I. Introduction

Scholars and activists have long suggested that every judicial or legislative victory for civil rights is tempered by the fact that the new rights won must be incorporated within a system largely designed to maintain the status quo. This Article examines this tension by addressing the struggle for equal access to health care in the United States. Access to health care was a significant, if underpublicized, aspect of the civil rights movement, and disparities in access to health care remain one of the most significant pieces of unfinished business in our country's ongoing struggle toward racial equality. Not surprisingly then, this summer's Supreme Court decision upholding the constitutionality of the Patient Protection and Affordable Care Act (ACA) fits neatly into our country's ongoing civil rights narrative--a victory tempered by new hurdles to altering the status quo. As such, this Article suggests that by upholding the individual mandate as a constitutional exercise of Congress's power to tax, articulating limits on Congress's ability to use the commerce power, and turning the ACA's Medicaid expansion into a state option, the Court, particularly Chief Justice John Roberts, may have altered the pathways by which Congress may reform and regulate health care and, equally significantly, protect the civil rights of minority groups.

This Article is part of a larger exploration of how our society comes to consensus about particular health care issues. As a nation, we have been and remain embroiled in a divisive debate about our health care system and the package of reforms enacted by Congress in 2010 that will alter or affect almost every aspect of that system--from access, to financing, to service delivery. Some of this law is controversial; however, much of it is not. This Article will unpack the complex array of issues in the American health care system and explore one area of consensus, because it is only through identifying consensus on basic principles that we can move forward to address health disparities and reform our health care system. Such analysis will provide insight into opportunities missed by defenders of the ACA and potential paths forward to achieving the ACA's larger goals.

This Article locates the Obama Administration's health care reform efforts--namely the Patient Protection and Affordable Care Act--within an overarching narrative about the consequences, some of them unintended, of health care statutes. The particular statutes that this Article will address--the Hill-Burton Act, the Medicaid and Medicare statutes, the Emergency Medical Treatment and Active Labor Act (EMTALA), and the Affordable Care Act--are all parts of the story of the development of our modern health care system, and all may be considered attempts to reduce or eliminate health disparities in the United States. These statutes are rooted in part within the civil rights movement, however they extend well beyond it, telling a story about the twin difficulties of forging a consensus as to how we will take care of our sick and disabled fellow citizens and further, how to act on that consensus. Ultimately, they help to explain why health care reform has become unavoidable and raise the question of whether the incremental reforms that have characterized our system can advance the fight to reduce health disparities.
By thinking and talking about health care reform as civil rights legislation, we can gain insight into these themes. In particular, this Article will focus on the Emergency Medical Treatment and Active Labor Act (EMTALA)-- why it was adopted, its status as a civil rights enactment, and some of its consequences. EMTALA gives individuals an explicit right to emergency medical treatment by hospitals that participate in the Medicare program. It reflects the blunt national consensus that in the United States, we do not allow the sick and the injured to die in the streets. And yet, Americans have never achieved the same consensus about how to pay for the treatment provided pursuant to EMTALA or how to manage its requirements.

*142 This problem of turning consensus into policy has plagued policymakers throughout the history of our nation's attempts at health care reform. Policymakers must design policies that implement agreed-upon principles without destroying the national consensus about those principles. They must consider whether constituents would be more likely to support a health care policy or set of policies if our national consensus was more explicit and the consequences of that consensus were better understood, and then they must act accordingly. For example, they must decide whether it is better to develop a single national health care system, or whether the limits of consensus compel a more incremental and flexible approach with a variety of state options.

Part II of this Article will review some of the United States' post-World War II legislative attempts to address particular disparities in our health care system at the federal level, examining the passage and implementation of the Hill-Burton Act, Medicare, and Medicaid. In doing so, it will describe how those enactments set the stage for the passage and implementation of EMTALA. Part III describes EMTALA, its enactment, and some of its consequences--both intended and unintended. It will elucidate how a simple, four-page statute enacted without fanfare in 1986 has proven to be one of our country's most successful civil rights laws, and how its consequences have made significant changes to our health care system virtually inevitable. Part IV will discuss the Patient Protection and Affordable Care Act and explain how some of its most critical and controversial provisions--most notably the individual mandate--can be seen as a response to the consequences of EMTALA. Further, it will expose how the national consensus about the need for EMTALA appears to dissolve when we attempt to determine how to fund its requirements. Finally, Part V will address the arguments before the Supreme Court and the Court's rulings on the issues presented in National Federation of Independent Business (NFIB) v. Sebelius, the case that considered the constitutionality of certain provisions of the Patient Protection and Affordable Care Act. During oral argument, both the parties and the Court seemed hesitant to even mention EMTALA, nor is EMTALA given much emphasis in the Court's opinions. This reflects a missed opportunity. By failing to argue that the ACA was civil rights legislation, building on prior enactments such as EMTALA and Medicaid, the law's proponents gave the Court an opening to draft a very narrow decision, limiting the extent of their victory.

Moreover, because the oral arguments and the Court's ultimate decision are themselves part of the national debate over health care reform and health care policy, it is crucial to the implementation of health care reform that we forge broad and strong links between areas of national consensus about health care policy and enacted health care reforms. Talking about health care reform as a civil rights issue is critical to moving forward with implementation of those reforms. It may still be that the individual mandate--the requirement that all Americans purchase health insurance--will become a part of our consensus about how to take care of the sick and disabled and will be incorporated into the status quo. However, it is now equally likely that the Supreme Court's decision will affect the ability of activists to address health care disparities, and perhaps achieve other civil rights victories, because it limits Congress's ability to make incremental legislative changes and to enact national policy through cooperative federalism programs like Medicaid.

II. How we Got Here--Hill-Burton, Medicare, and Medicaid
From the late eighteenth century forward, Congress “repeatedly declined invitations to regulate even minimally in the health field . . . .” 34 When Congress did enter the health field in a significant way after the Civil War, it did so awkwardly and with poor results, struggling to determine how large a role the federal government should play in administering health care in the Southern states. 35 Following the Emancipation Proclamation, the federal government had taken responsibility for the health of former slaves *144 or freedpeople. 36 Able-bodied males generally joined the Union Army; however, little provision was made for their families and children. 37 After the war, the Freedman's Bureau, which included a medical division, set up hospitals in the South to care for those freedpeople who were unable to support themselves. 38 Because of Congress's ambivalence over whether such hospitals would cause freedpeople to become dependent on the federal government, the federally-operated hospitals did not last past the end of Reconstruction--those that did not close reverted to state or local government control. 39 From that point forward, medical care in the South became subject to the same Jim Crow strictures as every other aspect of life. 40

This state of affairs remained largely unchanged until after World War II, when the federal government again took an interest in expanding access to health care and addressing health disparities. Even as it did so, the federal government chose to reserve much of the control over the actual federal health programs to the states, establishing a tradition of cooperative federalism. 41 This Part will describe some of those post-World War II health care programs, discuss their place in the civil rights struggle, and explain how they helped set the stage for the enactment of EMTALA in the 1980s. Further, it will show that while the federal government was attempting to address health disparities, it also was pouring resources into the development of our modern American medical system, creating the circumstances that ultimately would necessitate the reforms contained in the ACA. 42

A. The Hill-Burton Act

Forty-six years to the day before the Supreme Court began hearing oral arguments in NFIB v. Sebelius, Dr. Martin Luther King, Jr. made his famous pronouncement on health care: “Of all the forms of inequality, injustice in *145 health care is the most shocking and inhumane.” 43 King undoubtedly was familiar with the segregated hospital system encouraged and perpetuated by the Hill-Burton Act, also known as the Hospital Survey and Construction Act, signed into law in 1946. 44 Hill-Burton was the only part of President Truman's three-pronged program 45 of comprehensive health care reform legislation that was enacted by Congress. Hill-Burton was a program of cooperative federalism that worked in a manner similar to the way that the Medicaid program operates today. 46 The legislation authorized matching federal grants for the construction of public and nonprofit private health facilities. 47 Each state designated an agency to administer the program, survey the state's health facility needs, and develop a state plan acceptable to the federal government, revising the plan every two years. 48

From 1947 to 1971, the Hill-Burton Act provided billions of dollars of federal funding to the states, ostensibly to address the disparities in access to acute care in inpatient hospital facilities that existed across the country after World War II. 49 However, Hill-Burton also contained the unique provision, inserted by Senator Lister Hill of Alabama, that while the facilities built with federal funds were to be available to all persons “without discrimination on account of race, creed or color . . . an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.” 50 Thus, Hill-Burton may have been the only twentieth century statute to specifically incorporate the *146 doctrine of separate but equal into its language. 51 This is not to say that Hill-Burton created the segregated system of medical care in the South that existed in 1966, but it also did nothing to alleviate it, either. 52

By the time Dr. King gave his speech on health care, he was riding a wave of progress that would significantly improve the access to health care for African Americans and, indeed, all poor Americans. In 1963, the United States Court of Appeals for the Fourth Circuit ruled that Hill-Burton's separate but equal provision was unconstitutional, and in 1964, the Supreme Court
denied certiorari, thereby upholding the lower court's ruling. That same year, the Civil Rights Act of 1964 was passed. In 1965, President Johnson signed into law the legislation that created Medicare--which covered hospital care and physician services for elderly Americans--and Medicaid--which covered medical care provided to welfare recipients. Both programs were set to begin operating on July 1, 1966.

Accordingly, Dr. King was encouraging activists to cement those victories by continuing to prod the Department of Health, Education, and Welfare (HEW) to enforce the anti-discrimination provisions of Title VI of the Civil Rights Act of 1964 in Southern hospitals. In 1965, those activists had filed hundreds of complaints against hospitals across the South. HEW was sufficiently chastened to launch an investigation and a drive to bring some 9000 hospitals across the country into compliance with Title VI before the Medicare program went into effect on July 1, 1966. Despite a predictable Southern backlash against HEW's campaign of Title VI enforcement, the federal government cleared most hospitals to receive Medicare funds by the program's implementation date.

**B. Medicaid and Medicare**

In a capitalist society, it is not surprising that equal access to health care hinges in part on an individual's ability to pay for health care. Medicare and Medicaid were extraordinary and necessary legislative accomplishments; however, the scope of the two programs was far more limited when they first came into being than it is now. Even though the combined effect of the implementation of Medicare and the accompanying enforcement of Title VI's requirements led to the desegregation of hospitals across the country, that and the implementation of the two new programs still would not be enough to guarantee equal hospital access to all, or even to put much of a dent in health disparities linked to income and race.

Medicare and Medicaid were programs designed to provide health care access only to narrow segments of the population. Initially, Medicare was conceived only as a “compulsory hospital insurance program under Social Security” for the elderly (now known as Medicare Part A). In order to win passage in Congress, its sponsors added a program of “government-subsidized voluntary insurance” to cover outpatient physician bills (now known as Medicare Part B). Medicaid, however, was and remains an insurance program that enabled individuals to gain access to public and private health care providers. The version enacted in 1965 covered only those individuals who were eligible for public cash assistance, such as the Aid to Families with Dependent Children (AFDC) welfare program, Aid to the Permanently and Totally Disabled, and Aid to the Aged, Blind, or Disabled.

The programs also were supported by different payment schemes. The Medicaid Act offered states the option to participate in a federal-state cooperative partnership designed to improve the health access and status of poor Americans. The Act created an entitlement for states to receive federal funding for at least half of the costs of both health care services and the administration of the program itself. States with lower per capita incomes received funding at higher match rates than more prosperous states.

In contrast, Medicare was not stigmatized by an association with welfare programs. Medicare also had “uniform national standards for eligibility and benefits.” It allowed physicians to charge higher rates than Medicaid. Indeed, by establishing Medicare and Medicaid as separate programs--one fully funded by the federal government and the other funded by a combination of state and federal revenue--Congress ensured that the two programs would have different payment rates. Accordingly, Medicare became far more attractive to providers than Medicaid. Thus, while physicians were initially as reluctant to participate in Medicare as Medicaid, those who accepted Medicare soon discovered it was a “bonanza.”
In addition, in the states where Medicaid was needed most—those states identified as being the poorest and therefore entitled to have the largest share of Medicaid costs paid by the federal government—eligibility for the program tended to be the most severely limited. Thus, it became much easier to qualify for Medicaid in New York than in Mississippi. This, in turn, meant that there were more uninsured poor in the poorest states, despite the advent of the Medicaid program.

Finally, there were additional flaws in the Hill-Burton Act. The law ceded virtually all control in the siting of hospitals and awarding of federal funds to state rather than federal control. While Hill-Burton did succeed in equalizing hospital bed access across poor and wealthy states, within the states, hospital construction funds tended to go to fewer low-income communities. This resulted from the requirements that communities raise two-thirds of the construction costs on their own and show that the hospitals supported by federal grants would be financially viable. Thus, the $3.7 billion of federal funds allocated to hospital construction and improvements between 1947 and 1971 produced a modern American hospital system that was often out of reach of the poorest Americans.

C. The Changing Role of the Hospital

As one can easily imagine, this influx of funds into the hospital system made the hospital the focus of the medical profession as the chief location where care should be provided. Unlike other countries that developed their health care systems around local clinics and primary care facilities, the United States focused its resources on technology and hospitals first. As hospitals grew, so did their need to fill beds to compensate for these changes, creating the need for even more specialists capable of filling those beds with patients in need of hospital procedures. Primary care was no longer the place to be for health professionals. Despite significant infusions of funds in the mid-to-late 1960s and early 1970s, neighborhood health centers never became more than a marginal alternative. Much of the federal money dedicated to such neighborhood health centers was temporary funding directed toward demonstration projects (where it was expected that other sources of funding would be identified if the project proved to be effective) and went away after a short period of time.

III. EMTALA: What it Is and What it Means

As the American health care system entered the 1980s, the passage and implementation of Medicare largely had succeeded in ending hospital segregation by race, but it had not erased the dual system of care established by Hill-Burton and other policies intended to fund hospitals rather than primary care efforts. Nor had Congress equalized the funding provided to Medicare and Medicaid providers. Thus, hospitals developed a new form of discrimination—discrimination based on insured status, with private insurance being most favored, Medicare second, Medicaid a distant third, and the uninsured last. The practice of rejecting either un- or under-insured patients unable to pay for services came to be known as “patient dumping.”

At the time of EMTALA’s enactment, twenty-two states had some form of statute or regulation aimed at requiring hospitals to provide emergency care to patients in need of emergency medical treatment. However, most policies were not enforced or had no teeth, nor did the common law impose a duty to treat. It was estimated that each year, 250,000 emergency room patients were “transferred or discharged from hospitals because of an inability to pay for necessary medical services.” Further, “[a] disproportionate number of the transferred patients were minorities, and the delay in receiving appropriate medical care caused significant increases in complications and mortality” among those transferred.
Accordingly, Congress decided to address the problem by creating federal sanctions that could be enforced against non-compliant hospitals. Until Congress acted, nothing in federal law had prohibited hospital emergency departments from transferring patients with no or less-favored forms of insurance to county hospitals or other public institutions that would not or could not afford to refuse to see them. The enactment of the *152 Emergency Medical Treatment and Active Labor Act (EMTALA) changed that state of affairs.

A. What EMTALA Is

On April 7, 1986, President Ronald Reagan signed the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) into law. COBRA was a large budget bill that, among other things, contained the provision that required employers and insurance companies to make insurance coverage available to employees who lost their jobs, or would have lost coverage for some other reason, at the employee's own expense. More importantly, COBRA contained the four pages of the Emergency Medical Treatment and Active Labor Act (EMTALA) that sought to put an end to patient dumping.

EMTALA requires all hospitals that have Medicare provider agreements and an emergency department to provide medical care to anyone who comes to the emergency department without regard to their ability to pay for the care they receive. Specifically, all individuals (documented or undocumented) who present to the emergency department must be given a screening examination, and if an emergency medical condition or active labor is discovered, the hospital must “stabilize” the individual, even if stabilization requires the help of on-call physician specialists.

While there is no right to health care enshrined in the United States Constitution, EMTALA created a federal right to receive emergency medical treatment. Further, it is important to note that EMTALA differs from the Affordable Care Act in that it specifically requires that, in certain circumstances, a hospital must treat certain patients. In contrast, the ACA requires all citizens and legal residents of the United States to obtain health insurance or face the prospect of paying a fine or penalty. There is no concatenate requirement that those possessing the required insurance be treated wherever they might present. Nor is there even a guarantee that all persons will be able to obtain the required insurance, despite the detailed requirements that the federal government establish exchanges or make sure that the states do so and provide subsidies to those who cannot afford to purchase insurance.

The right created by EMTALA is far less contingent. Hospitals that fail to comply with EMTALA’s requirements can be fined, sued by other hospitals who assert that they have suffered a financial loss as a result of patients having been dumped on them, or sued in tort by any individual who suffers harm as a result of the hospital's failure to comply. However, EMTALA does not provide a cause of action against physicians. The Center for Medicare and Medicaid Services and, when racial discrimination is a potential issue, the Office of Civil Rights at the Department of Health and Human Services are charged with enforcing the requirements of EMTALA.

EMTALA became law without any particular fanfare, obscured as it was within the enormous COBRA bill, and yet it has been hailed by some as ranking with the Civil Rights Act of 1964 as one of the most important anti-discrimination statutes ever enacted. Indeed, the limited right to emergency health care established by EMTALA has been internalized by most Americans. The requirements imposed by EMTALA have become such a well-accepted part of the medical landscape that in a speech in Cleveland, Ohio on July 10, 2007, then-President George W. Bush assured his audience: “[P]eople have access to health care in America. After all, you just go to an emergency room.” Here, then, we have consensus on a right to health care: in the United States, if anyone needs medical care, they can go to an emergency room and get it.
B. What EMTALA Means

Notwithstanding the superficial approval it appears to enjoy across the political spectrum, EMTALA is not without its critics, at least among those who understand its consequences. EMTALA always has been an unfunded mandate. It may not have created the hospital practice of cost-shifting, but it certainly exacerbated the practice of charging higher rates for care provided to patients insured by private insurance in order to pay for the care provided to uninsured patients. It is estimated that in 2009, cost-shifting to cover emergency care provided to uninsured patients added $1,100 to the annual cost of a family health insurance policy--and this, of course, was in an environment in which insurance companies still were permitted to cherry-pick their clients, denying coverage for patients with pre-existing conditions.

In addition to the costs of providing care, EMTALA imposed additional costs on hospitals and doctors for tort liability arising out of emergency medical treatment. EMTALA does not provide a cause of action against physicians; however, it does not protect physicians who provide charity care from being sued for medical malpractice. Accordingly, hospitals have found it costly to maintain a roster of on-call specialists because of the high cost of medical malpractice insurance premiums.

Indeed, EMTALA may be responsible for a variety of hospital advertisement campaigns. Because the average hospital has had to invest significant resources to equip and staff an emergency department capable of meeting the requirements of EMTALA, hospital administrators then require that emergency department to be busy in order to recoup some of the sunk costs. Therefore, some hospitals have attempted to attract well-insured patients to their emergency departments by promising to provide care in less than thirty minutes--better service than you might get with your primary care doctor. Rather than turning Medicaid recipients and uninsured patients away in order to maintain a profitable mix of payors, hospitals have chosen simply to spend more resources trying to attract more privately-insured patients to tilt the payor mix toward profitability. However, inappropriate emergency department usage only further contributes to the cost and inefficiency of the overall system.

Finally, one of the most critical consequences of EMTALA may be that it has ultimately made health disparities and the problems with our fragmented health system an issue for most, if not all of us. In his most recent book, Paul Starr describes what he calls "the American health policy trap": [A] system of employer-provided insurance that conceals its true costs from those who benefit from it; targeted government programs that protect groups such as the elderly and veterans, who are well organized and enjoy wide public sympathy and believe that, unlike other claimants, they have earned their benefits; and a financing system that has expanded and enriched the health-care industry, creating powerful interests averse to change. Arguably, EMTALA works against the trap because it is not targeted at any particular, sympathetic, well-organized group. It was intended primarily to benefit the indigent, but its benefits are available to anyone. Moreover, it challenges the powerful health care industry, forcing hospitals to treat patients that have no means to pay for their care. This does not mean that hospitals have not pushed back or become more ingenious in their methods of assuring a profitable mix of payment streams for the care provided in their emergency departments. Rather, their chief method of paying for uncompensated care provided pursuant to EMTALA requirements has been to shift costs to insured patients. This method thereby threatens the third leg of the trap as defined by Paul Starr: the system of employer-provided insurance that conceals its true costs from those who benefit from it.

Throughout much of the last fifty years, the tax break given to employers that provide health insurance to their employees has led to employers paying a greater share of health insurance premiums than they might otherwise. Thus, consumers were
insulated from increases in the costs of services that drive up the cost of premiums for employers. However, over the twenty-five years of EMTALA's existence, the cost-shifting resulting from the mandate for universal emergency room care has worn away that insulation. When health care costs rise significantly faster than the rate of inflation in a recessionary economy, employers are forced to shift those costs to employees who therefore cease to be so wholly insulated from the real costs of their care. As a consequence, while “COBRA coverage” was believed to be the much more noteworthy legislative achievement at the time of its enactment, today it is almost useless because so few unemployed Americans can afford to pay the premiums for continuing coverage.

C. Responses to EMTALA's Consequences

EMTALA's significance is evidenced in part by the number and variety of responses engendered by its costs and requirements. Without attempting to assemble an exhaustive catalog of those responses, it is worth a brief examination of a few of them in order to have some context for the reforms enacted as part of the Affordable Care Act. One type of proposed reform is intended to reduce the costs of EMTALA by limiting what hospitals must do to comply with the law and by limiting state tort liability for doctors who provide free care pursuant to EMTALA's requirements. Another reform tactic would reduce inappropriate emergency department usage by educating patients and providers about alternatives. However, the most comprehensive response to date has been the Affordable Care Act, which includes a panoply of remedies to address EMTALA's unfunded mandate.

1. Tort Reform

Only a few years after the enactment of EMTALA, President George H.W. Bush began warning Americans of the menace posed by tasseled-loafer-wearing trial lawyers. While EMTALA was not the sole reason why doctors and hospitals joined with business in seeking tort reform, it is more than a mere coincidence that tort reform became an issue in virtually every state in the 1990s, with most choosing to limit recoveries in medical malpractice and other personal injury actions in some form. Indeed, even though tort reform is no longer a major political issue in most states, the potential for tort liability resulting from EMTALA continues to spawn legislation.

Again, it is worth noting that only hospitals, not doctors, may be sued under EMTALA. However, as case law has developed, some courts have found that EMTALA imposes a duty on treating physicians that, if breached, can result in tort liability under state law. In 2004, for example, Ohio extended its laws granting immunity to volunteer health care providers, including non-profit health care referral systems intended to assist the uninsured in getting care. This occurred despite the fact that most of those covered by the protections of this law arguably would have been immune from suit under the federal Volunteer Protection Act of 1997. Eight years later, the Ohio Senate debated Senate Bill 129, which would have provided immunity from suit to medical professionals who provide emergency treatment specifically pursuant to the requirements of EMTALA.

However, these types of reforms only address a small portion of the cost problem. Indeed, if doctors are made more willing by favorable tort law to treat uninsured patients pursuant to EMTALA, then the aggregate cost of uncompensated care might actually increase. There still remain the problems of inappropriate emergency department usage and too many uninsured patients requiring expensive care who must be treated as a result of EMTALA.

*160 2. Managed Care
As the Medicaid program has grown, states have sought to reduce costs through a variety of measures, including relying on managed care providers to administer much of the delivery of Medicaid-funded services. In exchange for connecting Medicaid patients with a panel of doctors willing to accept Medicaid payment rates for their services, including specialty care, managed care providers receive a capitation payment or a monthly payment for each Medicaid patient enrolled in their plan. As a result of this arrangement, managed care plans have good reason to seek to control emergency department usage, keeping enrollees away from the emergency department.

However, Medicaid patients have found those thirty-minute emergency department guarantees just as enticing as patients holding private insurance. EMTALA requires that anyone who presents at the emergency department to be screened and stabilized. By the time the screening is completed, many physicians would rather treat the patient than try to make a more appropriate referral. Many Medicaid recipients have begun to use the emergency department as their source for primary care because Medicaid imposes virtually no co-pays on recipients and because it is often easier to find a hospital emergency room than a neighborhood clinic or a primary care provider with a timely open appointment. Because the emergency department is the most expensive place in which to receive primary care, appropriate emergency department usage has become an acute concern for state Medicaid agencies.

Medicaid managed care plans in Ohio have begun implementing their own intensive case management programs to build relationships between primary care physicians and their patients. If a patient has lived most of his life without having a primary care physician because of limited access to one, he is not likely to change his behavior upon receiving his first Medicaid card. Because the plans have some control over the doctors, they can encourage them to inform patients of alternatives to the emergency department, facilitate referrals, schedule next-day appointments and take other steps to narrow the “convenience gap” between the primary care physician and the emergency department. In this way, private sector Medicaid managed care plans that contract with the states can be seen as trying to fill the gap created long ago by federal funding that favored the creation of hospital infrastructure over primary care and community clinic infrastructure.

This is both a lesson and a limited victory. The lessons learned from educating patients and providers and encouraging both to try to avoid inappropriate emergency department usage can be carried over into the world of private insurance, but will have no effect on the uninsured population. Absent a viable free clinic system, the only place where the uninsured can count on reliably receiving treatment is the hospital emergency department. Thus, it seems that the only way to compel the uninsured to obtain health care in the most appropriate venue is to provide him or her with insurance.

IV. The Affordable Care Act

The Affordable Care Act passed by Congress in 2010 begins with the premise that the way to provide the best care in the most appropriate setting is to reform the health insurance markets to give the uninsured access to health insurance, thereby granting access to health care to millions of currently uninsured individuals and families. However, it also incorporates private sector contractual incentives not unlike those seen in connection with Medicaid managed care plans to control costs and usage through payment reform and Accountable Care Organizations. The ACA also expands Medicaid significantly for those states willing to accept the expansion. Quite simply, it is the most comprehensive response to the requirements and unfunded mandate of EMTALA to date.

A. The Minimum Coverage Provision

The most controversial reform in the ACA is the individual mandate. The individual mandate requires everyone under sixty-five years of age to obtain basic health insurance coverage either through an expanded Medicaid program, employer-
based insurance, or by purchasing health insurance through a state-operated insurance exchange. Those who do not qualify for Medicaid, but are not able to pay the full cost of premiums, will be entitled to receive subsidies distributed as advance tax credits. Those who fail to obtain the required minimum coverage will be assessed a penalty on their tax return.

By imposing the mandate, Congress sought to do two things: 1) to relieve some of the upward pressure on health care prices and make affordable health insurance more widely available by spreading the costs of providing care to the uninsured over a much wider pool of policyholders, making guaranteed issue and community rating possible; and 2) to find a source of funding for the uncompensated care that EMTALA mandated. Thus, Judge Jeffrey Sutton of the United States Court of Appeals for the Sixth Circuit described Congress's choice in Thomas More Law Center v. Obama:

*163 If Congress has the power to regulate the national healthcare market, as all seem to agree, it is difficult to see why it lacks authority to regulate a unique feature of that market by requiring all to pay now in affordable premiums for what virtually none can pay later in the form of, say, $100,000 (or more) of medical bills prompted by a medical emergency. . . . When Congress guarantees a benefit for all (by securing certain types of medical care), it may regulate that benefit (by requiring some to pay for it).

B. Accountable Care Organizations

Section 3022 of the ACA goes beyond simply finding a funding stream for EMTALA; it seeks to transform health care delivery as well. Section 3022 created the Medicare Shared Savings program, which will permit Accountable Care Organizations (ACOs) to contract with Medicare beginning in 2012 to oversee and manage the care of Medicare beneficiaries. The ACOs will link payments to quality improvements that reduce overall costs. ACO demonstrations are also being undertaken in the Medicaid program.

Overall, the purpose of the ACO is to create payment and care systems that incentivize appropriate care, in contrast to current systems, which incentivize increased numbers of procedures. Under this new scheme, a primary care physician might be paid a capitation rate for a patient but receive additional incentive payments if the patient completed an annual physical, controlled his diabetes, or managed his high blood pressure. The doctors would lose the incentive payments if their patients failed to control their blood pressure or ended up in the hospital.

In the case of Medicaid ACOs, the incentives would encourage primary care providers to build relationships with their patients and make sure that they did not seek primary care services in the emergency room. The doctors themselves might see the need to invest in more intensive case management programs to ensure that their patients utilize care appropriately and get appointments when they need them. In turn, the emergency departments could return to focusing on emergency medicine rather than primary care.

C. The Medicaid Expansion

Finally, the ACA includes an expansion of Medicaid designed to fill in the coverage gaps present since Medicaid's enactment. Beginning on January 1, 2014, any United States citizen or legal resident can be eligible for Medicaid if his or her income is less than 133% of the federal poverty level. This expansion was intended to create a new national uniform eligibility standard for Medicaid, simplifying the patchwork of differing state standards that currently exists. Congress chose the 133% income level because, at the time the legislation was drafted, 133% was the highest income eligibility level for an existing Medicaid population (pregnant women and children under the age of six). This expansion, if fully implemented,
is estimated to cut state spending on uncompensated care for the uninsured in half, saving in the aggregate from $26 billion to $52 billion, and is further expected to reduce state spending on individuals with mental illness, saving in the aggregate from $11 billion to $22 billion during the time period from 2014 to 2019.

V. The Supreme Court, the ACA, and Civil Rights

The Supreme Court arguments revealed a divided Court unwilling to talk about health care reform as a civil rights issue, and disinclined to mention EMTALA by name. By all accounts, the Supreme Court arguments were surprising in that they intimated an apparent willingness on the part of the Court's conservative wing to strike down the ACA, despite the belief of most law professors that the law's provisions fell squarely within established Commerce Clause precedent. While commentators chided the Court for introducing hypotheticals regarding the federal government's authority to require individuals to purchase broccoli into oral argument, the fact remains that the concerns of the Court, as manifested in the Court's questions to the advocates arguing before it, were not merely partisan but also reflective of deep-seated philosophical concerns regarding government action. Although the outcome of the case differed somewhat from what the oral arguments foreshadowed, close analysis of those arguments is warranted because the concerns raised at oral argument appeared prominently in the Court's opinions.

A. The Arguments

Advocates argued the two main substantive challenges to the ACA--the challenge to the individual mandate and to the Medicaid expansion--on the second and third days of oral argument, respectively. Given the path of federal legislative enactments up to and through EMTALA, as well as the fact that both the individual mandate and the Medicaid expansion address some of the consequences of EMTALA, it would not have seemed extraordinary for advocates to mention EMTALA by name, to discuss the ACA's potential to address health disparities, or to even talk about health care in the context of civil rights. Unfortunately, this did not happen. Neither the justices nor the advocates mentioned EMTALA by name during oral argument, and all often seemed anxious to avoid opportunities to talk about the statute and its consequences.

1. The Individual Mandate

Seeking to tally votes for a potential majority, much of the news media focused on a particular question asked by Justice Anthony Kennedy: I understand that we must presume laws are constitutional, but, even so, when you are changing the relation of the individual to the government in this, what we can stipulate is, I think, a unique way, do you not have a heavy burden of justification to show authorization under the Constitution? Indeed, they were right to hone in on this dilemma. Justice Kennedy's concern with “changing the relation of the individual to the government”--seen as a deep skepticism about the constitutionality of the ACA--found its way into Justice Roberts's opinion as part of his Commerce Clause analysis. Thus, as it had seemed during oral argument, the government failed to allay Justice Kennedy's concerns.

Beyond Justice Kennedy's telling question, another striking aspect of the second day of oral argument was the amount of time spent questioning counsel about how the cost of guaranteed-issue and community rating would be shifted to healthy young adults who, claimed the justices, would be forced to purchase unnecessary coverage in order to make it possible for older and sicker adults to have health insurance. Justice Kennedy stated that “the young person who is uninsured is uniquely proximately very close to affecting the rates of insurance and the costs of providing medical care in a way that is not true in
other industries." The Court (or at least the conservatives on the Court) seemed to be following an agenda not obviously connected to the case before them. This was evidenced by a burial insurance hypothetical brought forth by Justice Alito. Justice Scalia's insistence that the market being regulated by the ACA was the insurance market and not the health care market, and the question of whether the Tenth Amendment requires that individuals be left to decide whether they want to buy insurance.

Given the fact that none of the individuals in the cases docketed were healthy young people faced with the prospect of buying insurance they neither wanted nor needed, the amount of time spent discussing such situations seemed to be disproportionate at best. Indeed, the amicus brief filed on behalf of the coalition of youth-focused organizations puckishly calling themselves the “Young Invincibles” urged the Court to uphold the ACA as vital to the health of young adults. Furthermore, the amicus brief argued that most young people would like to be able to buy health insurance, but many cannot do so because the cost of coverage is prohibitive.

Nevertheless, nearly a third of the time spent by the Solicitor General arguing on behalf of the government in favor of the individual mandate as an appropriate congressional exercise of the commerce power was spent on these issues. Never once did the Solicitor General or any of the justices note that there was not a plaintiff before the Court who would be affected in the manner that concerned the Court. Justice Kagan came the closest when she suggested to NFIB counsel Michael Carvin that his clients' challenge to the law might be more forceful as an “as-applied” challenge rather than a facial challenge.

This focus on the rights of young people not before the Court also led to some odd exchanges relating to EMTALA, which was never identified by name during the oral argument. It almost appeared that the Court and the litigants focused so much attention on the rights of young people in order to avoid directly addressing the right to health care created by Congress through EMTALA. As noted above, the conservative justices pressed hard on the question of whether Congress was regulating the insurance market or the health care market. The government and the liberal justices contended, much as Judge Sutton did, that the operation of EMTALA makes all individuals' eventual participants in the health care market. That is, every individual who chooses not to buy insurance and then receives care for which she cannot pay affects the cost of health care because of EMTALA-related cost-shifting, which in turn affects the cost of insurance for all those who choose to buy insurance. Thus, there were two primary justifications for the individual mandate argued before the Court: 1) creating a funding stream for the uncompensated care mandated by EMTALA, and 2) broadening the insurance risk pool so that insurance companies could provide coverage to those with pre-existing conditions. The government's decision to not discuss EMTALA directly meant that the oral arguments remained focused on insurance rather than health care, which was friendlier terrain for the challengers given the focus of the Court's conservatives on the insurance market rather than the health care market.

Counsel for the State petitioners, Paul Clement, portrayed the minimum coverage requirement as shifting the costs of insurance from expensive-to-insure sick people to cheap-to-insure healthy people, not as a means of funding the right to health care created by EMTALA. Indeed, he sought to distinguish between EMTALA cost-shifting and the “much bigger” shifting of costs of insurance onto healthy people who are “[forced] into an insurance market precisely because they are healthy.” Michael Carvin, counsel for the NFIB, echoed this sentiment: Since the founding, whenever Congress has imposed that public responsibility on private actors, it has subsidized it from the Federal Treasury. It has not conscripted a subset of the citizenry and made them subsidize the actors who are being hurt, which is what they're doing here.

They're making young, healthy people subsidize insurance premiums . . . for the cost that the nondiscrimination provisions have put on insurance premiums . . . and insurance companies. This argument ignores some of the American health care system's structural problems, which are magnified by EMTALA. Thus, during oral argument there was no acknowledgement that both the place where one receives care and the type of care received can increase costs that then are shifted onto other market
participants. The ACA seeks to address the costs and consequences of EMTALA in a variety of ways, not just through the minimum coverage requirement. By making it possible for the sickest among us to purchase or otherwise obtain insurance, the ACA enables those individuals to access primary care and to receive care for chronic conditions so that they will not need more expensive emergency room care.

This argument, however, seemed lost on the anti-ACA advocates. NFIB counsel Michael Carvin claimed that the number of individuals receiving uncompensated care must be small because “it has got to be a relatively small fraction” of the uninsured that have expensive health care catastrophes. Further, he emphasized that the free riders in the system were those who “default on their health care payments [...] an entirely different activity than being uninsured.” On its face, this seems to be a curious statement-- surely there is a correlation between being uninsured and having to default on one’s health care bills. Nevertheless, he maintained that “[t]he people who impose the costs on the rest of us are people who engage in a different activity at a different time, which is defaulting on their health care payments. It's not the uninsured.”

While being scathingly critical of Congress, Carvin avoided criticizing EMTALA directly or challenging the right to receive emergency health care. He did not suggest ending EMTALA; rather, he proposed finding a different source of funding to cover its costs by requiring the purchase of insurance at the point of sale. However, this would not address the problems of the place where one receives care and the type of care received, and therefore would not be as effective or efficient a solution as that *provided by the minimum coverage requirement.*

Above all, the advocates chose their words carefully when characterizing and discussing the American right to health care created by EMTALA. Carvin and Clement painstakingly attempted to disconnect the services provided pursuant to EMTALA from the individual mandate, and both avoided suggesting that EMTALA should be repealed or that poor people should be denied emergency health care. For his part, the Solicitor General referred to the guarantee of emergency care provided by EMTALA as a “deeply embedded social norm,” but avoided mentioning the statute by name.

This unease reflects the power and pervasiveness of Paul Starr’s “American health policy trap” and our ongoing national inability to directly address the consequences of our limited national consensus about health care. No one, other than Justice Scalia, expressed support for Congress ending guaranteed access to emergency care in the United States. As described above, the challengers to the minimum coverage provision tried to act as though that provision of the ACA had no connection to the cost of the right to emergency care. The government, in turn, avoided referring to EMTALA’s grant of a right to emergency care as a congressional enactment, lest it be highlighted as an unfunded mandate.

2. The Medicaid Expansion

In 1947, the United States Supreme Court observed that “[t]he offer of benefits to a state by the United States dependent upon cooperation by the state with federal plans, assumedly for the general welfare, is not unusual.” This was an early description of cooperative federalism--the model used to implement and expand federal programs like the Medicaid program. When Congress enacted Medicaid, it invited states to accept federal funding--payment of half or more of the participating states’ total expenditures--in return for the states’ promise to develop and implement plans to provide health insurance coverage for specific groups of people for a specific set of medical services. Since 1965, Medicaid has been amended numerous times in order to expand the number of individuals and the array of medical services covered. Yet, until the advent of the ACA, virtually no one had suggested that these expansions raised constitutional questions. In this regard, oral argument again proved to be an accurate barometer of the Court’s concerns.
During oral argument, the Court's conservative majority clearly was troubled by the ACA's expansion of Medicaid, even though the federal government would pay almost all of the costs of the expansion under the ACA. The leading Supreme Court case on spending power enactments, South Dakota v. Dole, set forth four limiting factors to be considered when evaluating spending power enactments such as Medicaid: 1) does the exercise of the spending power promote the general welfare?; 2) did Congress "condition the States' receipt of federal funds . . . unambiguously . . . , enabling the States to exercise their choice [to participate] knowingly, cognizant of the consequences of their participation [?]"; 3) are the conditions on the grants of funds related or unrelated to the federal interest in the particular program and its overall objectives?; and 4) are the conditions themselves unconstitutional? The possibility of the federal government withholding all Medicaid funds from a state that chose not to implement the expansion called into question whether, in accordance with Dole, the states could choose to participate knowingly in the expansion, or whether the expansion was too coercive and violated the limits on the spending power set forth in Dole.

Thus, the Court focused primarily on the question of what authority the federal government would have to withhold funds from states that chose not to implement the Medicaid expansion. For example, during the third day of oral arguments, Chief Justice Roberts stated that it may be something they gave up many decades ago when they decided to live off of Federal funds, but I don't think you can deny that it's a significant authority that we are giving the Federal Government to say you can take away everything if the States don't buy into the next program. The Chief Justice was overstating the case here because the compliance provision at issue, 42 U.S.C. § 1396c, permits but does not require the federal government to withhold all Medicaid funding from a non-compliant state. Further, that compliance provision has been in place and little used since 1965. Nonetheless, the mere possibility of the federal government withholding all of its Medicaid funding in order to compel a state to comply with either the proposed ACA expansion or some future expansion proved disturbing to the justices, who did not appear to entertain the possibility that states might welcome an expanded Medicaid program that would benefit their uninsured citizens.

Justice Scalia asked: "Is it conceivable to you that any State would have said no to this program? Congress didn't think that, because some of its other provisions are based on the assumption that every single State will be in this thing." Even more troubling to the Chief Justice than the difficulty of resisting initial entry into the program was the possibility that the federal government might change the terms of the program in later years. Chief Justice Roberts pressed the Solicitor General, saying "you've been emphasizing that the Federal government is going to pay 90 percent of this. And it's not something they can take to the bank, because the next day or the next fiscal year, they can decide we're going to pay a lot less . . . ."

In essence, the focus of the arguments was entirely divorced from any of the key problems that the ACA was intended to address: improving health outcomes by improving access to health care, reducing racial disparities in health care, addressing some of the consequences of EMTALA's requirement that hospitals provide uncompensated care, etc. From the viewpoint of the Court's conservative wing, no state would possibly want to take advantage of the ACA Medicaid expansion to improve the health and productivity of its citizens, not to mention the solvency of its hospital infrastructure, at least not if there were federal rules attached to doing so.

**B. Challenging Incrementalism**

One way to understand the tenor of the ACA oral arguments, particularly with respect to the Medicaid expansion, is to credit the Court's conservative majority with a distaste for incrementalism. For the purpose of analyzing the Court's approach in the oral arguments, incrementalism may be described as a legislative approach characterized by policy adjustments occurring in multiple steps, as opposed to a single dramatic or sweeping change. At some level, almost every legislative enactment is incremental,
as it is rare that legislation is developed, drafted, and adopted from a completely clean slate. The progression of health care legislation discussed in this Article could be characterized as incremental, gradually extending government-supported health care coverage to more and more individuals over the years in an effort to extend equal access to health care to minorities and reduce or eliminate health disparities. Further, the ACA could be described as a collection of incremental changes designed to fill gaps left by prior incremental changes, particularly when compared to other health care reform proposals such as a Canadian-style, government-operated, single-payer system, or “Medicare for All.”

There is no constitutional jurisprudence of incrementalism, nor have concerns about incremental legislation eroding the Tenth Amendment's limit on the spending power played a role in prior cases. However, in an article published prior to the enactment of the ACA, University of Chicago Professor Saul Levmore challenged the conventional notion that incrementalism is a prudent path for lawmakers to take in seeking to address complicated issues, arguing instead that incrementalism enables interest groups to achieve victories above and beyond their political power. As Levmore explained, “[t]he incrementalism problem is that a legal intervention might be both socially inefficient and democratically disfavored yet come about because advocates can nudge the law to that end step-by-step, taking advantage of uncoordinated opponents.” Moreover, “the problem of incrementalism remains more remarkable when compliance with an earlier step in the regulatory process is irreversible.” In other words, every piece of compromise legislation can be viewed, with some suspicion, as both a partial victory taken by interest groups without enough political power to achieve in one enactment their full agenda, and the first step down a slippery slope. Levmore's chief conclusion seems to be not that all incrementalism is bad, but rather that better alternatives exist for cautious legislators--for example, in lieu of implementing a broad, incremental reform, a legislature could test a new regulatory approach by enacting a targeted, time-limited pilot program that might constitute an even more radical policy change.

The ACA arguments on the minimum coverage provision revealed a conservative Supreme Court majority that certainly seemed to share Levmore's concerns with the problems of incrementalism. For example, Levmore contends that incrementalism can be seen “as a problem of nondisclosure, or even as a kind of fraud.” In line with this theme, Justice Kennedy criticized the individual mandate, noting that “[i]n one sense, it can be argued if this [taxing citizens in order to fund a national health insurance system] is what the government is doing, it ought to be honest about the power that it’s using and use the correct power.” Thus, in this and other instances, the conservative justices appeared to chide the government for not having the courage or the votes to implement a simpler system, hinting that a simpler system might not have been so fraught with constitutional peril. Picking up on these hints, Justice Ginsburg was inspired to remark “[t]here's something very odd about that, that the government can take over the whole thing and we all say, oh, yes, that's fine. But if the government wants to get - to preserve private insurers, it can't do that.”

The conservative justices' concerns with incrementalism may have been even more evident in the arguments concerning the Medicaid expansion than in the arguments over the minimum coverage provision --“[t]he Medicaid expansion was significant, but was clearly an incrementalist modification to the existing program.” Even more significantly, to use Levmore's parlance, Medicaid may be the ultimate irreversible program. Hospitals and nursing homes depend on Medicaid as a part of their financing mix--no state goes without it, or as Justice Kennedy put it during oral argument, states are “frozen in.” Thus, the “irreversibility” of the Medicaid program engendered the question of whether an incrementalist modification could be coercive.

What the Court's conservatives seem to have missed, theoretically speaking, is Levmore's contention that incremental changes are undesirable, primarily if they are made in such a way that experimentation and learning cannot take place. However, experimentation and learning have been hallmarks of the Medicaid program. Over its history, the Medicaid program has been characterized by a series of optional expansions that eventually became requirements once generally accepted by states.
While the expansions have tended not to be reversed, there is no evidence that any of the expansions would not withstand cost-benefit analysis. Indeed, there was no colloquy during oral argument on Medicaid’s failures or suggestion that expanding Medicaid would not produce better health outcomes. Instead, there was only the speculative fear, articulated by Justice Roberts, that states might one day in the future have to pay more for those improved outcomes.

C. The Court’s Opinion

On June 28, 2012, the Supreme Court issued its decision in NFIB v. Sebelius. In an opinion written by Chief Justice Roberts and joined by Justices Ginsburg, Kagan, Breyer, and Sotomayor, the Court upheld the individual mandate as a valid exercise of the taxing power and upheld the Medicaid expansion as a valid exercise of the spending power, provided that it is optional and not mandatory for the states. Ultimately, the Court’s concerns about incrementalism seem to have prevailed in theme and language, if not results. Despite the apparent agreement of five justices that the mandate provision exceeded the authority granted to Congress by the commerce power, the mandate was upheld, surprising most commentators. Indeed, this was reflected in the confusion that arose when the decision was issued--two news networks reported that the mandate had been struck down based on Chief Justice Roberts's Commerce Clause analysis in his opinion. Even the President was said to have thought, for a brief period of time, based on erroneous news reports, that the Supreme Court had struck down the Act as unconstitutional.

However, as further analysis of the opinions revealed that the Court had upheld the ACA but rejected the government's Commerce Clause analysis, and turned the statute's Medicaid expansion into an optional program, it became clear that the concerns expressed by the Court's conservative wing during oral argument had accurately foreshadowed the opinions that would be written. While the Court's opinions certainly did nothing to limit Congress's taxing power, they clearly acknowledged and validated the concerns previously expressed as to the scope of the commerce power and the irreversibility of the Medicaid program. Finally, the Court continued to avoid discussion of EMTALA and its implications, with each of the three opinions issued by the justices referencing it only once, and only the dissenters mentioning it by name.

Perhaps this is not surprising, given the advocates' reluctance to discuss EMTALA during oral arguments. Nevertheless, the Court's scant references to EMTALA suggest that in evaluating the ACA, the Court chose not to examine a critical justification for its existence--the fact that it was intended to address some of our country's unfinished business on civil rights and had the potential “to do enormous good for the health needs of racial and ethnic minorities and [do more] to reduce racial and ethnic health disparities than any other law in living memory.” The fact that the advocates who argued to uphold the law largely failed to raise this issue is disappointing, if not inexplicable.

1. The Individual Mandate

Justice Roberts first found that the individual mandate could not be authorized by the commerce power, citing his accord with the case's four dissenters--Justices Scalia, Kennedy, Thomas, and Alito. In doing so, he returned to Justice Kennedy's concern about regulating “what we do not do” and fundamentally changing the relationship between the citizen and the federal government. Commentators have cast doubt on the claim that Congress has never regulated inactivity. Nevertheless, Justice Roberts made the distinction between activity and inactivity central to his Commerce Clause analysis.

This distinction is worth examining in light of this Article's emphasis on EMTALA and civil rights. First, by definition and by design, most anti-discrimination laws change the relationship between the citizen and the government. Through anti-discrimination laws, the government limits the associational choices of its citizens. Second, much of what is regulated by
anti-discrimination laws could be characterized as inactivity--not hiring a prospective employee, not serving a potential patron at a business, or not renting to a prospective tenant.

Despite these issues, Chief Justice Roberts quickly distinguished civil rights cases such as Katzenbach v. McClung and Heart of Atlanta Motel, Inc. v. United States. Somewhat unconvincingly, he asserted that those cases involved regulation of activities (operating restaurants and hotels, respectively) with anticipated effects on commerce, whereas the ACA seeks to regulate anticipated activity (the purchase of health care). It remains an open question as to whether he would have drawn this distinction so easily if forced to acknowledge that the ACA was civil rights legislation, and further, that the individual mandate was intended to address the economic effects of discrimination, just as the economic effects of discrimination were at issue in Katzenbach and Heart of Atlanta.

Ultimately, the owners of the restaurants and motels affected by the provisions of Title II of the Civil Rights Act of 1964 at issue in Katzenbach and Heart of Atlanta had their relationship with the federal government fundamentally altered because the government began to dictate who they must serve, which required them to engage in commerce with people of all races. Like the ACA, Title II required the owners to engage in commercial activities they wished to avoid in order to remedy “the disruptive effect that racial discrimination has had on commercial intercourse.” Moreover, when Congress enacted Title II of the Civil Rights Act of 1964, it sought to do more than affect the behavior of business owners; it also sought to change the behavior of their customers. By forcing businesses to desegregate, Congress forced their customers to patronize or support desegregated businesses by taking away their ability to choose not to support desegregated businesses, thereby regulating an anticipated activity.

In light of the consequences of EMTALA, one can describe the effects of the ACA in similar terms. EMTALA requires hospital emergency departments to serve all those who present with medical emergencies, regardless of race or ability to pay. Through the individual mandate, the ACA requires individuals to support those desegregated emergency departments by guaranteeing payment for services. As in Katzenbach and Heart of Atlanta, Congress has taken away the individual's ability to choose not to support a desegregated business--in this case, a hospital emergency department.

In an article arguing against the constitutionality of the individual mandate, Ilya Somin suggests that the mandate may lead to an unstoppable "mandate for mandates." In doing so, he specifically addresses the government's justification for the individual mandate, raising the question of whether health insurance is a special case. Ultimately, he confronts the fact that health care providers are required to provide emergency treatment to the uninsured and asks: "[b]ut why is that difference constitutionally relevant?" One could respond that the difference is constitutionally relevant because EMTALA, the federal statute requiring such emergency treatment, is a civil rights statute, and, at least since Reconstruction, civil rights traditionally have been a federal concern.

Thus, the ACA's efforts to address one of the economic harms caused by discrimination place it squarely within Congress's commerce power.

2. The Medicaid Expansion

An equally surprising aspect of the decision in NFIB v. Sebelius was the Court's 7-2 ruling that the ACA's expansion of Medicaid to cover all non-disabled and non-elderly adults up to 133% of the federal poverty level would be unconstitutional unless determined to be optional by the Court. The ruling was surprising for a number of reasons. First, even Republican governors had not expected to win on this issue, having lost in the lower courts. Second, the justices did not divide along presumed ideological lines, with Justices Kagan and Breyer joining the conservative majority that found the Medicaid expansion to be unconstitutionally coercive on the states. Third, because it makes the Medicaid expansion optional for the states, the Court's ruling may mark the end of Congress's ability to use Medicaid to implement national health policy.
Justice Roberts’s insistence that the Medicaid expansion reflects a difference “in kind” of program, “not merely degree,” is most striking. He concluded that the expansion could not be viewed as part of the old Medicaid program, but must be seen as an entirely new program. This is Levmore’s concern about irreversibility writ large. By linking the ACA’s Medicaid expansion to funding for the existing, largely irreversible version of the Medicaid program, Congress, in Justice Roberts’s view, reached a result that the states never would have accepted when they originally signed up for the Medicaid program.

In terms of spending power jurisprudence, the Roberts opinion implicates two of the limits articulated in Dole, clear notice and germaneness, but fails to convincingly attribute its conclusion to either. First, as to notice, Chief Justice Roberts emphasized that states must voluntarily and knowingly accept the federal funds offered pursuant to the spending power. This requires that the states be given clear notice, which, as Justice Ginsburg found in her dissent, the ACA and the Medicaid Act clearly did. The ACA itself was enacted in 2010, with states having until January 1, 2014 to implement the Medicaid expansion. In addition, Congress explicitly retained for itself the right to amend Medicaid when it was enacted in 1965, and has continued to maintain that right. Thus, while states may not have anticipated that Medicaid would become as large and influential a program as it has become, it cannot seriously be argued that the states were not aware that the federal government could alter Medicaid program requirements or that they were not given sufficient time to plan for the ACA’s Medicaid expansion.

Turning to the germaneness question, Chief Justice Roberts claimed that the Medicaid expansion was a new form of Medicaid that was “no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.” Furthermore, “[a] state could hardly anticipate that Congress’s reservation of the right to ‘alter’ or ‘amend’ the Medicaid program included the power to transform it so dramatically.” Thus, given the size of the expansion and the entrenched nature of the Medicaid program in most state budgets, clear notice either was irrelevant or impossible.

This conclusion ignores even recent Medicaid history. States are authorized to obtain federal funding to implement Medicaid demonstration projects. By 2008, eighteen states had elected to use this authority to provide coverage to non-disabled and non-elderly adults. Indeed, in making the argument that the Medicaid expansion is an entirely new program, not merely an extension of an existing one, Justice Roberts cited the very provision that links the Medicaid expansion to those state demonstration projects. The ACA would have transformed those demonstration projects into a mandatory requirement, creating some national uniformity in Medicaid coverage, while providing historically high amounts of federal matching funds to pay for the expanded coverage.

Commentators have criticized Chief Justice Roberts for “[a]rtificially slicing Medicaid in two” in order to conclude that funds for the existing Medicaid program were not related to the expansion, implicating Dole’s germaneness limitation, and for failing to articulate “any kind of rule, test, standard, method, or other structure for understanding coercion beyond the facts of NFIB.” While these criticisms certainly are accurate, they tend to obscure what came through both at oral argument and in Chief Justice Roberts’s opinion: in addition to the limitations set forth in Dole, the Court’s conservative wing sees the irreversibility of a large, entrenched government program like Medicaid as a limit on the spending power. Hence, rather than crafting an opinion that hewed closely to the Dole factors and their application to the case at hand, Chief Justice Roberts resorted merely to incendiary language, describing the Medicaid expansion as “economic dragooning” and a “gun to the head,” to express its rationale. As a consequence, the Court’s failure to define impermissible coercion leaves open a multitude of questions as to the future of the Medicaid program and the implementation of the ACA itself.
Whether an expanded and more uniform national Medicaid program will eventually develop has become the subject of much speculation.\footnote{321} It *183 seems likely that most states will participate in the expansion.\footnote{322} However, that is a limited victory compared to what might have been. Reform advocates intended not just to add to Medicaid but to transform it:

If Title II [of the ACA] is implemented as written, by 2014, there will be near-uniform Medicaid eligibility across the nation, a single method to calculate income to determine eligibility, and no more categorical distinctions. Officials involved in implementation believe the program will begin to look different in many basic ways. No longer a program of “last resort,” Medicaid will be open to nearly everyone with family incomes below 133 percent of the federal poverty level. A substantial bump in federal support means the program will be run differently.\footnote{323}

It is harder to imagine this vision of the Medicaid program developing out of an optional expansion. Disappointingly, the Court proceeded as though it needed to discourage a long pattern of congressional overregulation of the states. In fact, the opposite is true.\footnote{324} Further, history suggests a congressional tendency to leave substantial discretion to the states in implementing the requirements of the Medicaid program.\footnote{325} Indeed, Medicaid’s state-based administration, poor reputation, and lower rate of payment have prevented it from becoming a “coherent and unified force for health system reform.”\footnote{326} The Court’s ruling upends cooperative federalism as a way for Congress to implement national programs and, in this case, address health disparities. Now that the Medicaid program has been effectively deemed “too big to amend,” the Court’s decision may well keep Medicaid forever mired in its status as the least desirable form of governmental health coverage, even as it consumes an ever larger share of state budgets.\footnote{327}

*184 VI. Conclusion: The Future of Health Care Reform and Civil Rights

The Affordable Care Act is legislation designed and intended to incorporate a civil rights advance into the existing health care status quo—rather than nationalizing health insurance or health care, as claimed, it requires and assists individuals to purchase health insurance from private companies. It remains a conservative piece of legislation despite all of the uproar against it. As one commentator put it: “[the ACA] is an incomplete and unfinished reform.”\footnote{328} NFIB v. Sebelius is not only one of the first battles over the ACA, but it is also likely to be one of the first of many battles over the necessity of greater institutional control in our health care delivery system.\footnote{329} And yet, even a conservative piece of civil rights legislation has turned out to not be immune from the limitations that seem to accompany all civil rights advances. The health care system in the United States can be reformed only in incremental steps, and the Supreme Court, while allowing some of those steps to proceed, has made subsequent reforms more difficult to achieve.

This is particularly problematic given what is at stake. After all, without incrementalist strategies, there could have been no civil rights movement. The enactment of EMTALA was one incremental step toward ending racial disparities in health care. Many more, including those set forth in the ACA, are needed.

Ultimately, the Court’s ruling in NFIB v. Sebelius seems likely to have three effects: it may narrow the opportunities for expansion of civil rights, it will complicate the implementation of the ACA and other public health measures, and it will limit Congress’s ability to use Medicaid to effectuate national health policy. The conservative majority’s support for an inactivity/activity limitation on the commerce power will embolden those who wish to challenge governmental regulation by arguing that it infringes on individual liberty. For example, one of the most prominent civil rights issues of the present day is marriage equality for gay and lesbian couples. The Supreme Court recently granted certiorari in two marriage equality cases to be heard in the 2013 session,\footnote{330} and, in time, it is likely that a refusal *185 of service case similar to Heart of Atlanta will reach the Supreme Court. How will that Court weigh an asserted liberty interest in not renting a motel room to a married gay couple against congressional power to address the economic effects of discrimination?
Before such a case reaches the Supreme Court, the Court will likely have the opportunity to rule in a variety of cases relating to the ACA and health care. For example, lawsuits filed by Catholic institutions challenging the ACA’s requirement that they provide their employees with insurance that covers contraception are now pending in a number of federal courts around the country. How these and other conflicts are resolved will shape the ongoing debate on health care and determine whether our country can reach a consensus that will allow it to develop a universal and sustainable health care system.

Perhaps in this next set of cases, advocates will seize the opportunity to talk about health care reform as civil rights work aimed at addressing health disparities. Perhaps they will even have the opportunity to mention EMTALA by name. Through the widely publicized oral argument and the NFIB v. Sebelius decision, the Supreme Court has focused the health care debate on insurance markets and big government, rather than on health disparities and access to care. Only by talking about health care reform as civil rights work can citizens and advocates re-focus the debate, find national consensus and move forward to implement and inevitably improve the Affordable Care Act.

Keeping the ACA largely intact was no small victory. Critically, the ACA provides a framework within which reforms--both those currently scheduled and those not yet envisioned--can be implemented. Advocates for reform will not have to start over. However, that framework may be exceedingly narrow. Beyond utilizing the broad taxing power granted by the Court in NFIB v. Sebelius, Congress will have to learn how to enact public health measures without altering the relationship between the government and the individual. Further, Congress may have to do so without using the Medicaid program as a means for achieving its public health goals. While most states are likely to implement the ACA’s Medicaid expansion, there is no guarantee that all will do so, even if it is in their financial interest.

On a more positive note, long-time advocates for the expansion of Medicare may finally develop the momentum they need to wage a successful “Medicare for All” campaign that would extend Medicare coverage beyond the aged and chronically disabled. To be sure, the scarcity of resources in the American health care system cries out for reforms that will bring more national control and standardization. If those reforms cannot be achieved through the Medicaid program, then Congress may need to follow the Court’s lead by raising taxes and expanding Medicare instead.

After NFIB v. Sebelius, one thing remains clear: the job of reforming our health care system will take years. Finally, however, progress has been made towards effectuating significant changes to our health care system. As we move forward through these years of reform, we would do well as a nation to dwell on those areas where we share a consensus on health care. Only by talking openly and directly about them will we be able to reach our goals together.

Footnotes

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3 Nat’l Fed’n of Indep. Bus. (NFIB) v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 470-72, 482-90 (2012) [hereinafter NFIB v. Sebelius]. At the time of printing, NFIB v. Sebelius had yet to be printed in either the Supreme Court Reporter or the United States Reports. As such, all citations are to the United States Supreme Court Reports, Lawyer’s Edition. The slip opinion of this decision is available at http://www.supremecourt.gov/opinions/11pdf/11_393c3a2.pdf.

5  NFIB, 183 L. Ed. 2d at 474-80.
6  See id. at 474-80. It remains an open question as to what precedential effect this portion of Justice Roberts's opinion has, given the fact that the dissenters did not join him. Roberts, however, cites the dissenting opinion as in “accord” with his opinion. Id. at 481-82. To be sure, any attorney seeking to avoid a Commerce Clause regulation on behalf of a client will look to Roberts's opinion for guidance.
7  Id. at 490-98.
17 See Ruger, supra note 11, at 222-33.
19 Id. at 24.
20 See John E. McDonough, Inside National Health Reform 304-05 (2011) (arguing that the ACA is a significant reform that will reduce disparities in insurance coverage, but much more must be done to eliminate disparities in health care).
22 NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 501 (2012) (Ginsburg, J., concurring in part, concurring in judgment in part, and dissenting in part) (noting that “embedded social norms” require hospitals and physicians to provide care when it is most needed, regardless of ability to pay). See also Transcript of Oral Argument at 30, Florida v. Dep’t of Health & Human Servs. (No. 11-400) [hereinafter Transcript of Oral Argument Day 3], available at http://www.supremecourt.gov/oral_arguments/argument_transcripts/11-400.pdf (statement of Justice Sotomayor) (“The uninsured are a problem for States only because they, too, politically, just like the Federal Government, can't let the poor die.”).
23 See Ruger, supra note 11, at 222 (suggesting that the drafters of the ACA could have called the individual mandate an “‘EMTALA risk adjustment payment’” to more accurately describe its purpose).
24 See Remedy and Reaction, supra note 18, at 1-24. See also McDonough, supra note 20, at 17 (describing the “three ingredients” necessary to move “public health knowledge into public health policy, action, legislation, and law”--“the knowledge base, social strategy, and political will”). This Article primarily addresses the third ingredient, political will, focusing on how political will is
maintained beyond the enactment date of legislation and through its implementation. This would seem a particularly salient inquiry in light of the ACA's complexity and its multi-year implementation schedule.

25 See Remedy and Reaction, supra note 18, at 1-11.
26 See id.
27 See id. at 17-24.
28 See infra Part II.
29 See infra Part III.
30 See infra Part IV.
31 See infra Part IV.
32 See infra Part V.
33 Only Justice Scalia mentions the statute by name, in his dissenting opinion. NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 559 (2012) (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).
34 Ruger, supra note 11, at 227.
35 See generally Jim Downs, Sick From Freedom: African-American Illness and Suffering During the Civil War and Reconstruction (2012).
36 See id. at 42-52.
37 Id. at 18-21.
38 Id. at 65-94.
39 Id. at 65-94, 152-55.
40 Id. at 155.
41 Ruger, supra note 11, at 232-35.
42 See McDonough, supra note 20, at 25-28 (noting that the United States health care system lagged in quality despite its costs); Remedy and Reaction, supra note 18, at 63-76, 161-93 (describing how the United States reached the 1990s with both the most expensive health care system in the world and rising numbers of uninsured individuals, and how public attention returned to this problem in 2006-2008). See generally Paul Starr, The Social Transformation of American Medicine 379-88 (1982) [hereinafter Social Transformation] (describing how this trend toward more expensive care available to fewer individuals began in the 1970s).
43 Dr. King made his statement in Chicago, Illinois at the second annual convention of the Medical Committee for Human Rights (MCHR) on March 26, 1966. Dittmer, supra note 2, Preface & n.1. The MCHR was the medical arm of the civil rights movement, emerging out of two separate imperatives: 1) the need to protect participants in the Mississippi Freedom Summer activities; and 2) to address the American Medical Association's ongoing failure to discipline state and county medical associations in the South that continued to practice segregation, leaving many Southern Blacks with no access to medical care. Id. While the organization never satisfactorily resolved the tension over whether the MCHR's mission was to end health care disparities attributable to poverty and racial segregation or to provide medical support and assistance to the radical organizing and protest activities of the political left, it is clear that King's remarks were addressed to the MCHR's 1966 health care agenda. See generally id. at 130-228.
45 Social Transformation, supra note 42, at 281-83 (describing President Truman's three “recommendations”--expansion of hospitals, increased support of public health and maternal and child health services, and federal aid to medical research and education--and their legislative fates).
Compare id. at 348-51, with Ruger, supra note 11, at 232-35.

Social Transformation, supra note 42, at 348-51.

Id.

See id.

Dittmer, supra note 2, at 18.


See Downs, supra note 35, at 155 (“By 1877, the federal government’s effort to rebuild the South ended. While some state governments had assumed responsibility for freedpeople’s medical care, other freedpeople throughout the South continued to be denied support and admission to health facilities by local and state governments. Not having access to medical services during the Reconstruction period would, for a number of black Southerners, serve as the beginning of a system of discrimination that would only worsen in the 1880s and beyond.”). See also Social Transformation, supra note 42, at 350 (“Many hospitals in the South aided under [Hill-Burton] refused to treat black people.”).


Id.

Desegregating Southern hospitals and enrolling Black senior citizens in Medicare were major efforts of the MCHR in 1966. See Dittmer, supra note 2, at 133-40.

Id. at 134-35.

Id. at 136. Still, HEW did not have the resources to investigate individual doctors' offices. Id. Thus, some “white doctors in the South maintained segregated waiting rooms well into the 1970s.” Id.

Id. at 139. By the early 1970s, the Southern hospitals were the “most integrated facilities in their communities.” Id.


See McDonough, supra note 20, at 304 (describing the ACA's potential as "the most dramatic assault on health inequality in America since the 1965 passage of Medicare and Medicaid"). Implicit in this description are the facts that Medicaid and Medicare were dramatic assaults on health inequality and that there remains much to be done to address health inequality.

Id. at 141; Social Transformation, supra note 42, at 369-70.

Social Transformation, supra note 42, at 369.

Id.

Social Transformation, supra note 42, at 370.


See 42 U.S.C. §§ 1396b(a), 1396d(b) (Supp. IV 1965-1968); Remedy and Reaction, supra note 18, at 47.

42 U.S.C. §§ 1396b(a), 1396d(b) (Supp. IV 1965-1968); Remedy and Reaction, supra note 18, at 47.

Social Transformation, supra note 42, at 370.

Id.

Id.

See id. at 369-70; Remedy and Reaction, supra note 18, at 46-47.

See Social Transformation, supra note 42, at 369-70.

Id. at 370.

Remedy and Reaction, supra note 18, at 47.

Id. (noting that because of variations among states in their criteria for welfare, “many of the poor who could qualify for Medicaid in, say, New York could not qualify in Mississippi”).

Id.

See Social Transformation, supra note 42, at 350-51; Ruger, supra note 11, at 232.

Social Transformation, supra note 42, at 349.

Id. at 350.

Id.

Id. The original Medicaid program limited eligibility to income levels of no more than 133% of the maximum income permitted by a particular state for eligibility for welfare benefits. Remedy and Reaction, supra note 18, at 47. Therefore, states that were less generous with cash welfare assistance also were less generous with the access to health care provided by Medicaid. Id. Further, the consequences of the Hill-Burton matching fund requirement meant that even Medicaid-eligible individuals might not live close enough to a hospital or clinic to have meaningful access to health care. See Social Transformation, supra note 42, at 350.

Social Transformation, supra note 42, at 359.

See id. at 352-59.

Id. at 359.

See id.

Id. at 371-72.

Id. at 366, 371-72.

In 1978, there were approximately twenty-six million people in the United States without health insurance, public or private, not to mention those whose insurance would be inadequate if they suffered a serious illness. Social Transformation, supra note 42, at 417. The “corridor” between private insurance and government-funded care “was especially wide in states, many of them in the South, that severely restricted Medicaid eligibility.” Id. The first federal attempt to address the problem of hospital access for the
uninsured and those on Medicaid actually came through an amendment to Hill-Burton itself in 1979. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979). The community service assurances prohibited hospitals that had received Hill-Burton construction or modernization funds from denying emergency room services to anyone residing in the hospital’s service area. Id.

Congress noted that patient dumping had become a more acute problem since the implementation of the Medicare prospective payment system in 1983. See H.R. Rep. No. 99-241, at 27 (1986), reprinted in 1986 U.S.C.C.A.N. 726, 726. The prospective payment system pays a predetermined sum to a hospital based on the “DRG” (diagnosis-related group) in which a patient's particular condition falls. Remedy and Reaction, supra note 18, at 64. This made Medicare patients less attractive to hospitals but still more attractive than Medicaid patients for whom reimbursement would be set by the individual states and not the federal government. See id. at 63-65.

For example, the Humana hospital system's pre-EMTALA policies were described as follows:
Privately insured patients can be charged what the market will bear. When a hospital has empty beds, Medicare and Medicaid patients are better than cold sheets, and Humana charges off every penny of overhead on them the government will allow. But if it isn't trying to fill a lot of empty beds, Humana treats as few of those patients as possible.
Social Transformation, supra note 42, at 436 (quoting Gwen Kinkead, Humana's Hard-Sell Hospitals, Fortune, Nov. 17, 1980, at 68-81). Further, under these policies, if Humana staff determined a patient to be uninsured, they would transfer the patient to a public hospital. Id.

See Debbery v. Sherman Hosp. Ass’n, 741 F. Supp. 1302, 1304 (N.D. Ill. 1990) (defining patient dumping as the “refusal to treat an emergency patient, even though the hospital is physically capable of doing so, simply because the patient may be unable to pay”). See generally George J. Annas, Your Money or Your Life: ‘Dumping’ Uninsured Patients from Hospital Emergency Wards, 76 Am. J. Pub. Health 75 (1986) (discussing patient dumping as the transfer of unstable patients or refusal to render emergency treatment to patients based on grounds unrelated to need or the hospital’s ability to provide services).


See Gionis, Camargo, Jr. & Zito, Jr., supra note 21, at 185-86.


Id.


See Annas, supra note 95, at 75-77 (referring to the shrinking and limited “nonstatutory right” of United States citizens to emergency room medical treatment).


Specifically, the law amended the Employee Retirement Income Security Act of 1974 (ERISA) to require the sponsor of each group health plan to provide that each qualified beneficiary who would lose coverage because of a qualifying event is entitled to elect continuation coverage. See 29 U.S.C. §§ 1161-1169 (2006). The law defines a qualifying event as:
(1) The death of the covered employee.
(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
(3) The divorce or legal separation of the covered employee from the employee's spouse.
(4) The covered employee becoming entitled to [Medicare] benefits ....
(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan ....

See § 1163.

“Emergency medical condition” is defined in part as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in ... [inter alia] placing the [[patient's health] ... in serious jeopardy[,]” 42 U.S.C. § 1395dd(e)(1)(A)(i) (2006).

“Stabilize” means “to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility[.]” 42 U.S.C. § 1395dd(e)(3)(A) (2006). Thus, EMTALA does not completely prohibit transfers to other hospitals but seeks to ensure the safety of patients during such transfers. “Transfer” is defined to include moving the patient to an outside facility or discharging him at the direction of anyone affiliated with the hospital. 42 U.S.C. § 1395dd(e)(4) (2006).

42 U.S.C. § 1395dd(b) (2006) (“[T]he hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department[.]”). See also Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1134 (6th Cir. 1990).

See Gionis, Camargo, Jr. & Zito, Jr., supra note 21, at 178-79. But see generally Elizabeth Weeks Leonard, State Constitutionalism and the Right to Health Care, 12 J. Const. L. 1325 (2010) (arguing that there is no federal right to health care and that state law rights to health care could serve as important catalysts for state and federal health care legislation).

42 U.S.C. §§ 1395dd(b), (g) (2006).


See McDonough, supra note 20, at 130 (noting that undocumented immigrants, and Medicaid-eligible persons who opt not to enroll will not be covered under the ACA).


§ 1395dd(d)(2)(B).

§ 1395dd(d)(2)(A).

§ 1395dd(d)(1)(B)(i). However, physicians can be subject to civil monetary penalties. Id.


See, e.g., Gionis, Camargo, Jr. & Zito, Jr., supra note 21.

See Ruger, supra note 11, at 222 (suggesting that the individual mandate could have been labeled an “‘EMTALA risk adjustment payment’” to more accurately describe its function (citing the Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, 100 Stat. 165 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006))).


127 See Gionis, Camargo, Jr. & Zito, Jr., supra note 21, at 241.

128 See id. See also Ohio Rev. Code Ann. § 2305.234 (West 2009) (intending to protect volunteers from tort liability).

129 According to one study conducted through the use of surveys, “[w] hen asked whether hospitals were providing incentives to specialists to take calls, 8% said their hospitals were paying stipends, 15% were guaranteeing certain levels of payment for services, and 14% were providing some measure of medical liability coverage for on-call commitments.” Am. Coll. of Emergency Physicians, On-Call Specialist Coverage in U.S. Emergency Departments: ACEP Survey of Emergency Department Directors 4 (2004), available at www.acep.org/workarea/downloadasset.aspx?id=8974. The Centers for Medicare and Medicaid Services (CMS) have sought to limit the costs of this requirement by permitting hospitals to participate in community call plans in which a specific hospital in a region can be designated the on-call facility for a period of time or for a specific service. See 42 C.F.R. § 489.24(j)(2)(iii) (2011).


131 “EDs have high fixed costs associated with 24-hour staffing and the need for a wide array of medical equipment to diagnose and treat all types of injuries and illness.” Moskop, supra note 124, at 477. “Because the ED functions 24 hours per day, seven days per week, it has high fixed costs (those costs that are not dependent on volume) for medical staff, ancillary services, supplies, overhead, and administration; and very low marginal costs (the additional cost for one additional visit).” Lynne D. Richardson & Ula Hwang, Access to Care: A Review of the Emergency Medicine Literature, 8 Acad. Emergency Med. 1030, 1033 (2001).

132 A simple Google search using the search term “30 minute emergency room” produces links to numerous hospitals making such a guarantee. The most recent search, conducted on January 7, 2013, produced what appeared to be no fewer than ten different emergency departments from around the country offering a thirty minute guarantee.

133 “The ED may even be seen by hospital administration as a ‘loss leader.’ A ‘loss leader’ is defined as a service or product that is sold below cost or at a loss to entice customers to buy other goods.” Jesse M. Pines, The Economic Role of the Emergency Department in the Health Care Continuum: Applying Michael Porter’s Five Forces Model to Emergency Medicine, 30 J. Emergency Med. 447, 449 (2006). The latest variation on this theme appears to be the development and marketing of “senior emergency rooms” targeted to addressing the needs of the elderly--that is, Medicare recipients. E.g., Alyson Martin & Nushin Rashidian, Emergency Rooms Built with the Elderly in Mind, N.Y. Times (Mar. 14, 2011, 8:00 AM), http://newoldage.blogs.nytimes.com/2011/03/14/hospitals-building-emergency-rooms-for-the-elderly/.


135 Remedy and Reaction, supra note 18, at 123.

136 See generally Lynn Healey Scaduto, Comment, The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for its Intended Beneficiaries, 46 UCLA L. Rev. 943 (1999) (arguing that Congress should have limited EMTALA’s coverage only to the indigent).

137 See id.
138 Pines, supra note 133, at 449.
139 Furnas & Harbage, supra note 125.
140 Remedy and Reaction, supra note 18, at 123.
141 Id.
142 See Moskop, supra note 124, at 477.
144 Indeed, part of the American Recovery and Reinvestment Act of 2009 (ARRA) included subsidies provided to individuals to help them afford to pay the premiums for the continuing coverage made possible by COBRA. See 26 U.S.C. § 6432 (Supp. IV 2010).
146 See infra notes 161-168 and accompanying text.
151 See supra text accompanying note 117.
152 See Gionis, Camargo, Jr. & Zito, Jr., supra note 21, at 208-10.
156 See supra Part III.B. (suggesting that if doctors are not afraid to be held liable for their treatment of uninsured patients, they will be less likely to avoid these patients. Presumably, as the amount of uncompensated care increases because doctors are more willing to see uninsured patients, so would the costs for these services).
157 van Caulil, supra note 134, at 390.
Since the passage of EMTALA, all EDs [sic] are mandated to complete a medical screening examination of any patient seeking medical treatment, whether or not the patient has the ability to pay or provides evidence of medical coverage and further, whether the patient's presenting condition is emergent or non-urgent. The result has been a nationwide increase in the utilization of EDs [sic], especially as it pertains to use of the ED for non-urgent purposes.
Id. (citations omitted).
See supra notes 106-109 and accompanying text.

See Richardson & Hwang, supra note 131, at 1033-34.

Galewitz, supra note 130.

Ohio Press Release, supra note 161.

See, e.g., id.

Id.

See Social Transformation, supra note 42, at 372 (describing the government’s failure to adequately fund community health centers in the 1960s despite their success in reducing hospital usage by low-income patients).

McDonough, supra note 20, at 116-26.

Remedy and Reaction, supra note 18, at 264.

McDonough, supra note 20, at 144-48.

Mark V. Pauly, Patricia Damon, Paul Feldstein, and John Hoff first proposed the idea of an individual mandate in their article, A Plan for ‘Responsible National Health Insurance.’ Mark V. Pauly et al., A Plan for ‘Responsible National Health Insurance,’ 10 Health Aff. 5, 8 (1991).

26 U.S.C. § 5000A(a) (Supp. IV 2010) contains the requirement that individuals maintain minimum essential coverage. “Minimum essential coverage” is defined at 26 U.S.C. § 5000A(f) (Supp. IV 2010). The Medicaid expansion provision is codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2010). The exchanges are created at 42 U.S.C. § 18031 (Supp. IV 2010). An “exchange” provides an “organized marketplace” in which individuals and businesses can purchase insurance. McDonough, supra note 20, at 127. It can be run by a non-profit, a government agency, or a private sector company. Id. The exchange can operate like a “yellow pages,” providing information about plans and how to purchase coverage, or it can take on more of an advocacy role, setting and enforcing standards that insurers must meet in order to be listed in the exchange. Id.

The ACA modifies the Internal Revenue Code, 26 U.S.C. § 36B, to provide federal tax credits to assist household with incomes between 133% and 400% of the federal poverty level. See 26 U.S.C. § 36B (Supp. IV 2010).


42 U.S.C. §§ 300gg-1(a), 300gg-3(a) (Supp. IV 2010).

§ 300gg.

See Ruger, supra note 11, at 222.


Id.

See McDonough, supra note 20, at 144.


To be fair, Judge Roger Vinson first raised the broccoli hypothetical in the Florida case, Florida ex rel. Bondi, 780 F. Supp. 2d 1256, 1289 (N.D. Fla. 2011).

See infra Part V.B.


Transcript of Oral Argument Day 2, supra note 120, at 11-12.

Id. at 12; NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 477 (2012) (“Accepting the Government's theory would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal Government.”).

See NFIB, 183 L. Ed. 2d at 477-78.


Id. at 106.
202  Id. at 7-10.
203  Id. at 13-14, 26-30.
204  Id. at 30.
205  The Brief for the Private Respondents listed only four individual plaintiffs other than the National Federation of Independent Business (NFIB) itself. None of those plaintiffs was younger than age forty-eight. Unopposed Motion for Leave to Add Parties Dana Grimes and David Klemencic, NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450 (2012) (attaching declarations originally submitted to the district court in support of Plaintiffs' Motion for Summary Judgment on November 4, 2010, and establishing plaintiffs' ages, as of that date, as follows: Dana Grimes, 48; David Klemencic, 50; Mary Brown, 55; and Kaj Ahlburg, 51).
206  Brief of Young Invincibles as Amicus Curiae in Support of Petitioner, Nat'l Fed'n of Indep. Bus., 567 U.S. ___, 183 L. Ed. 2d 450 (2012) (No. 11-398), 2012 WL 195303 (supporting the position of the Secretary of the Department of Health and Human Services against the State Defendants and urging the Court to uphold the minimum coverage provision).
207  Id. at 17.
209  See generally id.
210  Id. at 93-94.
211  See generally id.
212  Id. at 13-14, 26-30.
213  Id. at 76.
214  Transcript of Oral Argument Day 2, supra note 120, at 102.
215  See supra notes 180-187 and accompanying text.
216  See supra Part IV.
217  Transcript of Oral Argument Day 2, supra note 120, at 84, 102.
218  Id. at 85-86.
220  Transcript of Oral Argument Day 2, supra note 120, at 94.
221  Id. at 100 (blaming Congress for the consequences of EMTALA and implicitly challenging Judge Sutton's conclusion: “We, Congress, have driven up the health insurance premiums, and since we've created that problem, this somehow gives us authority that we wouldn't otherwise have. That can't possibly be right.”).
222  Id. at 101-02.
223  See id. at 75-109.
225  The conservative justices were more straightforward regarding their feelings about EMTALA. In response to the Solicitor General's invocation of “social norms” that obligate us to provide emergency health care, Justice Scalia asked: “Well, don't obligate yourself to
that. Why--you know?" Transcript of Oral Argument Day 2, supra note 120, at 21. Justice Alito complained that “[H]ere the reason why there is cost-shifting is because the government has mandated that.” Id. at 89.

Id. at 21.

Id. at 21.


See Ruger, supra note 11, at 224.


Id. Congress enacted mandatory amendments to Medicaid in 1967, 1972, 1988, and 2003 that expanded coverage requirements for children; extended Medicaid coverage to the aged, blind, and disabled who qualified for the Supplemental Security Income (SSI) program; delinked Medicaid eligibility for children and pregnant women from the AFDC welfare program; and required states to fund part of the Medicare Part D prescription drug expansion, respectively. Huberfeld, Leonard & Outterson, supra note 188, at 15-17.

Rosenbaum & Jost, supra note 229, at 488-89.


The coercion doctrine has its origins well before Dole. Indeed, Justice Cardozo warned that the doctrine, if enforced by the Court, could “plunge the law into endless difficulties.” Steward Machine Co. v. Davis, 301 U.S. 548, 589-90 (1937).


Id. Here, Justice Roberts’s statements foreshadow his opinion, which treats the Medicaid expansion as a new program. NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 494-96 (2012).

Transcript of Oral Argument Day 3, supra note 22, at 49-58. See also Huberfeld, Leonard & Outterson, supra note 188, at 30 & n.250 (noting that the provision that made the ACA’s Medicaid expansion coercive, according to the Court, actually was part of the pre-ACA Medicaid Act).

See, e.g., Transcript of Oral Argument Day 3, supra note 22, at 65.

Id.

Id. at 77-78.


See Huberfeld, Leonard & Outterson, supra note 188, at 7 (“[T]he ACA built upon the United States' existing path-dependent, public-private healthcare sector.”). See also Ruger, supra note 11, at 226. Under the ACA, states retain primary regulatory authority over health care financing and delivery, as the statute extends and supports state regulatory authority rather than subverting it. Id.


Levmore, supra note 241, at 816-17.

Id. at 822.

Id. at 828.

See id. at 835-36.

See, e.g., Transcript of Oral Argument Day 2, supra note 120, at 106 (statement of Justice Kennedy) (“[T]he Government tells us that's because the insurance market is unique. And in the next case, it'll say the next market is unique.”).
Levmore, supra note 241, at 827.

Transcript of Oral Argument Day 2, supra note 120, at 25. Ultimately, this was what Chief Justice Roberts did for the government in his opinion—identifying the taxing power as the constitutional power of sufficient breadth to enable Congress to enact the individual mandate. *NFIB v. Sebelius*, 567 U.S. ___, 183 L. Ed. 2d 450, 466-67, 498 (2012).

Transcript of Oral Argument Day 2, supra note 120, at 24, 88-91.

Id. at 92.

Transcript of Oral Argument Day 3, supra note 22, at 61-62

Huberfeld, Leonard & Outterson, supra note 188, at 21.

See Levmore, supra note 241, at 827-28. See also *NFIB*, 183 L. Ed. 2d at 497. This proved to be critical to Justice Roberts's analysis of the Medicaid expansion. Id. at 498-99.

Transcript of Oral Argument Day 3, supra note 22, at 61-62 (statement of Justice Roberts); id. at 74 (statement of Justice Kennedy).

Id. at 74.

See Levmore, supra note 241, at 835-36.

See McDonough, supra note 20, at 143 (“[Because of the] relentless culture of innovation in fifty state laboratories, ... innovators' ideas can catch on quickly across borders.”).


Transcript of Oral Argument Day 3, supra note 22, at 3-41, 81-87.

Id. at 76-78.

*NFIB*, 183 L. Ed. 2d at 450.

See generally id.

Id.

Id.

Id.

Hart, supra note 193.

Tom Goldstein, We're Getting Wildly Differing Assessments, SCOTUSblog (July 7, 2012, 10:04 PM), http://www.scotusblog.com/2012/07/were-getting-wildly-differing-assessments/.

Id.

See supra Part V.A.

See supra Part V.A. and Part V.B.

*NFIB v. Sebelius*, 567 U.S. ___, 183 L. Ed. 2d 450 (2012); id. at 509-10, 511 (Ginsburg, J., concurring in part, concurring in judgment in part, and dissenting in part); id. at 559 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

McDonough, supra note 20, at 304.
Perhaps there was some concern on the part of the current administration that mentioning race in the context of the health care reform debate would have negative political consequences. See generally Michael Tesler, The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race, 56 AM J. Pol. Sci. 690 (2012). The only group that appears to have argued explicitly that the ACA was civil rights legislation was the National Women’s Law Center, which argued that the Court should uphold the ACA because it remedied discrimination against women. Brief of the National Women's Law Center et al. as Amici Curiae Supporting Petitioner on the Minimum Coverage Provision at 24-33, Dep't of Health & Human Serv. v. Florida, 132 S.Ct. 2566 (2012) (No. 11-398), 2012 WL 160240 at *24-33.

NFIB, 183 L. Ed. 2d at 481-82.
Id. at 477.
NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 477-78 (2012) (“To an economist, perhaps, there is no difference between activity and inactivity; both have measurable economic effects on commerce. But the distinction between doing something and doing nothing would not have been lost on the Framers ....”).
See, e.g., Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241, 250 (1964) (noting that the Commerce Clause grants Congress the power to enact provisions of the Civil Rights Act of 1964 that preclude discrimination in places of public accommodation).
See id. at 260-61 (“[I]n a long line of cases this Court has rejected the claim that the prohibition of racial discrimination in public accommodations interferes with personal liberty.”) (citing District of Columbia v. John R. Thompson Co., 346 U.S. 100, 110 (1953)).
Groome Res. Ltd. v. Parish of Jefferson, 234 F.3d 192 (5th Cir. 2000).
Katzenbach, 379 U.S. 294.
Heart of Atlanta, 379 U.S. 241.
See Katzenbach, 379 U.S. at 304; Heart of Atlanta, 379 U.S. at 260-61.
See Katzenbach, 379 U.S. at 304; Heart of Atlanta, 379 U.S. at 260-61.
See supra note 178 and accompanying text (suggesting that the mandate guarantees payment for services made available to all regardless of ability to pay).
Id. at 84.
Id. at 85.
See United States v. Allen, 341 F.3d 870, 881 (9th Cir. 2003) (upholding federal hate crimes legislation under the Commerce Clause).
Relying on Jim Downs’ book Sick From Freedom, see supra note 35, one might even argue that eradicating inequality in access to health care could be considered an action taken pursuant to U.S. Const. amend. XIII, § 2 to redress the badges and incidents of slavery. See also Rebecca E. Zietlow, Free at Last! Anti-Subordination and the Thirteenth Amendment, 90 B.U. L. Rev. 255, 260-61 (2010).

NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 490-91 (2012); id. at 561 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

Florida v. Dep’t of Health & Human Serv., 648 F.3d 1235, 1268 (11th Cir. 2011) (“Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act’s Medicaid expansion.”) (citing South Dakota v. Dole, 483 U.S. 203, 211 (1987)).

See Huberfeld, Leonard & Otterson, supra note 188, at 4.

Id.

NFIB, 183 L. Ed. 2d at 495.

Id. at 496-97.

See supra notes 243-246 and accompanying text.

See supra notes 243-246 and accompanying text.


Id. at 529-32 (Ginsburg, J., concurring in part, concurring in judgment in part, and dissenting in part).


Id. at 531-32 (citing 42 U.S.C. § 1304 (2006)).

Id. at 496.

Id.


See Keavney Klein & Sonya Schwartz, Nat’l Acad. for State Health Policy, State Efforts to Cover Low-Income Adults Without Children 1, 3 fig.2 (2008), available at http://nashp.org/sites/default/files/shpmonitor_childless_adults.pdf?

NFIB v. Sebelius, 567 U.S. ___, 183 L. Ed. 2d 450, 491 (2012) (citing 42 U.S.C. § 1396a(k)(1) (Supp. IV 2010), which allows states that were granted expansion waivers to use the same “benchmark coverage” for the ACA expansion).


See § 1396d(y)(1).

Huberfeld, Leonard & Otterson, supra note 188, at 28-29.

For a more detailed explanation of just how inappropriate and incendiary these phrases were, see id. at 53.

See generally id.


See January Angeles, Ctr. on Budget & Policy Priorities, How Health Reform’s Medicaid Expansion Will Impact State Budgets: Federal Government Will Pick Up Nearly All Costs, Even as Expansion Provides Coverage to Millions of Low-Income Uninsured Americans (2012), available at http:// www.cbpp.org/files/7-12-12health.pdf. While state governors may choose not to pursue the Medicaid expansion, they are likely to come under pressure to do so from hospitals that, pursuant to the provisions of the ACA, will

McDonough, supra note 20, at 152.

See Ruger, supra note 11, at 224.

Id.

McDonough, supra note 20, at 152.


Ruger, supra note 11, at 215.

See id. at 216.


See Angeles, supra note 322, at 1 & n.1 (noting that the Governors of Florida, Louisiana, Mississippi, South Carolina, and Wisconsin have said they will not expand Medicaid).

See Ruger, supra note 11, at 224.

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