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BETTER HEALTH, BUT LESS JUSTICE: WIDENING HEALTH DISPARITIES AFTER NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS

EMILY WHELAN PARENTO* & LAWRENCE O. GOSTIN**

I. Introduction

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) into law. The ACA was widely applauded by health activists, as it meant that the United States would at last join the overwhelming majority of industrialized countries in providing its population with guaranteed access to affordable health care. Indeed, the ACA was widely perceived as guaranteeing health care to all Americans, and many Democratic legislators referred to the realization of the recently deceased Senator Edward M. Kennedy's long quest to ensure that all Americans had "decent, quality health care as a fundamental right and not a privilege."

The ACA was designed as a fix for the "patchwork" United States system, filling in gaps in the existing framework by (i) eliminating the ability of insurance companies to discriminate based on pre-existing conditions and strictly limiting pricing based on age, (ii) requiring individuals who lack access to an affordable employer-based insurance option to purchase private insurance (with subsidies for individuals from 100 to 400% of the Federal Poverty Level (FPL), and (iii) expanding eligibility for Medicaid to include all adults with income less than 138% of the FPL.

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^{1.} Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of Title 26 and 42 of the U.S. Code) [hereinafter ACA].

^{2.} Senator Edward M. Kennedy, Speech to the Democratic National Convention (August 26, 2008).

If the ACA was fully implemented, the overwhelming majority of United States residents³ were intended to be able to access affordable health care, with thirty-two million people projected to acquire insurance after implementation.⁴

But the ACA's universality was short-lived, expiring before it even began. Roughly half of the states (twenty-six, all led by Republican governors)⁵ joined in *National Federation of Independent Business v. Sebelius* (*NFIB*),⁶ decided by the Supreme Court on June 28, 2012. The plaintiffs raised many challenges to the ACA, contesting the constitutionality of the so-called "individual mandate" (requiring most people to purchase insurance or pay a tax penalty for failure to do so), as well as the portion of the ACA requiring states to expand Medicaid eligibility to include all adults below 138% of the FPL⁷ or risk losing federal funding for their existing Medicaid programs. Although the Court upheld the constitutionality of the individual mandate, finding it a permissible exercise of Congress' taxing authority, it found the Medicaid expansion unconstitutionally coercive of states, holding that the Secretary could not threaten the loss of existing Medicaid funding to incentivize states to participate in the Medicaid expansion.⁸ The Court's ruling essentially converted the Medicaid expansion into an optional program in which states could choose to participate but would incur no penalty for opting out.

In a move both short-sighted and detrimental to public health, undocumented residents are neither eligible for the Medicaid expansion nor federal subsidies to purchase insurance via the exchanges established under the ACA. Even worse, the law bans undocumented residents from purchasing insurance on the exchanges solely at their own expense. 26 U.S.C. § 5000A(d) (Supp. V 2011) (mandate does not apply to undocumented immigrants); ACA, Pub. L. No. 111-148, § 1312(f)(3), 124 Stat. 119, 124 (2010) (banning undocumented immigrants from purchasing insurance via exchanges).

^{4.} Letter from Douglas Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010), available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

^{5.} Transcript of Oral Argument at 21, Florida v. Dep't of Health & Human Servs., 132 S. Ct. 2566 (2012) (No. 11-400), available at http://www. documentcloud.org/documents/329590-supreme-court-health-care-argumentmedicaid.html.

^{6. 132} S. Ct. 2566 (2012).

^{7.} The ACA provides for a Medicaid expansion to 133% of the FPL plus a 5% income disregard, making the threshold for Medicaid eligibility effectively 138% of the FPL. See Cong. Budget Office, Estimates for the Insurance COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT Supreme Court Decision (2012) [hereinafter Estimates for the Insurance COVERAGE PROVISIONS OF THE ACA], available at http://www.cbo.gov/sites/ default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

^{8.} NFIB, 132 S. Ct. at 2598 (mandate), 2607 (Medicaid expansion).

After the decision, early forecasts were that even most of the plaintiff states would eventually participate in the Medicaid expansion, mostly because of the exceedingly favorable funding terms: the federal government will pay 100% of the cost for newly eligible enrollees in the years 2014 through 2016, gradually declining to 90% in 2019 and thereafter. Thus far, however, the trend is not encouraging. As of late March 2013, fourteen states have said they will not participate, and another three have indicated they are leaning against participating. Though states face no firm deadline for opting into the expansion, there is no reason to think participation rates will be materially higher in future years than in 2014, when funding will be at its most generous level

The Congressional Budget Office's (CBO's) initial estimate of the number of individuals who were to gain coverage under the ACA has been reduced, from thirty-two to twenty-nine million. But the accuracy of these estimates is subject to question; given the number of states that are opting out, the number could be far higher. Regardless of the precise reduction in coverage that results from the Court's decision, the true injustice lies in the *composition* of the states who are opting out, which is largely comprised of very poor adults. Rather than expanding coverage to all Americans, and thereby *reducing* health disparities, as had initially been intended and predicted, the legacy of the ACA moving forward may be that it contributed to an *increase* in United States health disparities.

This result is an injustice that cries out for reform. A first step in that direction is ensuring that states are in possession of—and made to acknowledge—accurate information regarding the economic costs of the Medicaid expansion, which are far less than the potentially bankrupting amount that has been portrayed. A second step is to emphasize the importance of the incorporation of public health in health policy analysis and design; in addition to benefiting individual health, universal access to health services improves public health. Finally, and most critically, strong voices must demand that health policy be implemented such that it achieves justice for the poorest and

^{9.} ACA \S 1396d(y)(1); see also Robert Pear, Uncertainty over States and Medicaid Expansion, N.Y. Times, June 28, 2012, http://www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html.

^{10.} Where Each State Stands on ACA's Medicaid Expansion, Advisory Bd. Co. (Mar. 13, 2013), http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap.

^{11.} Estimates for the Insurance Coverage Provisions of the ACA, supra note 7, at 3.

most vulnerable among us. Without action to rectify the ACA's unintended consequences, the United States seems likely to consign its poorest and most vulnerable residents to a continued tenuous health status, in which the only options for care are emergency rooms and those institutions that are willing to provide free or nearly free health services.

Part II of this Article provides an overview of health disparities and access to health care in the United States. Part III explains the Medicaid program and its importance in mitigating health disparities in the United States. Part IV describes the ACA and its intended effect on health disparities. Part V explains the Supreme Court's ruling regarding the Medicaid expansion under the ACA, as well as subsequent legal developments regarding the ACA. Finally, Part VI argues against the deep injustice of leaving out the poorest Americans in the post-ACA system.

II. HEALTH DISPARITIES AND ACCESS TO HEALTH CARE IN THE UNITED STATES

A. Defining Health Disparities

Before describing efforts to reduce or eliminate "health disparities," it is necessary to define the term, as well as the closely related concepts of "health inequalities" and "health inequities." Health inequalities are, simply, inequalities in health status among individuals and population groups, 12 implying no value judgment as to whether those inequalities are unjust. By contrast, health disparities and health inequities are often used interchangeably and, broadly speaking, refer to a subset of health inequalities that are (i) based on factors such as socioeconomic status and racial/ethnic background and (ii) presumptively considered unjust.

There is no single agreed-upon definition of which health disparities should be considered unjust, and governments and international organizations have adopted varying definitions. For example, in its landmark report, "Closing the Gap in a Generation," the World Health Organization (WHO) Commission on the Social Determinants of Health (SDH) explained "[w]here systematic differences in health are judged to be avoidable by reasonable action . . . they are, quite simply, unjust." As Sir Michael Marmot, chair of the Commission, explained, "[n]ot all

^{12.} See Michael Marmot, Achieving Health Equity: From Root Causes to Fair Outcomes, 370 Lancet 1153 (2007).

^{13.} World Health Org. & Comm'n on Soc. Determinants of Health, Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health 26 (2008) [hereinafter Closing the Gap],

health inequalities are unjust or inequitable. If good health were simply unattainable, this would be unfortunate but not unjust. Where inequalities in health are avoidable, yet are not avoided, they are inequitable."¹⁴

Even in the United States, there are differences in definitions among agencies, programs, and laws. For example, the nation's "master blueprint for health," Healthy People 2020 (a project of the Department of Health and Human Services (HHS)), defines health disparities as "particular type[s] of health difference[s] that [are] closely linked with social, economic, and/or environmental disadvantage." However, the Centers for Disease Control and Prevention (CDC) in its first "Health Disparities and Inequalities Report" (issued in 2011)¹⁶ adopted a different interpretation of the terms stating:

Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes. Health inequalities, which is sometimes used interchangeably with the term health disparities, is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity). Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.¹⁷

 $\it available~at~http://whqlibdoc.who.int/publications/2008/9789241563703_eng.~pdf.$

[h]ealth disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Id

^{14.} Marmot, supra note 12, at 1154.

^{15.} Disparities, HealthyPeople.gov, http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx (last visited Apr. 18, 2013) (citing Sec'y's Advisory Comm. on Nat'l Health Promotion & Disease Prevention Objectives for 2020, U.S. Dep't of Health & Human Servs., Phase I Report, § IV (2010), available at http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917). In addition, Healthy People 2020 explains that

^{16.} Ctrs. for Disease Control & Prevention, Morbidity & Mortality Weekly Report 60, CDC Health Disparities and Inequalities Report—United States, 2011, at 4 (2011), available at http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.

^{17.} *Id.* at 3.

Still another variation exists in the ACA itself, which incorporates the definition of "health disparity population" contained in the United States Public Health Service Act:

A population is a health disparity population if, as determined by the Director of the Center after consultation with the Director of the Agency for Healthcare Research and Quality, there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.¹⁸

The commonality in all of these definitions is the acknowledgement of population-level differences in health associated with factors such as income, education, racial and ethnic group, gender, religion, geographic location, and income-related factors such as health insurance status. While the CDC and ACA do not expressly equate health disparities with health inequities, the majority view among public health activists is more in line with the WHO Commission's view—that if differences in health based on these factors are avoidable with reasonable government and societal effort, then these differences are presumptively unjust. And certainly, access to affordable health insurance and health care are factors that are remediable with reasonable effort, as is demonstrated by the fact that the United States is alone among industrialized countries in failing to guarantee at least some level of basic, non-emergency care for its population.¹⁹

Disparities in Health and in Access to Health Care in the United States

1. Health Disparities in the United States—Significant and Pervasive

Health disparities in the United States are both significant in scale and pervasive in nature, found in larger measure and across more socioeconomic levels than in most industrialized countries.20 The most recent data paint a stark picture of the inequi-

^{18.} ACA (citing 42 U.S.C. § 485E (2000)). Under the Public Health Service Act, "'health disparities research' means basic, clinical, and behavioral research on health disparity populations (including individual members and communities of such populations) that relates to health disparities . . . including the causes of such disparities and methods to prevent, diagnose, and treat such disparities." 42 U.S.C. § 285t(d)(3) (2000).

^{19.} See World Health Org., The World Health Report 2000, Health Systems: Improving Performance 155 (2000), available at http://www.who.int/ whr/2000/en/whr00_en.pdf (ranking the United States 37th among global health systems).

^{20.} Id.

ties among various population groups, particularly when compared with other developed countries. Although precise country comparisons are difficult given the differences in the way countries monitor health and health disparities, in general, the state of health equity in the United States appears to be worse than in most industrialized nations. 21 For example, among lower socioeconomic status groups in the United States and Canada (which has generally adopted more interventionist health promotion approaches than the United States, including a national health care system), adverse personal health-related behaviors have a more significant impact on the United States cohort than on the comparable Canadian group.²² Similarly, differences in health outcomes by racial and ethnic group are more pronounced in the United States than in Canada. 23 For example, a black, unemployed youth in Baltimore, Maryland has a lifespan thirty-two years shorter than that of a white corporate professional.24

These glaring inequalities are not inevitable, as progress in other, less wealthy, countries has demonstrated—Brazil, for example, has overcome vast inequities to achieve near universal coverage of skilled birth attendants. And the gap in Brazil between the prevalence of stunting among children in the richest and poorest quintiles shrank from 35% to 37% in 1989 to 5% to 7% in 2007. Brazil's accomplishments, along with many other successes, demonstrate that the extreme level of avoidable death and disease in disadvantaged populations is just that—avoidable, and deeply unjust.

^{21.} See Hilary Graham, Unequal Lives: Health and Socioeconomic Inequalities (2007); see also Stephen Bezruchka, Health Equity in the USA, 29 Soc. Alternatives 50 (2010).

^{22.} Kimberlyn M. McGrail et al., *Income-Related Health Inequalities in Canada and the United States: A Decomposition Analysis*, 99 Am. J. Pub. Health 1856, 1856–63 (2009).

^{23.} Arjumand Siddiqi & Quynh C. Nguyen, *A Cross-National Comparative Perspective on Racial Inequities in Health: The USA Versus Canada*, 64 J. EPIDEMIOLOGY & CMTY. HEALTH 29, 29–34 (2010).

^{24.} Vicente Navarro, What We Mean by Social Determinants of Health, 16 GLOBAL HEALTH PROMOTION 5 (2009).

^{25.} Zulfiqar A. Bhutta et al., Countdown to 2015 Decade Report (2000–2010): Taking Stock of Maternal, Newborn, and Child Survival, 375 LANCET 2032 (2010).

2. Access to Health Insurance in the United States—Uneven and Unfair

Although access to health care is not solely a function of health insurance coverage,²⁶ health insurance coverage is strongly linked to access to care. Access to care has widespread impact on all aspects of an individual's health, and reduced or limited access to health care negatively impacts the ability of individuals to reach their full potential and live a full and vibrant life.

Although estimates can vary depending on calculation method (i.e., whether a person is uninsured for a part or the whole of a year), the United States census estimated that approximately fifty million United States residents were uninsured at some point in 2010, when the ACA was signed into law.²⁷ Since the ACA was passed, the number of uninsured has fallen slightly, to approximately 48.6 million in 2011²⁸—a decrease attributed in part to the influx of young Americans who remained on their parents' insurance plans pursuant to the ACA's requirement that they be permitted to do so up to age twenty-six.²⁹

However, as would be expected, the proportion of uninsured Americans is not evenly distributed across racial and ethnic groups or socioeconomic levels.³⁰ In the 2011 census, evidence showed that socioeconomic status closely tracked health insurance coverage; uninsured rates decreased as household income increased, from 25.4% for those in households with annual income less than \$25,000, 21.5% for those with incomes from \$25,000 to \$49,999, 15.4% for incomes of \$50,000 to \$74,999, to 7.8% in households with income of \$75,000 or more.³¹ In addition, the average rate of uninsured (15.7%) masks wide variations across racial and ethnic groups, ranging from a rate of

^{26.} For example, Healthy People 2020 considers that access to health services involves four components: coverage, services, timeliness, and workforce. *Access to Health Services*, HealthyPeople.gov, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=1 (last visited Apr. 18, 2013).

^{27.} Carmen DeNavas-Walt et al., U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2011, at 22 (2012); *see also* Ctrs. for Disease Control & Prevention, *supra* note 16, at 35 (estimating over fifty million uninsured in 2010).

^{28.} DeNavas-Walt et al., supra note 27, at 21.

^{29.} See N.C. Aizenman, Number of Uninsured Americans Drops by 1.3 Million, Census Report Shows, Wash. Post, Sept. 12, 2012, http://articles.washingtonpost.com/2012-09-12/national/35494577_1_young-adults-number-of-uninsured-americans-employer-sponsored-coverage.

^{30.} See DeNavas-Walt et al., supra note 27.

^{31.} Id. at 25.

11.1% of non-Hispanic whites uninsured to 30.1% of Hispanic (any origin) uninsured.³²

C. The Link Between Health Insurance, Health Services, and Health Disparities

The significance of access to affordable health care services, particularly primary care, to both individual and population health is well-demonstrated by empirical evidence, which has clearly linked health services with health outcomes—not as the sole determinant of health (other factors such as public health services and the social determinants of health play large roles in individual and population health),³³ but as a key input.³⁴ Not only does access to health services improve individual health, universal access to health care is also associated with a more equitable distribution of health among populations.³⁵

Indeed, an essential condition for good individual and population health is a well-functioning healthcare system that provides clinical prevention, treatment, and palliative care for all individuals who are ill, injured, or suffering.³⁶ Health systems should ensure high quality health care (e.g., primary, emergency, and specialized care for acute and chronic diseases and injuries), including essential vaccines and medicines for all inhabitants (not merely citizens or legal residents).³⁷ The importance of universal access to health care is such that in December 2012, the United Nations General Assembly unanimously adopted a resolution on global health and foreign policy, encouraging governments to plan or pursue the transition

^{32.} Id. at 22.

^{33.} For example, life expectancy is dragged down in the developing world in large part due to childhood deaths owing to elementary gaps in public health: under-nutrition, unsafe water, rough sewage, suboptimal breastfeeding, and vitamin A and zinc deficiencies. Paul E. Jarris, *Challenging Times for the Governmental Public Health Enterprise*, 18 J. Pub. Health Mgmt. & Prac. 372 (2012). Similarly, the social determinants of health strongly contribute to health outcomes. *See* Closing the Gap, *supra* note 13.

^{34.} See, e.g., Barbara Starfield et al., Contribution of Primary Care to Health Systems and Health, 83 MILBANK Q. 457 (2005).

^{35.} *Id*.

^{36.} World Health Org., The World Health Report, Health Systems Financing: The Path to Universal Coverage (2010), available at http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf.

^{37.} World Health Org., Everybody's Business: Strengthening Health Systems to Improve Health Outcomes (2007), available at http://www.who.int/healthsystems/strategy/everybodys_business.pdf; World Health Org., The Selection and Use of Essential Medicines: Report of the WHO Expert Committee, 2003 (2010), available at http://www.who.int/healthsystems/strategy/everybodys_business.pdf.

towards universal access to affordable and quality health care

In the United States, access to affordable health care services overwhelmingly occurs via health insurance, either governmentsponsored (such as Medicare and Medicaid) or from private insurance companies. For those without insurance (primarily lower-income people), the only option to receive health care is to pay out of pocket, seek out charity care, or go to an emergency room (the federal "anti-dumping" law, the Emergency Medical Treatment and Active Labor Act (EMTALA)), requires virtually all emergency rooms to provide stabilization care regardless of a patient's ability to pay or insurance status).³⁹

Some have argued that there is no need to focus on expanding insurance to the uninsured, who can "just go to an emergency room." This argument ignores the fact that emergency rooms cannot and do not provide essential health services, and also ignores the costs of uncompensated care that are passed along to broader society in the form of higher premiums for the insured. Others have twisted the arguments in favor of improved public health measures and attention to social determinants to argue that society should not expend resources and effort to develop a system of universal coverage because such measures would not guarantee equal health among rich and poor-for example, economist Tyler Cowen's statement against the ACA mandate, arguing that the United States should "reject healthcare egalitarianism" and "accept the principle that sometimes poor people will die just because they are poor."41

Notwithstanding these objections, and acknowledging the critical importance of public health measures and the social determinants to individual and population health, empirical evidence has shown that insurance status does impact health outcomes—much research has shown that uninsured persons are more likely to have negative health outcomes than those with insurance, 42 to say nothing of the increased financial stability

^{38.} G.A. Res. 67/81, U.N. Doc. A/RES/67/81 (Mar. 14, 2013).

^{39.} Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2010).

^{40.} President George W. Bush, Address at the Intercontinental Hotel, Cleveland, Ohio (July 10, 2007) (transcript available at http://georgewbushwhitehouse.archives.gov/news/releases/2007/07/20070710-6.html).

^{41.} Tyler Cowen, What Kind of Mandate Should "the Right" Have Supported?, MARGINAL REVOLUTION (June 20, 2012, 7:02 AM), http://marginalrevolution. com/marginalrevolution/2012/06/what-kind-of-mandate-should-the-righthave-supported.html.

See, e.g., Comm. on the Consequences of Uninsurance, Inst. of Med., Insuring America's Health: Principles and Recommendations (2004);

that results from protection against crippling health care bills (a 2007 study by Harvard researchers linked 62% of personal bankruptcies to unpaid health care bills, in most cases exceeding \$5000).⁴³

Most recently, the landmark Oregon Health Study showed the corollary—the positive improvements that can result from access to insurance. 44 In the study, Oregon established a lottery for previously ineligible single adults to gain Medicaid coverage, thereby creating a randomized controlled design, the "gold standard" for medical evidence. The results were impressive—a year into the study, results indicated that enrollment in Medicaid "substantially increases health care use, reduces financial strain, and improves self-reported health and well-being."45 Study participants were 25% more likely to report themselves in good to excellent health than the control group, and were also more likely to utilize "recommended preventive care" such as mammograms (60% more likely than the control group) and cholesterol monitoring (20% more likely). Insurance also appeared to guard against a decline in health, decreasing by 40% the probability that participants reported a decline over the preceding six months, as well as reducing the likelihood of depression

STAN DORN, URBAN INST., UNINSURED AND DYING BECAUSE OF IT: UPDATING THE INSTITUTE OF MEDICINE ANALYSIS ON THE IMPACT OF UNINSURANCE ON MORTALITY (2008); Inst. of Med., America's Uninsured Crisis: Consequences for Health AND HEALTH CARE (2009); INST. OF MED., CARE WITHOUT COVERAGE: TOO LIT-TLE TOO LATE (2002); J. DURHAM ET AL., CTRS. FOR DISEASE CONTROL & PREVEN-TION, MORBIDITY & MORTALITY WEEKLY REPORT 40, SELF-ASSESSED HEALTH STATUS AND SELECTED BEHAVIORAL RISK FACTORS AMONG PERSONS WITH AND WITHOUT HEALTHCARE COVERAGE—UNITED STATES, 1994–1995, at 176 (1998); Robert A. Fowler et al., An Official American Thoracic Society Systematic Review: The Association Between Health Insurance Status and Access, Care Delivery, and Outcomes for Patients Who Are Critically Ill, 181 Am. J. RESPIRATORY CRITICAL CARE MED. 1003 (2010) (linking health insurance status with health outcomes in the critical care field); Jack Hadley, Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition, 297 J. Am. Med. Ass'n 1073 (2007); Jennifer S. Haas et al., The Association of Race, Socioeconomic Status, and Health Insurance Status with the Prevalence of Overweight Among Children and Adolescents, 93 Am. J. Pub. Health 2105 (2003) (discussing the fact that health insurance status is associated with the prevalence of obesity in adolescents).

- 43. David U. Himmelstein et al., Medical Bankruptcy in the United States, 2007: Results of a National Study, 122 Am. J. Med. 741 (2009).
- 44. See Amy Finkelstein et al., The Oregon Health Insurance Experiment: Evidence from the First Year (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), available at http://www.oregonhealthstudy.org/en/researchers/Oregon_Health_Insurance_Experiment.pdf.
 - 45. Id. at 1.

(insured individuals were 10% more likely to not screen positive). 46

In the United States, the patchwork system of health insurance has led to significant disparities in access to care, particularly based on socioeconomic, racial and ethnic status. Critically, as HHS noted in its Action Plan To Reduce Racial and Ethnic Health Disparities:

Lack of insurance, *more than any other demographic or eco-nomic barrier*, negatively affects the quality of health care received by minority populations. Racial and ethnic minorities are significantly less likely than the rest of the population to have health insurance. They constitute about one-third of the U.S. population, but make up more than half of the 50 million people who are uninsured. ⁴⁷

Therefore, an essential component of reducing health disparities in the United States must be creation of a system of universal health insurance.

III. MEDICAID PRIOR TO THE ACA: LIMITED ELIGIBILITY AND COVERAGE

Created in 1965 as part of President Lyndon Johnson's Great Society, the Medicaid program, Title XIX of the Social Security Act, 48 has made an enormous difference in the lives of enrollees, giving them access to affordable health services and protection against financial ruin from health care bills. Medicaid is a joint federal-state program that pays for medical assistance for certain specified categories of individuals and families, and it is the largest source of funding for health services for America's poor. Though popular perception has been that being extremely poor will qualify a person for Medicaid, this is not and has never been the case—rather, to qualify for Medicaid, an adult individual must generally be poor *and* fit within a specified category: for example, having dependent children, being pregnant, or receiving Supplemental Security Income assistance.⁴⁹

^{46.} Id.

^{47.} U.S. Dep't of Health & Human Servs., Action Plan to Reduce Racial and Ethnic Disparities 2 (2011) (emphasis added).

^{48. 42} U.S.C § 1396 (1988).

^{49.} See Medicaid Program Description and Legislative History, U.S. Soc. Sec. Admin., http://www.ssa.gov/policy/docs/statcomps/supplement/2011/medicaid.html (last visited Apr. 18, 2013). Since 1997, very poor children have been eligible for care under terms more inclusive (though not more comprehensive) than Medicaid, pursuant to Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP). CHIP was initiated in 1997 and operates to fund health care for low-income children who did not qualify for Medicaid and

One of the hallmarks of the Medicaid program (and a core issue in the ACA litigation) is the extent to which the federal government can condition funding on adherence to federally established requirements for services to be covered (or comprehensiveness of coverage, such as cost-sharing requirements). In general, under the pre-ACA program, states have had broad discretion in determining which groups to cover, other than certain required categories of persons that all states were required to cover.⁵⁰

Under this system, the United States saw not only intrastate disparities in insurance coverage (in which racial and ethnic minorities were disproportionately uninsured, as described in Part II above), but also interstate variability. For example, as of January 2012, only half of the states (twenty-six, including the District of Columbia) cover children in families with incomes up to at least 250% of the FPL, (\$46,325 for a family of three in 2011), with four states restricting eligibility to children whose family income is less than 200% of the FPL. For pregnant women, thirty-nine states have expanded eligibility above the federal minimum of 133% of the FPL, to women with family incomes at or above 185% of the FPL (\$34,280 for a family of three in 2011). 52

The situation is much more critical for low-income parents and other adults, however. To begin with, the federal minimum for coverage of parents is below the FPL in *every* state and below even *half of the FPL* in nearly all states.⁵³ While a number of states have expanded parental eligibility, this expanded coverage is often subject to a combination of reduced benefits and higher cost-sharing—and states can cap the enrollment for these programs. As of July 2012, thirty-three states limited Medicaid eligibility for parents to less than 100% of the FPL (\$18,530 for a family of three in 2011), with seventeen states limiting eligibility to less than 50% of the FPL.⁵⁴ Poor, non-disabled adults with no dependent children are subject to the strictest eligibility require-

would otherwise be uninsured. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (1997) (codified in scattered sections of the U.S. Code). Current law has expanded funding for CHIP through 2015. Children's Health Insurance Program Reauthorization Act of 2009, 42 U.S.C. \S 1396 (2009); ACA, Pub. L. No. 111-148, 124 Stat. 119, 124 \S 10203 (2010).

^{50.} Medicaid Program Description and Legislative History, supra note 49.

^{51.} Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults, Kaiser Family Found., http://www.kff.org/medicaid/upload/7993-02.pdf (last updated July 2012).

^{52.} *Id*.

^{53.} Id.

^{54.} *Id*.

ments—prior to the ACA, states were statutorily prohibited from covering these adults unless they obtained a federal waiver. However, the ACA gave states an option to expand Medicaid to adults as of April 2010, prior to the scheduled 2014 expansion,⁵⁵ and since then, eight states have expanded coverage. ⁵⁶ Still, as of July 2012, coverage for this group remained exceedingly low, with only nine states providing full Medicaid coverage and seventeen additional states providing more limited coverage (and enrollment is closed in a number of these states).⁵⁷

Today, Medicaid covers roughly one in every five Americans, over sixty million people, and accounts for 16% of all personal health spending.⁵⁸ Children make up roughly half of all Medicaid enrollees (thirty-one million), and the remaining half is split about evenly between nonelderly adults (sixteen million, mostly parents) and seniors (six million) and people with disabilities (9.3 million, including 1.5 million children).⁵⁹ Financing for Medicaid is shared between the states and the federal government, with the federal government paying at least 50% in each state, but more in poorer states (74% in the poorest state in 2012), averaging 57% of overall Medicaid costs. 60 As the Oregon Health Study⁶¹ demonstrated, Medicaid makes a significant difference in the lives of enrollees, increasing their use of care, reducing financial instability and, critically, improving selfreported health and well-being.⁶²

Even so, the sharply limited eligibility for Medicaid left a large contingent of United States residents—approximately fifty million individuals—with essentially no ability to access care except via emergency rooms and, to a lesser extent, organizations that provide free care. In this environment, the ACA was viewed as a tremendous step toward increasing access to care and reducing health disparities.

IV. THE AFFORDABLE CARE ACT AND HEALTH DISPARITIES

One of President Obama's top priorities in his first term was health care reform. After a summer of contentious negotiations and an election in which Democrats lost a filibuster-proof (sixty-

^{55.} See infra Part IV.

^{56.} Id.

^{57.} Id.

The Medicaid Program at a Glance, Kaiser Family Found., http://www. kff.org/medicaid/upload/7235-05.pdf. (last updated Sept. 2012).

^{59.} *Id*.

^{60.} Id.

^{61.} See supra Part II.

^{62.} Finkelstein et al., supra note 44, at 4.

vote) majority in the Senate, the Senate passed a proposal for health care reform, the Patient Protection and Affordable Care Act.⁶³ The House had previously passed its own health care reform bill, but given the political reality that a compromise bill would be unable to pass the Senate following the loss of the late Senator Edward M. Kennedy's seat, the House passed the Senate's proposal, and President Obama signed the bill into law on March 23, 2010.⁶⁴ On March 30, 2010, the ACA was amended by the Health Care and Education Reconciliation Act of 2010.⁶⁵

At the time of passage, the ACA was projected to increase the number of insured United States citizens and documented immigrants by thirty-two million, ⁶⁶ which, based on the empirical evidence discussed above, should lead to a reduction in health disparities based on socioeconomic status and racial and ethnic background. In 2009, roughly half of this increase in insurance coverage was projected to come from uninsured individuals without access to affordable employer-based insurance complying with the controversial "individual mandate" and purchasing insurance via the exchanges.⁶⁷ The other half, approximately sixteen million, were to receive coverage via the ACA's Medicaid expansion provision, pursuant to which states would expand their Medicaid eligibility to include all persons with income less than 138% of the FPL, 68 in exchange for very generous federal funding of the new enrollees—100% of the costs for new beneficiaries from 2014 through 2016, scaling down to 90% in 2019 and indefinitely thereafter.⁶⁹

The CBO projected that the ACA would increase the percentage of legal nonelderly residents with insurance coverage to approximately 94%, up from 83%. The remaining twenty-three million uninsured would be roughly one-third undocumented immigrants, who—in a move both short-sighted and contrary to public health—are not only ineligible for subsidies but also statutorily forbidden from purchasing insurance (or enrolling in

^{63.} H.R. Res. 3590, 111th Cong. (2009) (enacted).

^{64.} ACA, Pub. L. No. 111-148, 124 Stat. 119, 124 (2010).

^{65.} H.R. Res. 4872, 111th Cong. (2010) (enacted).

^{66.} Letter from Douglas Elmendorf, supra note 4.

^{67.} Id.

^{68. 42} U.S.C. § 1396a(a) (10) (A) (i) (VIII) (2010); see also Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision, Kaiser Family Found. 6 (Aug. 2012), available at http://www.kff.org/health reform/upload/8348.pdf ("The ACA expanded coverage to 133% FPL and also provides for an income disregard of 5% FPL, effectively extending eligibility to 138% FPL. ACA § 2002(a), adding 42 U.S.C. § 1396a(e) (14) (I).").

^{69. 42} U.S.C. § 1396d(y)(1) (2010).

Medicaid) under the ACA.⁷⁰ The remainder would be a combination of persons eligible for, but not enrolled in, Medicaid, as well as those either unwilling to purchase insurance or unable to do so as a result of financial hardship, for which they can seek an exemption from the mandate.⁷¹

Beyond simply increasing insurance coverage, the ACA contains a number of provisions specifically targeted at health disparities, such as requiring reporting of health disparities data based on race, ethnicity, and language,⁷² reporting on workforce diversity,⁷³ efforts to support and increase community health workers,⁷⁴ creation of offices of minority health within individual federal agencies in the Department of Health and Human Services, 75 as well as support, albeit limited, for specific disparities research and preventive initiatives.⁷⁶ While the ultimate impact of these provisions remains to be seen, their existence is evidence of legislative intent to address the enduring health disparities that plague America.

Moreover, legislators' comments at the time the ACA was enacted strongly indicate the intent to create a system in which all United States citizens and legal residents can access affordable

^{70.} ACA § 1101(d)(1) (illegal immigrants ineligible to participate in high-risk pools); ACA § 1501 (illegal immigrants not subject to individual mandate); AĈA § 1312(f)(3) (illegal immigrants ineligible to purchase insurance via exchanges). The intentional decision not to cover disadvantaged populations, such as illegal immigrants, has significant public health implications, particularly in the area of communicable diseases. Undiagnosed and untreated infectious and sexually transmitted diseases, such as HIV, syphilis, and tuberculosis (especially multidrug resistant strains), pose a major risk to the population. See, e.g., Lawrence O. Gostin, Public Health Law: Power, Duty, RESTRAINT 415 (2d ed. 2008) (noting that disadvantaged groups with inadequate access to healthcare are more likely to develop drug resistant strains of disease than those receiving timely and appropriate care).

^{71.} Letter from Douglas Elmendorf, supra note 4.

^{72. 42} U.S.C. § 300kk(a)(1)(A) (2010); see also Dennis P. Andrulis et al., JOINT CTR. FOR POLITICAL & ECON. STUDIES, PATIENT PROTECTION AND AFFORDA-BLE CARE ACT OF 2010: ADVANCING HEALTH EQUITY FOR RACIALLY AND ETHNI-CALLY DIVERSE POPULATIONS 2 (2010) (explaining how reporting has the potential to "enhance the evidence-base for new health equity improvement initiatives for diverse communities, while, at the same time, raising awareness about the persistence of health disparities and the urgency for action among policymakers and the public").

^{73.} ACA § 5001.

^{74.} ACA § 5403.

^{75.} ACA § 10334.

^{76.} See, e.g., ACA § 6301 (creating a Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research and evaluate health care services outcomes' differences among persons of color); § 4102 (authorizing a national oral health campaign, with an emphasis on disparities). See Andrulis ET AL., *supra* note 72, for additional relevant provisions.

health insurance. For example, Vice President Biden's comments at the presidential signing ceremony immediately after the passage of the ACA were emblematic: "You have turned, Mr. President, the right of every American to have access to decent health care into reality for the first time in American history." Senator Patrick Leahy (D-Vermont) tied the ACA to civil rights legislation, observing the importance of the nondiscrimination provisions to equal access to health care:

These protections were necessary to remedy the shameful history of invidious discrimination and the stark disparities in outcomes in our healthcare system based on traditionally protected factors such as race and gender. . . . [and] to ensure that all Americans are able to reap the benefits of health insurance reform equally, without discrimination.⁷⁸

Representative Patrick Kennedy (D-Rhode Island), son of the late Senator Edward M. Kennedy, who made passage of universal health care a lifelong passion, placed his father's advocacy for health care in context with the efforts of President Kennedy and Dr. Martin Luther King, Jr.:

The parallels between the struggle for civil rights and the fight to make quality, affordable health care accessible to all Americans are significant. It was Dr. Martin Luther King, Jr., who said, Of all forms of inequality, injustice in health care is the most shocking and inhumane. *Health care is not only a civil right, it's a moral issue.*⁷⁹

In fact, shortly before his death, Senator Kennedy wrote a moving letter to President Obama in which he expressed his enormous pleasure that health care would finally become accessible to all Americans:

I saw your conviction that the time is now and witnessed your unwavering commitment and understanding that health care is a decisive issue for our future prosperity. But you have also reminded all of us that it concerns more than material things; that what we face is above all a moral issue; that at

^{77.} Remarks by the President and Vice President at Signing of the Health Insurance Reform Bill, WhiteHouse.gov (Mar. 23, 2010, 11:29 AM), http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill.

^{78.} Press Release, Patrick Leahy, U.S. Senator for Vt., Statement on Comprehensive Health Insurance Reform (Mar. 23, 2010), available at http://www.leahy.senate.gov/press/statement-on-comprehensive-health-insurance-reform.

^{79. 156} Cong. Rec. H1826 (daily ed. Mar. 21, 2010) (statement of Rep. Patrick Kennedy) (emphasis added).

stake are not just the details of policy, but fundamental principles of social justice and the character of our country.

And so because of your vision and resolve, I came to believe that soon, very soon, affordable health coverage will be available to all, in an America where the state of a family's health will never again depend on the amount of a family's wealth. And while I will not see the victory, I was able to look forward and know that we will—yes, we will—fulfill the promise of health care in America as a right and not a privilege.⁸⁰

Thus, hopes were high in the immediate aftermath of the enactment of the ACA that, finally, the United States would join the ranks of other wealthy, industrialized countries in providing affordable health care for all citizens and legal residents. However, lawsuits challenging the constitutionality of the ACA immediately followed the bill's signing. 81

V. THE SUPREME COURT'S DECISION ON THE AFFORDABLE CARE ACT AND SUBSEQUENT DEVELOPMENTS IN HEALTH REFORM

On March 23, 2010, the day that President Obama signed the ACA, the state of Florida, joined by twenty-five other states, filed a lawsuit challenging the constitutionality of the individual mandate and the Medicaid expansion. A second group of plaintiffs, including the National Federation of Independent Business (NFIB), also filed a lawsuit in Florida. Both cases were considered together by the Supreme Court, which upheld the individual mandate as a proper exercise of Congress' taxing authority, but found the Medicaid expansion unconstitutionally coercive under the spending power.

^{80.} Letter from Senator Edward M. Kennedy to President Barack Obama (May 12, 2009) (emphasis added), *available at* http://www.whitehouse.gov/the_press_office/Text-of-letter-to-the-President-from-Senator-Edward-M-Kennedy.

^{81.} Most prominent among them is Florida v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011), aff'd in part, rev'd in part, 648 F.3d 1235 (11th Cir. 2011), aff'd in part, rev'd in part, Nat'l Fed'n Indep. Bus. v. Sebelius (NFIB), 132 S. Ct. 2566 (2012).

^{82.} U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d at 1256. Florida was joined by Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. Id.

^{83.} NFIB, 132 S. Ct. 2566; see also Emily Whelan Parento & Lawrence O. Gostin, An O'Neill Institute Briefing Paper: The Supreme Court's Landmark Decision on the Affordable Care Act: Healthcare Reform's Ultimate Fate Remains Uncertain (Georgetown Law Sch. Commons Briefing Paper No. 7, 2012), available at

A. The Court's Decision: Giving States the Option to Decline the Medicaid Expansion

Although the Court's ruling on the individual mandate received the majority of the initial attention in the press and scholarly community, he Court's ruling on the Medicaid expansion is equally consequential to the decision on the mandate, because it goes to the heart of health care reform—achieving near universal coverage. Under the ACA, states are required to expand their Medicaid eligibility rules to cover all people with income less than 138% of the FPL. If they decline to do so, the ACA allows the Secretary of HHS to revoke not only the money for the Medicaid expansion, but also the federal funding for existing state Medicaid programs—a power that, in any event, the Obama Administration was very unlikely to exercise, but that the plaintiff-states challenged as unconstitutionally coercive. He in the plaintiff-states challenged as unconstitutionally coercive.

In a narrow decision,⁸⁷ the Court upheld the Medicaid expansion itself, but found that the Secretary cannot withdraw existing Medicaid funds for failure to comply with the Medicaid expansion, because the threat of full loss of funding is unconstitutionally coercive.⁸⁸ As one scholar observed, the decision can be seen as

forg[ing] a narrow path between two diametrically opposing points of view, agreeing with the dissenters that the

http://scholarship.law.georgetown.edu/ois_papers/42 (summarizing the Court's decision and its implications for health reform).

^{84.} See, e.g., Rachel Weiner, Individual Mandate Upheld as Tax: Supreme Court Updates, Wash. Post, June 28, 2012, http://www.washingtonpost.com/blogs/the-fix/post/individual-mandate-upheld-as-tax-supreme-court-udpates/2012/06/28/gJQA3gH58V_blog.html; see also Randy Barnett, We Lost. But the Constitution Won., Wash. Post, June 29, 2012, http://articles.washingtonpost.com/2012-06-29/opinions/35461381_1_individual-mandate-insurance-mandate-proper-clause; Jess Bravin & Louise Radnofsky, Court Backs Obama on Health Law, Wall St. J., June 29, 2012, http://online.wsj.com/article/SB1000142405 2702304898704577480371370927862.html.

^{85.} See ACA §§ 2001-02, 124 Stat. 271, 271-81 (2010).

^{86.} It is worth noting that thirteen states (California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, New York, Oregon, Vermont, and Washington) filed amicus briefs supporting the individual mandate and the Medicaid expansion, and two states (Iowa and Washington), were on both sides of the case, as their governors and attorneys general took opposite positions. *See* Kaiser Family Found., A Guide to the Supreme Court's Affordable Care Act Decision (2012), *available at* http://www.kff.org/healthreform/upload/8332.pdf.

^{87.} See id. (Figure 3 has an explanation of the voting breakdown among the Justices on the constitutionality of the Medicaid expansion and the proper remedy.).

^{88.} NFIB, 132 S. Ct. at 2607.

Medicaid expansion amounts to unconstitutional coercion, but then resurrecting the expansion from the dead by fashioning a remedy that ultimately saves its existence.⁸⁹

In essence, the Court considered Medicaid to involve two separate programs: the existing Medicaid program and the Medicaid expansion under the ACA. In his opinion, Chief Justice Roberts distinguished the two, observing that the "original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children," whereas the ACA transforms Medicaid "into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level."

Chief Justice Roberts said that the expansion transforms Medicaid such that "[i]t is 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."91 Though Chief Justice Roberts may be correct that the Medicaid expansion is part of the ACA's plan to provide universal access to health insurance, Justice Ginsburg rebutted Chief Justice Roberts' conclusion that the ACA transforms Medicaid from being a program to care for the neediest among us, aptly observing that "[s]ingle adults earning no more than \$14,586 per year—133% of the current federal poverty level—surely rank among the Nation's poor."92 Indeed, the Medicaid expansion is the sole mechanism by which the very poor are to be covered under the ACA. Nonetheless, Chief Justice Roberts maintained that the expansion constituted a "shift in kind, not merely degree." 93 Moreover, Roberts found that "the financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'-it is a gun to the head," observing that Medicaid accounts for more than 20% of state budgets, on average.94

From a constitutional perspective, the Court's Medicaid expansion decision was problematic. Supreme Court precedent holds that Congress has the power to withhold federal funds provided a reasonable relationship exists between the funding and

^{89.} Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 Health Aff. 1663, 1666 (2012).

^{90.} NFIB, 132 S. Ct. at 2605-06.

^{91.} Id. at 2606.

^{92.} *Id.* at 2636 (Ginsburg, J., concurring in part, concurring in the judgment in part, dissenting in part).

^{93.} *Id.* at 2605.

^{94.} Id. at 2604.

the conditions⁹⁵—in this case Medicaid funds as a condition of revising the program's rules. Congress created Medicaid, and made clear from the onset that it can alter or amend—even abolish—the program at any time.

However, conservative legal scholars have long argued that the spending power should be limited by the principle of coercion—meaning that if states truly have little choice but to comply with spending conditions, the condition would be deemed overly punitive. As other scholars have observed, underlying this argument is "a philosophy that favors a heavily circumscribed role for the federal government in matters of social policy."96 Previously, the Court granted the federal government wide leeway in setting conditions on spending, for example, by upholding the loss of a portion of federal highway funds for failure to raise the minimum drinking age in South Dakota v. Dole. 97 Although in prior cases the Court had accepted the coercion principle in theory, NFIB marked the first time the Court truly embraced it. From a broader perspective, what is most concerning about the decision is that public health, safety, and environmental programs are typically justified under the spending power, which may be in jeopardy going forward. As subsequent developments regarding the ACA have demonstrated, many states are manifestly unwilling to engage in programs benefiting the neediest, even at little to no cost in their budgets.

Notwithstanding the critical importance of the Medicaid expansion to the ACA, under the Court's ruling, states are now free to decline to participate in the Medicaid expansion with no penalty other than forfeiting federal funds that would apply to the expansion. Although the threat of withdrawal of Medicaid funding was always illusory—no administration would seriously consider cutting off a state's Medicaid funding and imperiling the millions who depend on it—the Court's decision has created political space for states to opt out of the expansion.⁹⁸

Thus, each state's decision whether to expand Medicaid will be enormously consequential, given that the expansion is projected to account for millions of newly insured persons who, in

^{95.} See S. Dakota v. Dole, 483 U.S. 203, 211 (1987); Steward Mach. Co. v. Davis, 301 U.S. 548, 590 (1937).

^{96.} Rosenbaum & Westmoreland, *supra* note 89, at 1666.97. *Dole*, 483 U.S. at 211 (upholding the constitutionality of a federal statute conditioning states' receipt of federal funds on adoption of a minimum drinking age of twenty-one).

^{98.} See infra Part V.B.

addition to being poor, are disproportionately members of racial and/or ethnic minority groups. 99

B. The Current State of the Medicaid Expansion

The Court's ruling on the Medicaid expansion has created a dire situation for the poorest United States residents: although persons with income between 100% and 133% of the FPL will be eligible for subsidies to enable them to purchase insurance via the exchanges, the very poorest—those with income below 100% of the FPL—will not receive subsidies, with the almost certain result that they will remain uninsured.

In the immediate aftermath of the decision, many governors expressed skepticism about expanding their Medicaid programs, primarily based on perceived budgetary concerns, ¹⁰⁰ and a number of state officials said they would wait until the November 2012 elections to make a decision. ¹⁰¹ Although the Medicaid expansion was scheduled to take effect in 2014, when the insurance exchanges and individual mandate become effective, the Court's ruling has given states an open-ended option to opt in or out. ¹⁰²

Early predictions were that states would successfully negotiate with the federal government to undertake a partial expansion of Medicaid on the same generous terms provided in the ACA (for example, expanding only to 100% of the FPL rather than 133% as specified in the law), 103 and that most states would even

^{99.} Following the Court's decision in *NFIB*, the CBO now estimates that six million fewer individuals will obtain coverage through Medicaid, but also estimates that three million of those individuals will be eligible for subsidies and purchase insurance via exchanges, leading to a net increase of three million uninsured. Estimates for the Insurance Coverage Provisions of the ACA, *supra* note 7.

^{100.} See Robert Pear & Michael Cooper, Reluctance in Some States over Medicaid Expansion, N.Y. Times, June 29, 2012, http://www.nytimes.com/2012/06/30/us/politics/some-states-reluctant-over-medicaid-expansion.html?page-wanted=all.

^{101.} Id.

^{102.} See Estimates for the Insurance Coverage Provisions of the ACA, supra note 7 (observing that after the Court's ruling in NFIB, states may choose to opt in or out of the Medicaid expansion after 2014).

^{103.} See Rosenbaum & Westmoreland, supra note 89, at 1670; see also CBO Assumes Medicaid Expansion Flexibility in Updated ACA Analysis, InsideHealthPolicy.com (July 24, 2012), http://insidehealthpolicy.com/Inside-Health-General/Public-Content/cbo-assumes-medicaid-expansion-flexibility-in-updated-aca-analysis/menu-id-869.html (observing that "a health care consultant says the updated CBO projections make it seem as though CBO received some guidance on that point to make such a 'strong assumption' about states being able to partially expand Medicaid").

tually expand their programs given the generous federal funding.¹⁰⁴ But neither has yet come to pass.

In December 2012, as part of a series of "Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid," HHS said states could not expand Medicaid to less than 133% of the FPL and still receive 100% of federal matching funds. Thus, states must fully implement the expansion in order to receive the generous funding specified under the ACA. However, states may proceed with partial implementation under existing (lower) federal funding terms. 106

Faced with the decision to opt in or out of the expansion, relatively few states have committed to expanding their programs. As of March 2013, fourteen states, all with Republican governors, have said they will not participate in the expansion: Alabama, Georgia, Idaho, Iowa, Louisiana, Maine, Mississippi, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, and Wisconsin. Another three states, also with Republican governors, have indicated they are leaning against participating. The trend is slightly less partisan among the twenty-five states (and the District of Columbia) that have decided to participate, with eight participating states (Arizona, Florida, Michigan, New Jersey, Nevada, New Mexico, North Dakota, and Ohio) led by Republican governors and one state (Rhode Island) with an independent governor.

^{104.} See Pear, supra note 9 (quoting Sara Rosenbaum, professor of health law and policy at George Washington University, saying "'only a small number of states' would pass up the opportunity to expand Medicaid, given the generous terms of the deal authorized by Congress").

^{105.} Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid, Ctrs. for Medicare & Medicaid Serv. (Dec. 10, 2012), available at http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf.

^{106.} *Id.*; see also Sara Rosenbaum & Timothy Westmoreland, *The Administration's Decision on Partial Medicaid Implementation: True to the Law*, Health Aff. Blog (Dec. 19, 2012), http://healthaffairs.org/blog/2012/12/19/the-administrations-decision-on-partial-medicaid-implementation-true-to-the-law/ (agreeing with the HHS interpretation of its (lack of) authority to allow partial implementation).

^{107.} See The Advisory Bd. Co., Where Each State Stands on the ACA's Medicaid Expansion, http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap (last visited Apr. 18, 2013), for an up-to-date database of states' decisions and statements regarding participation in the Medicaid expansion.

^{108.} Id.

^{109.} *Id.* Indeed, Arizona Governor Jan Brewer surprised many (and dismayed some) when she revealed in her January 2013 "State of the State" speech that she planned to participate in the expansion. *See* Fernanda Santos, *Medicaid Expansion Is Delicate Maneuver for Arizona's Republican Governor*, N.Y. TIMES, Jan. 20, 2013, at A20.

Among the states that have decided against participating in the expansion, many have rates of uninsured considerably higher than the national average of 16%—Texas has the highest rate of uninsured in the country, at 24%, and Georgia, Louisiana, South Carolina (each 20%) and Mississippi (19%) are close behind. 110 Moreover, in many of these states the uninsured are disproportionately comprised of racial and ethnic minorities. For example, in Texas the uninsured are 60% Hispanic¹¹¹ (compared to 38.1% of the general population),¹¹² and in Mississippi the uninsured are 48% Black¹¹³ (compared to 37.3% of the general population).114 Thus, given the composition of the uninsured population in these states, health disparities are likely to widen between the poorest individuals and the general population, as well as among racial and ethnic groups, an outcome no one foresaw when the ACA was passed. For most of these states, failure to participate in the Medicaid expansion will mean forfeiting tremendous reductions in the percentage of uninsured—in Texas, expansion would lead to a 51.6% reduction, with similarly large reductions in Georgia (51.3%), Louisiana (60.1%), and South Carolina (56.7%).¹¹⁵

In an additional wrinkle, many of these states have also declined to establish state-run insurance exchanges, leaving the federal government to step in and run them as provided by the ACA. 116 This development would be unremarkable except for the ongoing case brought by the Oklahoma Attorney General, in which some Texas plaintiffs have moved to intervene, seeking to invalidate an IRS rule affirming that the ACA provides that individuals whose state exchanges are federally-run are equally eligi-

^{110.} Health Insurance Coverage of the Total Population, States (2010–2011), U.S. (2011), Kaiser Family Found., http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3 (last visited Apr. 18, 2013).

^{111.} Texas: Uninsured Rates for the Nonelderly by Race/Ethnicity, States (2010–2011), U.S. (2011), Kaiser Family Found., http://www.statehealthfacts. org/profileind.jsp?ind=143&cat=3&rgn=45 (last visited Apr. 18, 2013).

^{112.} U.S. Čensus Bureau, State and County QuickFacts: Texas (2013), available at http://quickfacts.census.gov/qfd/states/48000.html.

^{113.} Mississippi: Uninsured Rates for the Nonelderly by Race/Ethnicity, States (2010–2011), U.S. (2011), Kaiser Family Found., http://www.statehealthfacts. org/profileind.jsp?ind=143&cat=3&rgn=26 (last visited Apr. 18, 2013).

^{114.} U.S. Census Bureau, State and County QuickFacts: Mississippi (2013), available at http://quickfacts.census.gov/qfd/states/28000.html.

^{115.} JOHN HOLAHAN ET AL., THE URBAN INST., THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE Analysis 8 (2012).

^{116.} State Decisions for Creating Health Insurance Exchanges as of April 1, 2013, Kaiser Family Found., http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17 (last visited Apr. 18, 2013).

ble for subsidies (in the form of premium tax credits) as those whose exchanges are state-run.¹¹⁷ Although the legal claims, which are a matter of statutory interpretation, are dubious at best, and in any event face significant procedural hurdles,¹¹⁸ the case is illustrative of the strong desire in some quarters to gut health reform. If the claims were to succeed, the millions of residents in the states whose exchanges will be federally-run (roughly two-thirds of those participating)¹¹⁹ would be ineligible for subsidies and likely to remain uninsured, thereby further widening socioeconomic, racial, and ethnic health disparities.

The months since the Court decided *NFIB* have not been kind to the ACA. While hopes were once high that almost all United States residents would have access to affordable health insurance, the reality appears to be that a great many poor people will be entirely left out of the ACA's Medicaid expansion, in addition to the undocumented immigrants who were purposely (and short-sightedly, from a public health perspective) excluded from participation in ACA's coverage expansion (either via Medicaid or the insurance exchanges), even at their own cost. Even worse, very little is being said about this unjust result and even less is being done, or even proposed, to remedy the situation.

VI. THE TREMENDOUS INJUSTICE OF LEAVING THE POOREST AND MOST VULNERABLE BEHIND AS THE UNITED STATES MOVES TOWARD "UNIVERSAL" COVERAGE

The importance of the Medicaid expansion to a more just distribution of health care in the United States cannot be overstated. If all states were to refuse the Medicaid expansion, Medicaid coverage would increase by only 5.7 million people by 2022, compared to 21.3 million people if the Medicaid expansion were fully implemented in all states. Without the expansion, the ACA would reduce the number of uninsured United States residents by only 15.1 million (including those with income between 100 and 138% of the FPL, who will be eligible for subsidies to purchase insurance via the exchanges as a fallback option in states who decline to expand Medicaid), compared to 25.3

^{117.} Complaint, Oklahoma *ex rel.* Pruitt v. Sebelius, No. CIV-11-030-RAW (E.D. Okla. Jan. 21, 2011). See Timothy Jost, *A Year-End Affordable Care Act Litigation Round-Up*, Health Affairs Blog (Dec. 31, 2012), http://healthaffairs.org/blog/2012/12/31/a-year-end-affordable-care-act-litigation-round-up/, for an excellent summary of ongoing ACA litigation.

^{118.} Jost, *supra* note 117.

^{119.} State Decisions for Creating Health Insurance Exchanges, supra note 116.

^{120.} Holahan et al., supra note 115, at 6.

million with full expansion implementation. 121 Thus, without the expansion, an additional ten million people will almost certainly be left without health care. With incomes below 100% of the FPL (a mere \$11,170 for an individual, or \$19,090 for a family of three), there is no feasible means by which these people could afford private health insurance or pay out of pocket for health

The clear intent of the ACA was to make affordable health care available to everyone (except undocumented immigrants), thereby reducing health disparities. Indeed, before the Court's decision in NFIB, the Obama Administration used the law as evidence of the fulfillment of United States obligations under international law. For example, in its 2010 period report to the United Nations Human Rights Council in conjunction with the Universal Periodic Review, the United States cited the ACA as evidence of the government's commitment to reduce discrimination in access to health care and health insurance, as well as the commitment to reduce health disparities: "[The ACA will] help our nation reduce disparities and discrimination in access to care that have contributed to poor health."122

But the initial promise of the ACA will remain unfulfilled without significant reforms, as a number of states decline to participate in the Medicaid expansion based on inaccurate and/or misleading cost objections and others refuse on overtly political

^{121.}

U.N. Human Rights Council, National Report Submitted in Accordance with Paragraph 15(a) of the Annex to the Human Rights Council Resolution 5/1: United States of America, ¶¶ 70–73, U.N. Doc. A/HRC/WG.6/9/USA/1 (Aug. 23, 2010). There have been other similar statements made by United States government officials, both in reports and in formal remarks by individual government officials. For example, U.S. State Department's Legal Adviser, Harold Koh, referred to the "recent landmark health care reform" as an example of a federal program created to "empower our citizens to live what FDR called a 'healthy peacetime life.'" Harold Hongju Koh, Response of the United States of America to Recommendations of the United Nations Human Rights Council, U.S. Dep't OF STATE (Nov. 9, 2010), available at http://www.state.gov/s/l/releases/ remarks/150677.htm; U.S. Dep't of State, Fourth Periodic Report of the United States of America to the United Nations Human Rights Committee Concerning the International Covenant on Civil and Political Rights $\P\P$ 27, 44, 88, 90, 434, 498 (2011), available at http://www.state.gov/j/drl/rls/ 179781.htm (noting inter alia that the ACA addresses ICCPR Committee "concerns regarding racial and ethnic disparities in health care access" and that the Medicaid expansion program expands access to care for vulnerable populations); Michael Posner, Assistant Sec'y, Bureau of Democracy, Human Rights & Labor, Address to the American Society of International Law (Mar. 24, 2011), available at http://www.state.gov/j/drl/rls/rm/2011/159195.htm (referring to the ACA as an example of U.S. commitment to basic social and economic needs of its people).

grounds. 123 A first step will be better publicizing accurate estimates regarding the cost of the expansion, which is far from the budget-busting enormity portrayed by some. A second step will be to remind state policymakers that it is in the long-term interest of the state to build a stronger public health by providing affordable health care to everyone—with a healthier population, everyone benefits. But an even more important step will be to demand justice for the least fortunate among us, who deserve better than their elected leaders are providing—for the simple truth is that it is deeply unjust to expend presumably communal government resources to improve the health of middle and upper income Americans while doing nothing for the poorest and most vulnerable, who already disproportionately bear the burdens of early morbidity and mortality.

A. The Unpersuasive "Cost" Arguments

Many states have indicated that cost is a critical—and in some instances deciding—factor in rejecting the Medicaid expansion. For example, Alabama Governor Robert Bentley announced on November 13, 2012 that Alabama will not participate in the Medicaid expansion because the State "simply cannot afford it." Governor Nathan Deal of Georgia similarly stated his belief that the expansion "is something our state cannot afford." Governor Rick Perry of Texas went further in a letter to HHS Secretary Sebelius, referring to the expansion as threatening Texas with "financial ruin." Other governors who have declined to participate or are leaning against expanding their programs have made similar references to budget constraints and concerns that the federal government will not live up to its commitment to fund the program at the levels prescribed by the ACA. 127

These arguments have intuitive appeal in times of serious budgetary constraints—but they are not borne out by empirical

^{123.} See infra Parts VI.A-B.

^{124.} Dana Beyerle, *Bentley: No Insurance Exchange, Medicaid Expansion*, Gadsden Times, Nov. 13, 2012, http://www.gadsdentimes.com/article/201211 13/NEWS/121119936.

^{125.} Kyle Wingfield, *Deal: No Medicaid Expansion for Georgia*, ATLANTA JOURNAL-CONSTITUTION, Aug. 28, 2012, http://blogs.ajc.com/kyle-wingfield/2012/08/28/deal-no-medicaid-expansion-for-georgia/.

^{126.} Letter from Governor Rick Perry to Secretary Kathleen Sebelius (July 9, 2012), *available at* http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf.

^{127.} See Where Each State Stands on the ACA's Medicaid Expansion, supra note 107, for a summary of governors' statements on the Medicaid expansion.

analysis. Rather, nonpartisan analysis shows that costs to states are relatively minimal, particularly when considering the offsetting gains in the reduction of uncompensated emergency care. As a first point, both the absolute and relative cost increases for states are small. In absolute terms, increased state spending on Medicaid under the ACA is projected to be \$76 billion, which, while considerable, still represents only a 3% increase over current spending and is much less than the \$952 billion in projected additional federal expenditures over the same period. When compared to implementing the ACA without the Medicaid expansion, states' share of the additional spending is even less, only \$8 billion from 2013 through 2022, which is a mere 0.3% over projected state Medicaid expenditures under the ACA without the expansion. 129 Moreover, the \$8 billion includes both costs for newly eligible adults (i.e., those who would become eligible only under the expansion) as well as additional participation among currently eligible populations (the "coming out of the woodwork" principle). 130 While \$8 billion is certainly a large expenditure, it pales in comparison to the projected \$800 billion that the federal government would spend, which is a 21% increase over projected expenditures with no states participating in the expansion.

Second, and critically, when accounting for additional factors that reduce costs, states as a whole are likely to see net savings from the expansion. As the Kaiser Commission estimated, combining Medicaid costs with a conservative estimate of \$18 billion in Medicaid savings on uncompensated care leads to a net savings for states of \$10 billion over the period between 2013 and 2022. 131 In addition, the Commission estimates that actual savings are "likely" to be even greater than \$10 billion because of the omission of additional factors that are difficult to estimate. 132 Admittedly, some individual states will see small net increases in their Medicaid expenditures as a result of the expansion—for example, Texas is projected to see a 2.3% net increase 133—but in no state is the increase estimated to exceed 7%, and the majority are projected to be far less. 134 Finally, it is worth noting that states are not bound to participate in the expansion in perpetuity—the Court's ruling essentially gives them the choice

HOLAHAN ET AL., supra note 115, at 1.

^{129.}

^{130.} Id.

^{131.} Id.

^{132.} Id.

^{133.} *Id.* at 11.

^{134.} Id. at 6.

to opt in and, if necessary, opt out at a later date (or participate at a less than "full expansion" level with the lower levels of federal funding applicable to the pre-ACA program). Thus, state refusals to participate in the Medicaid expansion on the ground that it would be a potentially bankrupting endeavor are simply unfounded.

B. Universal Coverage Improves Public Health

Although there has been intense debate about the design and impact of the ACA—with some accurately observing that the law is not structured to maximize population health —there is general agreement that a health care system that is universally available and accessible improves public health. As Gostin et al. have observed,

"an effective medical care system with universal coverage virtually frees public health from playing the role of medical care provider to the poor and uninsured, thereby freeing resources to pursue population-based disease prevention and health promotion activities." Public health agencies would not feel the need to expend scarce resources on safety-net health care clinics if the health care system were accessible and affordable for the entire population. ¹³⁶

The Court's ruling has removed the universality of access to insurance by making the Medicaid expansion optional—but opting out of Medicaid will harm not only the individuals left out but also the broader public health. Indeed, the intense lobbying by hospitals in favor of the expansion (to reduce the amounts they spend on uncompensated care pursuant to EMTALA) is evidence of the expansion's broader implications for public health. Still, state officials who have the long-term health of their residents in mind should understand that everyone is hurt

^{135.} See Lawrence O. Gostin et al., Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being, 159 U. Pa. L. Rev. 1777, 1814 (2011).

^{136.} *Id.* at 1785–86 (citing Thomas G. Rundall, *The Integration of Public Health and Medicine*, 10 Frontiers Health Serv. Mgmt. 3, 15 (1994)).

^{137.} See, e.g., Jeffrey Young, Health Care Reform Defiance by Republican Governors Worries Hospital Industry, HUFFINGTON POST (July 2, 2012, 11:28 PM), http://www.huffingtonpost.com/2012/07/02/health-care-reform-republican-governors_n_1644393.html. Young observes that hospitals support expansion of Medicaid, since without it they will remain uncompensated for care that they provide to uninsured individuals. The hospitals would rather be paid Medicaid rates, which are only a fraction of the true cost of procedures, than be paid nothing at all for services that they are required to provide the uninsured. Id.

when some are left behind. Moreover, this applies with special force to undocumented immigrants, who were purposely excluded and thus will not benefit from the ACA even if states do fully implement the law.

C. The Ethical Imperative to Seek Justice for the Poorest and Most Vulnerable

The injustice of the very poor and vulnerable being denied Medicaid coverage and being ineligible for federal subsidies cries out for reform. Without reform, the inevitable result is widening health disparities based on socioeconomic status and racial and ethnic background. And from an ethical standpoint, health has a special status not only for individuals but also for populations:

Without minimum levels of health, people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art, and provide for the common security. . . . Population health becomes a transcendent value because a certain level of human functioning is a prerequisite for activities that are critical to the public's welfare—social, political, and economic. 138

Public health suffers when there are widespread—and here, eminently avoidable—health disparities. As the WHO Commission on the Social Determinants of Health eloquently stated, "[p]utting right these inequities—the huge and remediable differences in health between and within countries—is a matter of social justice. Reducing health inequities is . . . an ethical imperative." ¹³⁹

This is not to prescribe a precise means by which to reduce health disparities, only to say that elective actions undertaken by states, such as the failure to participate in the Medicaid expansion, that will *inevitably* and *intentionally* harm already vulnerable populations, are inherently unjust. States should have the authority to set their own health priorities. Yet, in doing so, they have a responsibility to allocate scarce resources ethically. A state should fairly and efficiently distribute health services for its entire population. This requires paying special attention to the needs of the most disadvantaged, such as the poor, minorities, women, and people with disabilities. It requires that health services be accessible and acceptable irrespective of socioeconomic status, language, culture, religion, or locality.

^{138.} Gostin, supra note 70, at 8.

^{139.} *Id*.

Certainly, states that forego the Medicaid expansion fail to equitably allocate resources among their citizens. Moreover, even aside from the Medicaid expansion, Congress failed to act ethically toward undocumented immigrants when it purposely barred them from participation in the ACA's coverage-enhancing provisions, even at their own expense—what possible benefit can justify such pettiness? What is most dispiriting about the current state of affairs is how little discussion of the ACA's impact on the poor and vulnerable is found in the media and even the scholarly community. A few mentions regarding undocumented immigrants exist, ¹⁴⁰ as well as some commentary on the status of the Medicaid expansion. ¹⁴¹ But there is no outpouring of concern for those poor and marginalized among us who lack—and will likely always lack—political power and influence. The largely unnoticed tragedy of the Court's ruling in NFIB is that these individuals will be pushed further to the margins of society, their chances for full and rich lives materially diminished by their exclusion from access to affordable health care. Advocates for health for all people, everywhere, must be more vocal in their sup-

reasonable to anticipate an outpouring of concern over such a direction on many fronts—from consumer and patient advocates, civil rights organizations, health care providers who treat the poor and underserved, the managed care industry and other health care industry sectors that derive substantial revenues from their Medicaid business, local governments that bear the burden of uncompensated care, religious leaders, business leaders, and others,

sadly, this public concern does not yet appear to have materialized. *Id.* at 1671; see also Holahan et al., supra note 115; Melissa del Bosque, Rick Perry's Refusal to Expand Texas' Medicaid Program Could Result in Thousands of Deaths, Tex. Observer (Jan. 2, 2013, 3:04 AM), http://www.texasobserver.org/rick-perrysrefusal-to-expand-texas-medicaid-program-could-result-in-thousands-of-deaths/. Texas' decision not to expand Medicaid will contribute to the deaths of 9000 Texans each year, who will not be able to access life-saving care, such as care for chronic conditions. *Id.*

^{140.} See James O. Breen, Lost in Translation—¿Cómo Se Dice, "Patient Protection and Affordable Care Act"?, 366 New Eng. J. Med. 2045 (2012); Bonnie Jerome-D'Emilia & Patricia D. Suplee, The ACA and the Undocumented, 112 Am. J. Nursing 21, 21–27 (2012); Christina Zimmerman, Findings Brief: Undocumented Immigrants, Left Out of Health Reform, Likely to Continue to Grow as a Share of the Uninsured, 14 Health Care Fin. & Org. 1, 1–3 (2011); Julianne Zuber, Healthcare for the Undocumented: Solving a Public Health Crisis in the U.S., 28 J. Contemp. Health L. & Pol'y 350 (2012) (discussing the inequity faced by immigrants banned from purchasing insurance on the exchanges, the burden on the states that this will continue to cause since they will remain responsible for providing emergency care to undocumented people, and the public health issues to which this policy will contribute).

^{141.} See Rosenbaum & Westmoreland, supra note 89. Although Profs. Westmoreland and Rosenbaum opined shortly after the NFIB decision that it would be

port for the Medicaid expansion and its critical place in United States public health. And they must do so now, for if not now, when? It is hard to imagine a better deal for the states. Moreover, health advocates must argue for access to health care for undocumented immigrants, not only as a matter of justice but also in the interest of public health. Without significant changes, the ACA's likely legacy will be that it contributed to the widening of health disparities in the United States, a result unforeseen and unwanted by its supporters.

CONCLUSION

The ACA was structured with the intent of providing affordable health care for all United States residents, but it was upended by the Supreme Court's ruling in NFIB, making the critical Medicaid expansion optional for states. The ruling transformed the ACA from a scheme of universal coverage to, effectively, one more program through which specified classes of persons can access insurance—here, United States adult citizens and legal residents under age sixty-five with income above the FPL who do not have access to affordable employer-based coverage. For them, nondiscriminatory access is guaranteed, with the government subsidizing the cost of purchase. But for the poorest among us, access is imperiled, and states will retain the ability to give or take away the Medicaid expansion as political will ebbs and flows. Furthermore, the situation is even worse for undocumented immigrants, who have no access at all under the ACA.

As states are faced with the choice whether to expand their Medicaid programs, and as the undocumented struggle to access care, it is imperative that health advocates speak publicly and forcefully in favor of truly universal access, dispelling misconceptions about the impact on state budgets, emphasizing the public health benefits that will accrue and, above all, speaking plainly and directly to the tremendous injustice that will be perpetrated against the poorest and most vulnerable if they are left behind.