sup> See Weiner, *supra* note 235, at 354 & n.142 (discussing and citing state abortion cases, including *Byrne*, that "have gone beyond the Supreme Court's narrow interpretation of what constitutes government 'interference'").

<sup>313</sup> Describing the abortion cases as *sui generis*, the *Casey* Court noted:

Abortion is a unique act. It is an act fraught with consequences for others: for the woman who must live with the implications of her decision; for the persons who perform and assist in the procedure; for the spouse, family, and society which must confront the knowledge that these procedures exist, procedures some deem nothing short of an act of violence against innocent human life; and, depending on one's beliefs, for the life or potential life that is aborted.

*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 951 – 52 (1992); see also *Harris*, 448 U.S. at 325 ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life").

enforceable rights to health.<sup>314</sup> In all cases, the proposals failed. But in some states, the amendment debates served as catalysts for comprehensive legislative enactments. Even states typically considered progressive in many areas of health care reform have declined to constitutionalize universal health care rights. Like the adopted provisions, the proposed amendments share certain common features.

Notably, the rights-creating language in the proposed amendments is much more explicit than the provisions currently in effect in some states. All of the proposed amendments affirmatively require state action and adequate financing for health care. Also, the amendments typically suggest a universal right, not limited to the mental ill, indigent, helpless, in-custody, or other particular groups. The scope of the right would also be more comprehensive, including not just hospital or public health but a package of essential, comprehensive medical care. In addition, affordability is a key component of the proposed amendments, suggesting not just social or welfare rights but an economic right to health care. Overall, the proposals are much more detailed and explicit than existing state constitutions that mention health. The proposed amendments come closer to specific legislative enactments than general statements of public values or aspirations.<sup>315</sup>

In both Massachusetts<sup>316</sup> and Minnesota,<sup>317</sup> the proposed constitutional

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<sup>314</sup> See generally Kathrin Ruegg, *Embedding the Human Right to Health Care in U.S. State Constitutions: A Progress Review and Lessons for Advocates*, Working Document prepared for the Human Right to Health Program, National Economic & Social Rights Initiative and National Health Law Program, Feb. 2009 (tracking history of attempts to amend constitutions in Massachusetts, Minnesota, Michigan, and Oregon, and mentioning additional proposals in North Carolina and Florida), available at [http://www.nesri.org/programs/Constitutional\\_Amendment\\_Report\\_2-09.pdf](http://www.nesri.org/programs/Constitutional_Amendment_Report_2-09.pdf).

<sup>315</sup> See Gardner, *supra* note 64, at 819 (“state constitutions differ from the federal constitution in the level of detail in which they describe, and therefore the extent to which they constrain, governmental action with respect to subjects covered by the constitution”); G. Alan Tarr, *Understanding State Constitutions*, 65 TEMP. L. REV. 1169, 1181 – 83 (1992) (explaining prominence of “statutory” provisions in state constitutions, compared to U.S. Constitution).

<sup>316</sup> See Health Care for Massachusetts Campaign, *The Health Care Amendment* (“Upon ratification of this amendment and thereafter, it shall be the obligation and duty of the Legislature and executive officials, on behalf of the Commonwealth, to enact and implement such laws, subject to approval of the voters at a state wide election, as will ensure that no Massachusetts resident lacks comprehensive, affordable, and equitably finance health insurance coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices.”), available at <http://healthcareformass.org/about/amendment.shtml>.

<sup>317</sup> See, e.g., Minn. H.F. No. 683 (“Every Minnesota resident has the right to a basic set of essential, effective health care services. It is the responsibility of the governor and the legislature to implement all legislation necessary to ensure timely and affordable access to

amendments were not adopted, but the state legislatures, in the same year as the proposals were introduced, passed health reform packages.<sup>318</sup> Key lobbyists behind the Minnesota proposal acknowledged that the amendment was a starting point for health reform and a way to gather and demonstrate public support for comprehensive legislation.<sup>319</sup> In Massachusetts, sponsors of the Health Care Reform Act urged their colleagues to support the legislation instead of the proposed amendment vote. The constitutional amendment “would restrict legislators from quickly making inevitable tweaks to the reform” without going through a referendum vote for every change.<sup>320</sup> In Michigan,<sup>321</sup> the ballot proposal failed to gather the requisite signatures, getting lost in the Democratic Presidential Primary kerfuffle.<sup>322</sup> Oregon,<sup>323</sup> hailed as a leader in health reform innovation,<sup>324</sup> has seen three

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those services.”), *available at* <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H0683.0.html&session=ls85>.

<sup>318</sup> An Act Providing Access to Affordable, Quality, Accountable Health Care, ch. 58, § 142, 2006 Mass. Acts, *available at* <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>; Minn. S.F. No. 3780, *available at* <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S3780.1.html&session=ls85>; Minnesota Dep’t. of Health, 2008 Health Care Reform Summary, *available at* <http://www.health.state.mn.us/divs/opa/08reformssummary.html>.

<sup>319</sup> See Ruegg, *supra* note 314, at 8 (summarizing statement of Jennifer Schaubach, Legislative Director of AFL-CIO of Minnesota).

<sup>320</sup> See *id.* at 6; Jim O’Sullivan & Priscilla Yeon, *Lawmakers Nix Petition Guaranteeing Health Care Access*, STATE HOUSE NEWS SERVICE, Boston, Jan. 2, 2007, at 1 (summarizing Representative Patricia Walrath’s comments, *available at* <http://www.healthcareformass.org/press/documents/LAWMAKERSNIXPETITIONGUARANTEERINGHEALTHCAREACCESS.pdf>).

<sup>321</sup> See Michigan Universal Health Care Action Network, Ballot Initiative (“The state legislature shall pass laws to make sure that every Michigan resident has affordable and comprehensive health care coverage through a fair and cost-effective financing system. The legislature is required to pass a plan that, though public or private measures, controls health care costs and provides for medically necessary preventative, primary, acute, and chronic health care needs.”), *available at* <http://www.healthcareformichigan.org/Pages/HealthCareForMichiganPetition.pdf>. The Michigan proposal would have amended Article 4, § 51: “The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.”

<sup>322</sup> See Ruegg, *supra* note 314, at 11 (summarizing outcome in Michigan); MSNBC, *Democrats Punish Michigan for Early Primary*, Dec. 1, 2007, *available at* <http://www.msnbc.msn.com/id/22054151/>.

<sup>323</sup> OREGON CONST. art. I, § 46 (proposed) (“The people of Oregon find that health care is an essential safeguard to human life and dignity and that access to health care is a fundamental right. In order to implement that right, the Legislative Assembly shall establish by law a plan for a system designed to provide to every legal resident of the state access to effective and affordable health care on a regular basis.”), *available at* <http://www.leg.state.or.us/08ss1/measpdf/hjr100.dir/hjr0100.intro.pdf>.

failed attempts by health reform advocates to amend its constitution to include health care as a fundamental right.

One can only speculate about the reasons that the proposed amendments failed to be adopted.<sup>325</sup> But the experiences demonstrate that highly specific, rights-creating constitutional provisions on health have not gained political support, even in seemingly progressive states. Even if states are not willing to amend their constitutions to enshrine a right, it would not be accurate to infer that states do not value health care, especially because states rejecting amendments enacted broad legislative health care reforms. The breadth and specificity of the proposed amendments, which failed to pass, provide a useful contrast to the narrowly defined, non-mandatory tone of many of the currently enacted state constitutional provisions examined above. That contrast suggests reluctance by states to provide constitutional guarantees of health care or to bind themselves to terms that may be difficult to modify.

#### IV. LESSONS FROM STATE CONSTITUTIONS

The final Part provides a brief assessment and prescription for state constitutionalism and health care reform. States, consistent with the U.S. Constitution's negative rights tradition, do not seem inclined to recognize a universal right to health care under their constitutions. But a significant number of states give constitutional weight to health in certain, limited ways that federal law does not. Those narrow exceptions and states' reluctance to further extend the constitutional protections evidence the views of a broad section of society regarding the appropriate roles of government and individuals in health care.

##### A. Assessment

The existing diversity of state constitutional approaches to health reflects diverse views on state constitutionalism and states' roles with respect to individuals' health. More than a dozen states give constitutional

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<sup>324</sup> See, e.g., Lawrence Jacobs, Theodore Marmor & Jonathan Oberlander, *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161 (1999); Eric Lamond Robinson, *The Oregon Basic Health Services Act: A Model for State Reform?*, 45 VAND. L. REV. 977 (1992); Kathryn L. Tucker, *Federalism in the Context of Assisted Dying: Time for the Laboratory to Extend Beyond Oregon, to the Neighboring State of California*, 41 WILLAMETTE L. REV. 863 (2005); Casey Kauffman, Note, *Oregon v. Ashcroft, The Attorney General's Attempt to Override State Controlled Medical Practice*, 37 U.S.F. L. REV. 1065 (2003).

<sup>325</sup> See generally Rugg, *supra* note 314.

imprimatur to health.<sup>326</sup> Judicial decisions in the seven states examined demonstrate a general reluctance to recognize affirmative, enforceable health rights.<sup>327</sup> Indeed, there is not a single provision or case supporting a universal right to publicly funded health care. The clearest assertion of that sort of claim was soundly rejected before reaching the merits.<sup>328</sup> Several states recognize health as a fundamental or inalienable right and protect individuals' right to obtain their own health insurance or medical care, free from interference by the state or others. Many expressly require legislative action to protect and promote the vital interest in health.<sup>329</sup>

In a few cases, claims to health rights fare better under state than federal law. State constitutions that contain aspirational statements, guarantee freedom to seek individual health care, or recognize state authority (if not obligation) for public health are more protective than the U.S. Constitution. Treatment for mentally ill or indigent persons, or for abortion or hospital care, may be required in some states. But even those situations are limited to particular groups of individuals and particular types of services for reasons that do not support a universal right to health care.<sup>330</sup> Other constitutions mention health expressly but follow the federal preference for negative rights, declining to impose any affirmative duty on the state or right of individuals. States' recent attempts to adopt constitutional provisions enshrining clear, comprehensive health care rights and specific state duties have not received political support.<sup>331</sup>

States' reluctance to recognize constitutional claims to individual health care rights should not be read as rejection of health as an essential human interest or insensitivity to the health, welfare, and safety of citizens. Nor does the lack of judicial enforcement undermine the importance of health. United States tradition gives especial prominence to constitutional rights,<sup>332</sup> and grants courts, the Supreme Court in particular, a virtual monopoly on constitutional interpretation.<sup>333</sup> Accordingly, there is a sense that any right

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<sup>326</sup> See Appendix B (summarizing state constitutional provisions).

<sup>327</sup> See *supra* Part II.B.

<sup>328</sup> Michigan Universal Health Care Action Network v. State, 2005 WL 3116595 (Mich. App. 2005).

<sup>329</sup> See, e.g., WYO. CONST. art 7, § 20 (using "vital interest" language for health).

<sup>330</sup> See *supra* Part III.A – B.

<sup>331</sup> See *supra* Part III.C.

<sup>332</sup> See *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819) ("In considering this question, then, we must never forget that it is a *constitution* we are expounding"); Gardner, *supra* note 65, at 814 ("This crytic phrase aptly captures the judicial view, embraced consistently ever since, that a constitution is different from other types of documents that courts may be called upon to interpret").

<sup>333</sup> See *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803) ("It is emphatically the province and duty of the judicial department to say what the law is."); Michelman, *supra* note 9, at 682 (discussing "currently entrenched reliance on judicial review as an

worthy of attention must be subject to judicial enforcement.<sup>334</sup> But the legislative and executive branches are similarly compelled to abide the constitution in carrying out their tasks. Legislators are expected to prophylactically consider the constitutionality of proposed legislation as much as courts rule retrospectively on the enacted laws.<sup>335</sup> Moreover, courts may be ill-equipped to carry out the task of enforcing affirmative rights to adequate food, shelter, clothing, employment, and health care.<sup>336</sup> Provision of government services and implementation of social programs may be better handled legislatively than judicially.<sup>337</sup>

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indispensable guarantor of the rule of constitutional law”); *see also* Gary Jeffrey Jacobsohn, *The Permeability of Constitutional Borders*, 82 TEX. L. REV. 1763, 1771 (2004) (noting Americans’ “predominant inclination has been to view the judiciary as exercising a monopoly over constitutional interpretation”); Linde, *supra* note 62, at 168 (suggesting that “legitimacy” of judicial review “to set[] aside unconstitutional laws” is “the issue to which every law student is introduced by Chief Justice Marshall’s opinion in *Marbury v. Madison*”).

<sup>334</sup> *See* Sunstein, *supra* note 18, at 14 (suggesting that “in the American culture, constitutions are seen as pragmatic instruments suited for, and not inextricable from, judicial enforcement”); Tushnet, *supra* note 17, at 1211 (“[M]any appear to believe that, at least in advanced constitutional systems, civil rights must be enforceable through some sort of judicial proceeding”).

<sup>335</sup> Paul Brest, *Who Decides?*, 58 S. CAL. L. REV. 661, 670 – 71 (1985) (placing responsibility on all branches to consider constitutional issues, rebutting judicial exclusivity); Michelman, *supra* note 7, at 671, 685 (concluding that constitutional recognition of socioeconomic rights as a moral imperative on lawmakers may be separated from judicial review of constitutional law); Sager, *supra* note 9, at 435 (proposing an understanding that we are “obliged – constitutionally obliged – to address the injustice of poverty and entrenched racial disadvantage, but see the primary addresses of this obligation as elected officials rather than judges”); Sunstein, *supra* note 18, at 16 (refuting institutional explanation for lack of social and economic rights, suggesting that “courts could take steps to ensure that basic needs receive a degree of legislative priority, and to correct conspicuous neglect”).

<sup>336</sup> *See* Michelman, *supra* note 7, at 669 (“The choices needing to be made are subtle, technical, interactive, uncertain, subject-to-experience, and endlessly debatable. It is far from clear how courts of law can inject themselves into such matters with much credibility or authority.”); Mark Tushnet, *Social Welfare Rights and the Forms of Judicial Review*, 82 TEX. L. REV. 1895, 1896 (2004) (suggesting common argument against constitutional recognition of social welfare rights is that they “cannot be enforced in the courts because their enforcement requires the courts to make decisions that have large-scale consequences for government budgets”); *see also* Kinney, *supra* note 1, at 300 (“A more useful observation about individual enforcement of economic and social rights is that the determination of their content involves facts and issues that are not appropriate for courts or other adjudicative tribunals to determine”).

<sup>337</sup> Bork, *supra* note 9, at 700 (“Courts simply are not equipped, much less authorized, to make decisions” regarding repeal of welfare statutes); Michelman, *supra* note 7, at 669 – 71 (discussing widely-held view that courts “are ill-equipped for fine-tuned appraisals of governmental efforts” toward socioeconomic guarantees); Lawrence G. Sager, *supra* note 9, at 420 (implementation of social programs involves “immensely complex questions of

The role of the political branches in state constitutionalism is particularly salient. Although not as nimble as statutes, state constitutions are amended much more frequently and with much greater political involvement than the federal constitution.<sup>338</sup> Given the politics of state constitutionalism, it is appropriate that legislative and administrative roles figure prominently in state constitutional theory and interpretation.<sup>339</sup> Many states that include health in their constitutions, mandate legislative action or allow delegation to local authorities and agencies, as well as private actors, to address health or public health needs.<sup>340</sup> Ironically, some of those provisions have the effect of reducing protection for individuals by cloaking state actors with immunity from liability. In sum, state constitutional law suggests ambivalence about individual health rights.

### B. Prescription

States constitutionalism does not provide a roadmap for health reform but does suggest certain trends that federal and state lawmakers should consider as they debate the future of the health care system. Perhaps the clearest message that can be derived from state constitutionalism is that any proposal for universal right to health care, provided by the government,

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social strategy and social responsibility . . . that seem far better addressed by the legislative and executive branches of government, questions that seem virtually out of reach of the judiciary”); Sunstein, *supra* note 18, at 16 (“American courts have been reluctant to recognize social and economic rights, in part because of a belief that enforcement and protection of such rights would strain judicial capacities”); Tushnet, *supra* note 17, at 1211 (“courts are ill-suited to enforce social rights; courts cannot devise effective methods of ensuring that shelter, food or jobs are available to all citizens”).

<sup>338</sup> TARR, *supra* note 61, at 23 (noting that federal constitution has been amended less than once per decade, compared to states, which regularly amend and revise their constitutions); Daniel B. Rodriguez, *State Constitutionalism and the Domain of Normative Theory*, 37 SAN. DIEGO L. REV. 523, 527 (2000) (noting “key distinction between the federal and state constitutions concerns the frequency of amendments over time”); Sager, *supra* note 9, at 895 (noting that U.S. “Constitution is markedly obdurate to textual change”); Schapiro, *supra* note 65, at 429 – 30 (noting “greater ease of amending state constitutions and the greater electoral accountability of state judges”); Albert L. Sturm, *The Development of American State Constitutions*, 12 PLURIBUS: J. FEDERALISM 57, 57 (Winter 1982) (“Since 1776, the fifty states have operated under no fewer than 145 constitutions” and tracing history of various amendments and changes).

<sup>339</sup> Rodriguez, *supra* note 42, at 529 – 30 (noting “difference between federal and state constitutionalism is a shift in focus from courts as the ultimate audiences for normative constitutional theory to the legislature and administrative agencies”); *cf.* Kahn, *supra* note 61, at 471 (“An easily amended constitution may represent only a temporary resting place in an unsettled debate over public values. Such a constitution does not stand dramatically apart from ordinary politics.”)

<sup>340</sup> See *supra* Part II.B.1 – 5 (Michigan, New York, North Carolina, Mississippi, South Carolina); see also Appendices A (listing text of provisions), B (summarizing similarities).

would not be widely support. Even states that give greater constitutional recognition to the importance of health and recognize limited state duties to provide health care do not guarantee health care to all residents. Attempts to litigate those sorts of claims or enact amendments on universal health care rights have not succeeded. States, although raising the federal floor on protection of health in small degrees, generally adhere to the negative rights view that health is a matter of individual responsibility. To the extent that health is enshrined as a right in state constitutions, the provisions suggest merely that the state cannot interfere with individual health care decisions or access, not that the state must provide health care to all.

But there are other lessons that can be drawn from state constitutions. States seem to embrace their traditional reserved police powers to regulate public safety, public health, insurance companies, medical professions, and the environment, all areas of concern to individual health. Consistent with public safety and law enforcement functions, states recognize correlative duties to provide medical care to prisoners, as required by federal law, and the insane, even when federal law does not require. Although exercising some regulatory oversight, states generally leave patients free to control their own medical decisions and choose their own treatment providers, within limits, such as professional licensure and insurance coverage laws. Federal reforms that intrude on those areas of traditional state powers may meet resistance, especially if the reforms also intrude on individual autonomy. For example, proposals to federalize certain insurance industry pricing, coverage, and underwriting practices,<sup>341</sup> could face an uphill battle.

Protecting the public's health and environmental protection, in particular, are core state functions in organized society and consistent with communitarian values. If one person's land use impairs another's or the community's interests, government's role is to step in and referee the conflicts. Similarly, the state may have a public health duty to protect others and the community at large from infection by vaccinating, treating, or quarantining certain individuals. One possible implication from those examples is that if health care reform can be reframed as collective action or public goods problem, the proposals may gain better traction. Mandatory vaccination intrudes on personal autonomy and medical decisionmaking, but serves the common good by protecting society from the infectious

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<sup>341</sup> See Blumberg & Holahan, *supra* note 74, at 6 – 7 (discussing need for federal health insurance regulation); Timothy Stolfus Jost, *Health Insurance Exchanges: Legal Issues, Legal Solutions in Health Reform*, O'Neill Institute for National and Global Health at Georgetown Law, at 14 – 15 (summarizing traditional forms of state health insurance regulation), *available at* [http://www.law.georgetown.edu/oneillinstitute/projects/reform/Papers/Insurance\\_Exchange\\_s.pdf](http://www.law.georgetown.edu/oneillinstitute/projects/reform/Papers/Insurance_Exchange_s.pdf).

diseases. Similarly, mandatory health insurance arguably intrudes on individual economic rights<sup>342</sup> but serves the common good by effecting broader risk pools and making health insurance more affordable for all.<sup>343</sup>

A few states constitutionalize a duty to provide health care to the indigent, extending public assistance more explicitly and less categorically than federal law. That trend evidences the view of a significant portion of the population that health care is not entirely a matter of individual responsibility, at least when it comes to people who are unable to obtain health care on the private market through their own efforts. Brought into the health reform debate, those opinions suggest support for government subsidies for those unable to afford private health insurance and perhaps expansion of existing government health care programs.<sup>344</sup>

Some of the trends in state constitutionalism offer less clear implications for health reform. For example, states that constitutionally provide for the care of the insane likely reflect states' historical roles in caring for incompetent individuals or incapacitating dangerous ones, rather than progressive views on the importance of mental health treatment for all. Those states' constitutions should not be read as guarantees of state-funded care for anxiety, attention-deficit disorder, depression, or other conditions that otherwise functional individuals suffer.

The exception that some states recognize to provide medical care to prisoners and others in state custody is also a narrow right. The right derives from the fact that those individuals have been deprived by state action of the ability to access health care on their own. It would be a stretch to translate that unique, specific policy into the broader language of health reform. Any suggestions that the uninsured or others who are unable to access medical care are "incompetent" and in need of state protection, or that affirmative state action has placed them in that condition, are likely to be unconvincing.

Similarly, state constitutions that give greater protection to abortion rights than federal law reflect a host of moral, religious, political, and scientific views having little to do with health care more broadly speaking. The abortion rights debate has its own political discourse, which, if interjected into the health reform debate, would likely undermine support for health care rights. Indeed, current federal proposals to require any new

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<sup>342</sup> See Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, Legal Solutions in Health Reform, O'Neill Institute for National and Global Health at Georgetown Law, at 13, available at [http://www.law.georgetown.edu/oneillinstitute/projects/reform/Papers/Individual\\_Mandate\\_s.pdf](http://www.law.georgetown.edu/oneillinstitute/projects/reform/Papers/Individual_Mandate_s.pdf).

<sup>343</sup> See Blumberg & Holahan, *supra* note 74, at 6.

<sup>344</sup> See Hacker, *supra* note 261, at 2270; John K. Inglehart, *Congressional Action on Health Care Reform*, NEW ENG. J. MED., June 18, 2009, at 2593 – 94; Pear, *supra* note 261.

government health care benefit to cover abortions have drawn acrimonious responses.<sup>345</sup>

States that limit their duty to inpatient hospital care may represent nothing more than an outdated view on the role of medicine and value of routine, preventative care. Modern health insurance plans and government health care programs encourage early diagnosis and prevention of health conditions that become more expensive to treat later than sooner.<sup>346</sup> The hospital-only and other attempts by states to narrowly circumscribe their health care duties, as a whole, reflect the unavoidable reality that health care resources are scarce and must be rationed to some degree.<sup>347</sup> That tension persistently underlies much of the health reform debate. States' constitutions offer little guidance for lawmakers making those difficult resource-allocation choices.

Setting aside the specific protections in state constitutions, the larger lesson of this survey and analysis of state constitutional law is that states play a vital role in health care, despite the current focus on the national stage. The diversity of views expressed in states' constitutions demonstrates the continued relevance of federalism in health care. State laws, especially state constitutions, offer a wide range of approaches. That diversity should be cultivated, not suppressed. If health care is to be enshrined as a constitutional right at all, it should be at the state level. If a state ultimately does manage to enact a rights-creating constitutional amendment, other states could observe, evaluate, and perhaps follow. By contrast, a federal constitutional right would raise the minimum floor, narrowing the space for state experimentation.<sup>348</sup>

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<sup>345</sup> See, e.g., Karen Tumulty, *Could Abortion Sink Health-Care Reform?*, TIME, July 8, 2009; *Mandated Abortion Coverage Threatens Health Care Reform, U.S. Bishops' Official Say*, CATHOLIC NEWS AGENCY, Aug. 8, 2009, available at <http://www.catholicnewsagency.com/new.php?n=16798>.

<sup>346</sup> See Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489, 502 – 05 (1995); Utz, *supra* note 77, at 132; Robert S. Gold, *Opinion, An Ounce of Prevention for the Debate on Health Care Reform*, BALTIMORE SUN, Aug. 6, 2009, available at <http://www.baltimoresun.com/news/opinion/oped/bal-op.prevention06aug06.0.5754911.story>.

<sup>347</sup> See Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES MAG., July 15, 2009, available at <http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html?pagewanted=all>. But see David B. Rivkin & Lee A. Casey, *Is Government Health Care Constitutional? The Right to Privacy Conflicts with Rationing and Regulation*, WALL ST. J., June 22, 2009, available at <http://online.wsj.com/article/SB124562948992235831.html>.

<sup>348</sup> Gardner, *supra* note 64, at 490 (if the purpose of state experimentation “is to influence the Court’s development of federal constitutional law, the effect of success can only be to persuade the Court to raise the federal floor – thereby depriving the states of a

There is value in federalism, even if differing political norms are aligned only incidentally with state borders. There may be unique or characteristic values and experiences of residents of Montana, New York, or Mississippi. But more importantly, people all over the country have a range of views that are expressed through myriad state constitutions and state politics.<sup>349</sup> Coalitions organized around state politics to address state-level concerns may have stronger voices than they would at the federal level. States, as subunits of the federal government, offer greater access and opportunities to affect policy.<sup>350</sup>

The amendment debates demonstrate the value of state constitutionalism as opportunities to vet ideas and highlight policy concerns, even if, and perhaps because, the proposed amendments failed to be adopted.<sup>351</sup> Lawmakers and voters are compelled to consider whether health is a “constitutional” value or, at least, a public concern pressing enough to demand legislative action. Despite the failed constitutional amendment, the reform package enacted in Massachusetts now serves as a comprehensive model for federal reform.<sup>352</sup> Watching the results of that experiment, other states and federal policymakers can develop proposals that encompass the successes and avoid the pitfalls.<sup>353</sup>

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measure of their autonomy”).

<sup>349</sup> See Gardner, *supra* note 64, at 818 (“whatever currency the notion of local variations in character and values might have had, it is a notion that no longer described in any realistic way the politics of the present day states”); Paul W. Kahn, *Interpretation and Authority in State Constitutionalism*, 106 HARV. L. REV. 1147, 1150, 1168 (1993) (“If states are no longer the locus of a vibrant, community experience, then a state constitutionalism that looks to the unique state community for its sources of decisionmaking promises to remain a marginal factor in American public life,” urging instead state constitutionalism as “a process for giving voice to the state court’s understanding of values and principles of the national community”); Linde, *supra* note 62, at 194 (“Federalism divides out laws along state lines, but those lines do not match divisions in American society. ... What national theory treats as a minority is often a majority in part or all of a state.”); Schapiro, *supra* note 64, at 428 – 40 & n.148 (reviewing and rebutting state identity arguments but nevertheless identifying a role for independent interpretation of state constitutions).

<sup>350</sup> See Kahn, *supra* note 350, at 1166 (noting “a longstanding justification of federalism under which state governments provide a forum for discussion, disagreement, and opposition to actions of the national government”); Long, *supra* note 62, at 46 (“States will probably never be the primary community or source of identity for most Americans. On the other hand, states may play some small part, at least once in a while, for nearly all Americans. Intermittent state constitutionalism recognizes and encourages this polyvalent sense of cultural identity.”); Rodriguez, *supra* note 42, at 271 (state constitutions are “intrinsically important as legal frameworks for implementation of public policy”).

<sup>351</sup> See *supra* Part III.C.

<sup>352</sup> See *supra* notes 72 – 74 and accompanying text (describing Massachusetts 2006 Health Reform Plan and proposals under President Obama’s administration).

<sup>353</sup> See, e.g., Abby Goodnough, *Massachusetts Adjusts a Cut, Providing Some Health*

State constitutions are admittedly imperfect, incongruent, and politicized.<sup>354</sup> But the realpolitik of state constitutionalism does not entirely undermine its importance. Many people attach special resonance to constitutional statements and even moreso to constitutional rights. Scholars have comprehensively identified the many challenges associated with constitutional recognition of affirmative, enforceable rights.<sup>355</sup> Nevertheless, there is still something to be said for constitutionalizing certain values and bestowing with them that weight of importance.

Individual health is undeniably fundamental in the common parlance, non-constitutional sense of the word. Without a healthy body and mind, an individual cannot fully participate in many other aspects of society. Including health in state constitutions serves as “a constant headline,” guiding lawmakers and reminding the public of its importance.<sup>356</sup> State constitutions that provide even weak protection for health serve that headlining function, even if they do not create robust individually enforceable rights. By analogy, several nations’ constitutions contain similar nonjusticiable “directive principles” expressing fundamental values and requiring legislative action.<sup>357</sup>

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*Care for 30,000 Immigrants*, N.Y. TIMES, July 30, 2009; Robert Steinbrook, *The End of Fee-for-Service Medicine? Proposals for Payment Reform in Massachusetts*, NEW ENG. J. MED., July 29, 2009; *The Massachusetts Model*, N.Y. TIMES, Aug. 9, 2009, at wk 8.

<sup>354</sup> See, e.g., Gardner, *supra* note 64, at 763 (“state constitutional law today is a vast wasteland of confusing, conflicting, and essentially unintelligible pronouncements”); Linde, *supra* note 62, at 196 (“Most state constitutions are dusty stuff – too much detail, too much diversity, too much debris of old tempests in local teapots, too much preoccupation with offices, their composition and administration, and forever money, money, money.”)

<sup>355</sup> See, e.g., Bandes, *supra* note 17, at 2327 – 42 (discussing arguments against recognition of affirmative rights in section on “The Fear of Chaos: Floodgates, Slippery Slopes, and Judicial Incapacity”); Cross, *supra* note 17, at 878 – 93 (discussing various arguments from critics of positive rights, including cost, judicial competence, and politics); Michelman, *supra* note 7, at 668 – 72 (listing “instrumental reasons” for American constitutions’ failure to include socioeconomic rights); Sunstein, *supra* note 23, at 15 (suggesting litany of questions that would arise if constitution included affirmative rights).

<sup>356</sup> See Jacobsohn, *supra* note 333, at 1770 (quoting framers of Irish Constitution on inclusion of nonjusticiable Directive Principles (Const. of Ireland, 1937, art. 45 (Social Policy))).

<sup>357</sup> See, e.g., INDIA CONST. art. 37 (“The provisions contained in this Part [IV] shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.”); IR. CONST. ch. XIII, art. 45 (announcing “principles of social policy ... intended for the general guidance of Parliament” and specifying that they “shall not be cognisable by any Court under any of the provisions of this Constitution”); NIG. CONST. ch. II (Fundamental Objectives and Directive Principles of State Policy), art. 17(3)(a), (e); PAPUA N.G. CONST. pmb. para. 2.

Nonjusticiable constitutional expressions are not legally irrelevant,<sup>358</sup> as demonstrated by the state judicial decisions discussed above. The constitutional provisions on health were not always decisional but certainly instructive to the courts' opinions, even when they merely granted governmental immunity or approved state funding for health care providers. The right, duty, concern, or other constitutional reference to health at the very least called on courts to consider the impact of their decisions on the health of individuals in the state. As the survey of cases reveals, health bears on many other substantive areas of law, including criminal, disability, family, environmental, torts, poverty, and abortion. Health is central to state governance, whether it is explicitly recognized in the constitution or inextricably intertwined with other state laws and values. Therefore, ardent advocates of health care rights should not be troubled by the absence of constitutional guarantees of health in the U.S. or separate state constitutions. The multiple deficiencies in the country's health care system to provide essential health care to individuals inevitably will, and already are, receiving attention. Exactly how those concerns will be addressed can only benefit from the views of the public, expressed through their state constitutions.

#### CONCLUSION

Although state constitutions and case law offer little support for a cognizable right to health, the conclusion is not without promise for improving health care in the country. State constitutions are charter documents expressing citizen's values, priorities, and aspirations. The lack of enforceable state constitutional rights does not necessarily undermine the importance of health. Constitutional expressions, as well as constitutional debates, over health care rights and duties fuel the political process, ultimately allowing states to make various choices of how best to address the health concerns of their citizens. The diversity of approaches to constitutional recognition, or even non-recognition, of health is not a weakness but a value of the federalist system.

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<sup>358</sup> See Kinney, *supra* note 1, at 301 ("the right as a policy imperative requires bound states to take legislative action and array national budgetary priorities in ways that fulfill that policy imperative"); Tushnet, *supra* note 336, at 1898 (nonjusticiable rights "can be used to interpret ambiguous statutes" or "explain why the courts refuse to recognize other rights").

## Appendix A

Provision	Year of Adoption	Current Text
ALA. CONST. ART. IV, § 93.12	1946	The state ... may acquire, build, establish, own, operate and maintain hospitals, health centers, sanatoria and other health facilities. The legislature for such purposes may appropriate public funds and may authorize counties, municipalities and other political subdivisions to appropriate their funds, and may designate or create an agency or agencies to accept and administer funds appropriated or donated for such purposes by the United States government to the state upon such terms and conditions as may be imposed by the United States government.
ALASKA CONST. ART. VII, § 4	1956	The legislature shall provide for the promotion and protection of public health.
ARK. CONST. ART. 19, § 19	1874	It shall be the duty of the General Assembly to provide by law for the support of institutions for the education of the deaf and dumb and the blind, and also for the treatment of the insane.
HAW. CONST. ART. IX, § 1	1978	The State shall provide for the protection and promotion of the public health.
HAW. CONST. ART. IX, § 3	1978	The State shall have the power to provide financial assistance, medical assistance and social services for persons who are found to be in need of and are eligible for such assistance and services as provided by law.
ILL. CONST. PMBL.	1970	We, the People of the State of Illinois — grateful to Almighty God for the civil, political and religious liberty which He has permitted us to enjoy and seeking His blessing upon our endeavors — in order to provide for the health, safety and welfare of the people...
LA. CONST. ART. XII, § 8	1974	The legislature may establish a system of economic and social welfare, unemployment compensation, and public health.

MICH. CONST. ART. 4, § 51	1963	The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.
MISS. CONST. ART. IV, § 86	1869	It shall be the duty of the Legislature to provide by law for the treatment and care of the insane; and the Legislature may provide for the care of the indigent sick in the hospitals in the State.
MO. CONST. ART. 4, § 37	1972	The health and general welfare of the people are matters of primary public concern; and to secure them there shall be established a department of social services in charge of a director appointed by the governor, by and with the advice and consent of the senate, charged with promoting improved health and other social services to the citizens of the state as provided by law, and the general assembly may grant power with respect thereto to counties, cities or other political subdivisions of the state.
MONT. CONST. ART II, § 3.	1972	All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life's basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and seeking their safety, health and happiness in all lawful ways. In enjoying these rights, all persons recognize corresponding responsibilities.
N.C. CONST. ART. XI § 4	1970	Beneficent provision for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and a Christian state. Therefore the General Assembly shall provide for and define the duties of a board of public welfare.
N.Y. CONST. ART. 17, § 1	1938	The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature

		may from time to time determine.
N.Y. CONST. ART. 17, § 3	1938	The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.
S.C. CONST. ART. XII, § 1	1971	The health, welfare, and safety of the lives and property of the people of this State and the conservation of its natural resources are matters of public concern. The General Assembly shall provide appropriate agencies to function in these areas of public concern and determine the activities, powers, and duties of such agencies.
WYO. CONST. ART. 7, § 20	1890	As the health and morality of the people are essential to their well-being,... it shall be the duty of the legislature to protect and promote these vital interests

## Appendix B

State	Right, Duty, Public Concern	Shall/May	Term/Concept Appears in Provision			
			Environ.	Public Health	Mentally Ill	Indigent
ALABAMA	N/A	May				
ALASKA	Duty	Shall		X		
ARKANSAS	Duty	Shall			X	
HAWAII § 1	Duty	Shall		X		
HAWAII § 3	Duty	Shall				X
ILLINOIS	Right	N/A		X		
LOUISIANA	N/A	May		X		
MICHIGAN	Public Concern	Shall		X		
MISSISSIPPI	Duty	Shall			X	X
MISSOURI	Public Concern	Shall				
MONTANA	Right	N/A	X			
NEW YORK § 1	Public Concern	Shall				X
NEW YORK § 3	Public Concern	Shall		X		
N. CAROLINA	Duty	N/A				X
S. CAROLINA	Public Concern	Shall	X	X		
WYOMING	Duty	Shall		X		