

6-1-2010

State Constitutionalism and the Right to Health Care

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STATE CONSTITUTIONALISM AND THE RIGHT TO HEALTH CARE

Elizabeth Weeks Leonard^{*}

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

* Professor, University of Kansas School of Law. Gratitude to Dr. Sharon Lee, for compelling me to consider this question, and Neal Johnson, for tireless research assistance. The article benefited immeasurably from faculty workshops at University of the Pacific-McGeorge School of Law; University of Kansas School of Law; American Society of Law, Medicine, and Ethics Health Law Professors Conference; and AALS Conference on Clinical Legal Education; as well as comments by Judge Jeffrey Sutton, Bernard Black, Rob Schwartz, Wendy Parmet, Kevin Outterson, Steve McAllister, Sandy McKenzie, Rick Levy, Rob Glicksman, Chris Drahozal, Steve Ware, and Melanie Wilson.

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INTRODUCTION

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

Most everyone agrees that the system needs to be fixed, but there is sharp disagreement about the best approach. The debates inevitably evoke fundamental values and priorities. One issue is whether health care is a right or entitlement that government should provide to citizens, or whether health care should be distributed like any other market-based good or service, based on private choice and ability to pay. Another central theme is federalism and the respective roles of states and the federal government in health care delivery. Previous attempts to enact broad, federal health care reforms met opposition on both fronts. Private industry feared heavy-handed government regulation, and states feared one-size-fits-all solutions. The historic passage of the 2010 Patient Protection and Affordable Care Act¹ met vigorous opposition before, during, and after passage, especially from states and states' rights proponents.²

1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (as amended by Health Care and Reconciliation Act, Pub. L. No. 11-152, 124 Stat. 1029 (2010)).

2 See Complaint at 21, *Florida v. Sebelius*, No. 3:10-cv-91-RV-EMT (N.D. Fla., Mar. 23, 2010) (complaint by thirteen states, asserting various constitutional arguments, including violation of the Tenth Amendment, against the Patient Protection and Affordable Care Act); Complaint for Declaratory and Injunctive Relief at 6, *Virginia ex rel. Cuccinelli v. Sebelius*,

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

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

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

Proponents of the view that health is a fundamental right that the U.S. government should provide to all would need to identify a source of law supporting the claim. The first place to look for such a guarantee would be the highest law in the land, the U.S. Constitution. This Part affirms the conclusion of courts and other scholars that the U.S. Constitution does not explicitly or implicitly recognize health as a right. Several reasons justify that conclusion and point toward state constitutions as more likely sources of fundamental guarantees of health. First, the U.S. Constitution is primarily concerned with protecting individual liberties and freedom from government intrusion, not specifying governmental duties or obligations. Second, protection of health, safety, and welfare falls squarely within states’ Tenth Amendment reserved powers. Finally, states are better

sued to address diverse health care needs and competing priorities of their residents.

A. *Absence of Textual Support*

The U.S. Constitution contains no express textual reference and has never been interpreted to provide any specific protection for health,³ despite President Franklin D. Roosevelt's impassioned "Second Bill of Rights" State of the Union Address⁴ and recently proposed amendments by Representatives Jesse L. Jackson, Jr. and Pete Stark.⁵ The Preamble, a precatory, non-binding provision, lists among the Nation's goals, "promot[ing] the general Welfare."⁶ Under Article I, Congress is empowered to tax and spend for "the general Welfare,"⁷ but not health, specifically. The Fifth and Fourteenth Amendments provide that the government shall not deprive persons of "life, liberty, or property, without due process of law."⁸ By contrast to several state constitutions, the federal constitution does not ex-

³ See, e.g., TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 24 (2003) (exploring health care entitlements in the United States and the threat of disentanglement); George France, *The Form And Context of Federalism: Meanings for Health Care Financing*, 33 J. HEALTH POL. POL'Y & L. 649, 672 (2008) ("There is no generalized right to health care in either the U.S. Constitution or in federal law."); Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 353 (2008) ("The Federal Constitution is silent on the matters of health and health care."); Tom Stacy, *The Courts, the Constitution, and a Just Distribution of Health Care*, 3 KAN. J.L. & PUB. POL'Y 77, 77 (1993-94) ("[T]he Constitution, as interpreted and enforced by the judiciary, has virtually nothing to say" about distribution of health care.); Kenneth R. Wing, *The Right to Health Care in the United States*, 2 ANNALS HEALTH L. 161, 161 (1993) ("There is nothing that can be characterized—at least in any general sense—as a constitutional right to health care in the United States.").

⁴ President's Message to Congress on the State of the Union, 12 PUB. PAPERS 41 (Jan. 11, 1944) (expressly including the "right to adequate medical care and the opportunity to achieve and enjoy good health"); see also Kinney, *supra* note 3, at 346 (discussing Roosevelt's calling for a "second Bill of Rights"). See generally CASS R. SUNSTEIN, *THE SECOND BILL OF RIGHTS* (2004) [hereinafter SUNSTEIN, *SECOND BILL OF RIGHTS*] (arguing for a new vision of President Franklin D. Roosevelt, constitutional history, and our current political scene); Cass R. Sunstein & Randy E. Barnett, *Constitutive Commitments and Roosevelt's Second Bill of Rights: A Dialogue*, 53 DRAKE L. REV. 205, 205-216 (2005) (discussing Roosevelt's "Second Bill of Rights" speech).

⁵ H.R.J. Res. 30, 110th Cong. (2007) ("Section 1: All persons shall enjoy the right to health care of equal high quality. Section 2: The Congress shall have the power to enforce and implement this article by appropriate legislation."), available at <http://thomas.loc.gov/cgi-bin/query/z?c111:HJ.RES.30>.

⁶ U.S. CONST. pmb1.

⁷ U.S. CONST. art. 1, § 8, cl. 1 (granting Congress powers to "provide for the . . . general Welfare . . .").

⁸ U.S. CONST. amends. V, XIV.

pressly reference the word “health” in any provision. Setting aside well-meaning proposals, the likelihood of a federal constitutional amendment identifying health as a right is all but unimaginable.⁹

In other contexts, the U.S. Supreme Court has found implicit constitutional rights, most notoriously, privacy, in the “penumbras” and “emanations” of the Constitution.¹⁰ One might suggest that the right to health is implicitly and necessarily subsumed within the right to life. But no court has been willing to read the Constitution so broadly. Rather, the Court has expressly declined to recognize other asserted fundamental welfare rights, including financial assistance,¹¹ housing¹² and education.¹³ Federal courts have been increasingly reluctant to recognize new fundamental constitutional rights bearing on individual health, such as the right of terminally ill patients to assisted suicide¹⁴ or to access unapproved drugs to prolong their lives.¹⁵

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- 9 See Frank I. Michelman, *Socioeconomic Rights in Constitutional Law: Explaining America Away*, 6 INT’L J. CONST. L. 663, 670 (2008) (discussing unlikelihood of “a welfare-state amendment”).
- 10 See *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (“The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance.”).
- 11 *Dandridge v. Williams*, 397 U.S. 471, 487 (1970) (declining to find welfare rights in the Constitution). See generally Robert H. Bork, Commentary, *The Impossibility of Finding Welfare Rights in the Constitution*, 1979 WASH. U. L.Q. 695, 695 (discussing skeptical views on constitutional welfare rights); Lawrence G. Sager, *Justice in Plain Clothes: Reflections on the Thinness of Constitutional Law*, 88 NW. U. L. REV. 410, 411 (1993) (“[C]onstitutional claims pointing towards minimum welfare rights have been systematically rebuffed.”).
- 12 *Lindsey v. Normet*, 405 U.S. 56, 74 (1972) (holding that there is no fundamental right to housing).
- 13 *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 24 (1973) (declining to recognize federal right to public education); see also *Kadrmas v. Dickinson Pub. Schs.*, 487 U.S. 450, 458 (1988) (“Nor have we accepted the proposition that education is a ‘fundamental right,’ . . . which should trigger strict scrutiny when government interferes with an individual’s access to it.” (citing *Rodriguez*, 411 U.S. at 33–36)); *Plyer v. Doe*, 457 U.S. 202, 221 (1982) (“Public education is not a ‘right’ granted to individuals by the Constitution. But neither is it merely some governmental ‘benefit’ indistinguishable from other forms of social welfare legislation.” (citing *Rodriguez*, 411 U.S. at 35)); Susan H. Bitensky, *Theoretical Foundations for a Right to Education Under the U.S. Constitution: A Beginning to the End of the National Education Crisis*, 86 NW. U. L. REV. 550, 564–73 (1992) (discussing U.S. Supreme Court cases on public education); Daniel S. Greenspahn, *A Constitutional Right to Learn: The Uncertain Allure of Making a Federal Case Out of Education*, 59 S.C. L. REV. 755, 768 (2008) (“*Rodriguez* has been broadly viewed as denying a right to an education under the Constitution”); Kimberly Jenkins Robinson, *The Case for a Collaborative Enforcement Model for a Federal Right to Education*, 40 U.C. DAVIS L. REV. 1653, 1659 (2007) (describing Court’s holding in *Rodriguez* and citing scholarship advocating federal right to public education).
- 14 *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997); cf. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261 (1990) (finding Due Process liberty interest in patient’s right to refuse life-sustaining treatment but upholding state law requiring clear and convincing evidence of patient’s wishes).

Scholars made an intriguing but unavailing case for a property right to health care as a “public good,” based on the public’s considerable investment in medical education, research, and government health care programs.¹⁶ Several reasons explain the U.S. Constitution’s absence of textual recognition of health and, by contrast, several states’ inclusion of health in their constitutions.

B. Charter of Negative Rights

The U.S. Constitution traditionally is considered a charter of negative rights, whereas state constitutions may embody a broader view.¹⁷ The federal document limits governmental interference with individual rights but does not affirmatively grant rights to individuals or establish mandatory duties on the government.¹⁸ Under the Constitution, we have negative rights to be free from government interference, but not affirmative rights to government services or protection.¹⁹ Other countries, by contrast, do provide affirmative rights

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- 15 See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach*, 495 F.3d 695, 697 (D.C. Cir. 2007) (holding that there is no constitutional right to access experimental drugs); cf. *Gonzales v. Raich*, 545 U.S. 1 (2005) (rejecting Commerce Clause and other constitutional challenges to federal authority to prohibit marijuana use by seriously ill patients under state law). See generally Randy E. Barnett, *Scrutiny Land*, 106 MICH. L. REV. 1479 (2008) (regarding courts’ reluctance to recognize new fundamental rights).
- 16 Mark Earnest & Dayna Bowen Matthew, *A Property Right to Medical Care*, 29 J. LEGAL MED. 65, 67 (2008) (“[A]lthough American law has not directly created a right to health care, Americans’ public investment in the medical industry has.”).
- 17 Robert F. Williams, *Rights*, in 3 STATE CONSTITUTIONS FOR THE TWENTY-FIRST CENTURY: THE AGENDA OF STATE CONSTITUTIONAL REFORM 25–26 (G. Alan Tarr & Robert F. Williams eds., 2006) (discussing absence of positive rights in Federal Constitution and noting presence in some state constitutions).
- 18 See *Barksy v. Bd. of Regents*, 347 U.S. 442, 472–73 (1954) (Douglas, J., dissenting) (“The Bill of Rights does not say . . . what government must give, but rather what it may not take away.”); *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983) (“[T]he Constitution is a charter of negative rather than positive liberties. The men who wrote the Bill of Rights were not concerned that government might do too little for the people but that it might do too much to them.”).
- 19 See Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271, 2273 (1990) (scrutinizing the “conclusory incantation[s]” of a negative constitution); Frank B. Cross, *The Error of Positive Rights*, 48 UCLA L. REV. 857, 886–87 (2001) (describing how courts, even very liberal courts, have declined to implement any rights protecting the financial interests of the impoverished); David P. Currie, *Positive and Negative Constitutional Rights*, 53 U. CHI. L. REV. 864, 886 (1986) (“[T]here remain suggestions of limited affirmative duties in modern state-action cases, where the state has taken any action at all.”); Helen Hershkoff, *Positive Rights and State Constitutions: The Limits of Federal Rationality Review*, 112 HARV. L. REV. 1131, 1133 (1999) (describing the Supreme Court’s view of federal constitution as a “charter of negative rather than positive liberties”); Mark Tushnet, *Civil Rights and Social Rights: The Future of the Reconstruction Amendments*, 25 LOY. L.A. L. REV. 1207,

in their constitutions;²⁰ ours is viewed as exceptional.²¹ Rationales for declining to recognize affirmative constitutional rights include the cost of guaranteeing government services,²² the inappropriateness of courts adjudicating disputes over policy and budget,²³ and a heritage of free enterprise and economic liberties.²⁴

1213 (1992) (“Affirmative governmental action seems to be required to promote social rights In contrast, civil rights seem to be largely negative [merely requiring governments] to stand aside [and] not interfere.”). *But see* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 271–77 (1993) (rebutting conventional assumptions about negative and positive rights and the framers’ view of government’s role in health care).

20 *See* Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT’L L.J. 285, 285 (2004) (analyzing the provisions of the constitutions of countries that address health and health care); Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1, 4–8 (2005) (listing Switzerland, South Africa, India, Norway, Russia, and other examples of countries that specify social and economic rights in their constitutions); *see also* Lisa Forman, *Justice and Justiciability: Advancing Solidarity and Justice through South Africans’ Right to Health Jurisprudence*, 27 MED. & L. 661 (2008) (exploring the South African Constitutional Court’s jurisprudence on the right to health); Puneet K. Sandhu, Comment, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151 (2007) (arguing that the experiences of South Africa and Canada suggest that the creation of a legal right to health care in the United States would not raise justiciability problems).

21 *See* SUNSTEIN, SECOND BILL OF RIGHTS, *supra* note 4, at 127–38 (discussing constitutional exceptionalism); Stephen Gardbaum, *The Myth and Reality of American Constitutional Exceptionalism*, 107 MICH. L. REV. 391, 444–53 (2008) (reframing the issue of positive versus negative rights and surveying other countries’ constitutional recognition of social and economic rights); Judith Resnik, *Law’s Migration: American Exceptionalism, Silent Dialogues, and Federalism’s Multiple Ports of Entry*, 115 YALE L.J. 1564, 1582–83 (2006) (defending American Exceptionalism and unwillingness to conform to international norms, as part of “a special and unique destiny to lead the rest of the world to freedom and democracy”).

22 *But see* STEPHEN HOLMES & CASS R. SUNSTEIN, THE COST OF RIGHTS: WHY LIBERTY DEPENDS ON TAXES 37–52 (1999) (suggesting that it may be just as, if not more, expensive for courts to guarantee contract, tort, and property rights as affirmative social welfare rights); Sunstein, *supra* note 20, at 6–7 (suggesting that costs of ensuring fair trials under Fifth, Sixth, Seventh, and Eighth Amendments are much more costly and time consuming than implementation of social programs); Tushnet, *supra* note 19, at 1214–15 (noting that positive governmental action is required as much for protection of civil rights to vote, free exercise, or free speech as social rights to adequate housing, food, or employment).

23 *See* Bandes, *supra* note 19, at 2327–30 (discussing institutional competence argument); Michelman, *supra* note 9, at 668–71 (discussing argument “that courts are ill-equipped for fine-tuned appraisals of governmental efforts in this field”); Sager, *supra* note 11, at 420 (“[I]mmensely complex questions of social strategy and social responsibility [are] far better addressed by the legislative and executive branches of government [and] seem virtually out of the reach of the judiciary absent special circumstances.”); Sunstein, *supra* note 20, at 16 (“American courts have been reluctant to recognize social and economic rights, in part because of a belief that enforcement and protection of such rights would strain judicial capacities.”).

24 Bandes, *supra* note 19, at 2297, 2300–08 (explaining “penalty/subsidy distinction” for Court’s abortion funding decisions); Sunstein, *supra* note 20, at 17–18 (describing the

Accordingly, the U.S. Supreme Court has repeatedly rejected suggestions to recognize affirmative rights to various public benefits, basic subsistence, or services.²⁵ The government has no constitutional obligation to protect individuals from circumstances that endanger their health or well-being, as the Court famously held in *DeShaney v. Winnebago County Department of Social Services*,²⁶ denying a claim against the state by a severely abused child for failing to protect him from his own father.²⁷ The government also is not required to provide or pay for medical services even if a person's constitutionally protected rights to life or privacy are implicated.²⁸ For example, in *Harris v. McRae*, the Court squarely held that states have no constitutional obligation to pay for abortions, even when the woman's life is at risk.²⁹ A woman has a constitutional right to choose an abortion, but the right is not unduly burdened just because she cannot pay.³⁰ States

"cultural explanation" that social and economic rights are "correlated with the strength of socialist or left-wing elements").

25 For example, see cases *supra* notes 11–13.

26 489 U.S. 189 (1989).

27 See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 87 (2d ed. 2008) (discussing *DeShaney* as example of Supreme Court's "remain[ing] faithful to a negative conception of the Constitution, even in the face of dire personal consequences"); Hershkoff, *supra* note 19, at 1155 (describing *DeShaney* as a "notorious" example of the "baseline assumption that the U.S. Constitution does not guarantee positive rights against the government").

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

29 448 U.S. 297, 316 (1980) ("[A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls into the latter category."); see also *Maher v. Roe*, 432 U.S. 464, 469 (1977) ("The Constitution imposes no obligation on the States to pay for the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents.").

30 *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 507 (1989) (rejecting challenge to state ban on using state facilities for abortions, noting that "the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests.") (quoting *DeShaney*, 489 U.S. at 196); *Maher*, 432 U.S. at 473–74 (noting that right to abortion "protects the woman from unduly burdensome interference with her freedom whether to terminate her pregnancy" but imposes "no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds"); *Beal v. Doe*, 432 U.S. 438 (1977) (finding no Equal Protection violation in state Medicaid program funding childbirth and therapeutic abortions but not non-therapeutic abortions); see also *Rust v. Sullivan*, 500 U.S. 173, 192–93 (1991) (upholding federal regulation prohibiting federal funding to family planning facilities that provide abortion counseling); James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1378–80 (1981) (discussing abortion cases and concluding that

may voluntarily decide to provide certain government benefits, but nothing requires states to give services away for free.³¹ With respect to health care, the Court has recognized only a narrow right to medical care for prisoners and others in custody.³²

Beyond those exceptions, the only federal constitutional protections for health derive from the Equal Protection and Due Process Clauses. But those provisions are implicated only when the government voluntarily assumes a role in providing health care services, as it has under federal programs like Medicare and Medicaid. For Equal Protection purposes, there is a fairly strong case that any government health care services, whether federal or state, must be provided on a nondiscriminatory basis.³³ The chances of an Equal Protection claim succeeding, however, turn largely on the level of scrutiny applied. Claims alleging discriminatory provision of services would likely receive the lowest level, rational basis scrutiny, unless racial discrimination or other suspect classes were involved.³⁴ Thus, almost any go-

“government apparently is free to allocate its scarce medical resources in accordance with its own sense of priorities”); Wing, *supra* note 3, at 164–66 (discussing abortion cases in context of asserted right to health care).

- 31 See *Kadmas v. Dickinson Pub. Schs.*, 487 U.S. 450, 462 (1988) (“The Constitution does not require that such service be provided at all, and it is difficult to imagine why choosing to offer the service should entail a constitutional obligation to offer it for free.”).
- 32 See *Youngberg*, 457 U.S. at 322 (holding that an involuntarily confined mentally disabled individual had a right to minimally adequate training to avoid placement in physical restraints but not a broad right to care and treatment); *Estelle v. Gamble*, 429 U.S. 97, 104, 107 (1976) (holding that “deliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment but finding no violation where prisoner was seen seventeen times over three months); David W. Burgett, *Substantive Due Process Limits on the Duration of Civil Commitment for the Treatment of Mental Illness*, 16 HARV. C.R.-C.L. L. REV. 205, 213 n.32 (1981) (explaining that “right to treatment” does not suggest affirmative right to state services, but rather condition on states’ rights to confine citizens).
- 33 See Blumstein, *supra* note 30, at 1381–85 (considering the role of the Equal Protection Clause and the provision of health services); Currie, *supra* note 19, at 881–82 (1986) (“The only requirement being equality, in theory the state could have corrected the constitutional flaw by abolishing its entire welfare program.”); Stacy, *supra* note 3, at 82 (“But once the government chooses to devote resources to health care, it must do so in a way that promotes rough equality of access . . .”); Wing, *supra* note 3, at 164 (“If the term right to health care has any relevance in describing constitutional doctrine in the United States, it is in reference to those constraints imposed on the government’s discretion once it has exercised its broadly defined powers to provide or finance health or health-related benefits.”).
- 34 See, e.g., *Kadmas*, 487 U.S. at 462–63 (finding no Equal Protection violation in state school bus fee applied only to nonreorganized school districts); *Schweiker v. Wilson*, 450 U.S. 221 (1981) (rejecting Equal Protection challenge and applying rational basis scrutiny to uphold state Medicaid benefits classification); *Jefferson v. Hackney*, 406 U.S. 535 (1972) (finding no Fourteenth Amendment violation in state’s system for allocating fixed pool of welfare money); *Dandridge v. Williams*, 397 U.S. 471 (1970) (applying rational basis scrutiny to review state’s allocation of welfare benefits disproportionately to large

vernmental justification for drawing lines among individuals is likely to pass courts' constitutional muster.³⁵ Litigants have succeeded in Equal Protection challenges to states' denial of public benefits to new residents.³⁶ Nevertheless, Equal Protection does not get to the root of the issue: Whether government is obligated to provide health care in the first place.

Constitutional claims to health theoretically also could be brought under the Due Process clause.³⁷ Accepting that health is not a constitutionally protected right, any Due Process claim, like any Equal Protection claim, would be viable only if the government voluntarily undertakes to provide health care. Even then, the statute or regulation establishing the government service would have to create a legitimate claim of entitlement.³⁸ Furthermore, the government would be liable under Due Process only if it unjustly deprived individuals of the health care service or benefit.³⁹ Courts have been reluctant to find enforceable, individual rights in broad legislative schemes or admin-

and small families); see Wing, *supra* note 3, at 173–74 (discussing Equal Protection claim and unlikelihood of court identifying an implicated suspect class).

35 See Barnett, *supra* note 15, at 1480 (suggesting that claimant “needs a ticket into ‘Scrutiny Land’ where the government must justify its restrictions” by demonstrating a fundamental right, “[o]therwise, she automatically loses”); Hershkoff, *supra* note 19, at 1153 (describing how “prevalent understanding of rationality review” is that it “is not review at all” and “signals the Court’s view that a claim does not merit its institutional attention”). *But see* U.S. Dep’t of Agric. v. Moreno, 413 U.S. 528, 534 (1973) (striking down amendment to Food Stamp Act intended to exclude “hippies” and “hippie communes” from eligibility); Shapiro v. Thompson, 394 U.S. 618, 627 (1969) (holding unconstitutional state welfare program’s exclusion of individuals who had not lived in the state for a year, finding it was no basis for distinguishing old and new residents).

36 See, e.g., Saenz v. Roe, 526 U.S. 489, 498–507, 511 (1999) (holding that California durational residency requirement for Temporary Assistance to Needy Families (TANF) benefits violated Fourteenth Amendment right to travel); Memorial Hosp. v. Maricopa Co., 415 U.S. 250, 269 (1974) (holding that Arizona’s one-year residency requirement for free medical care to indigents violated Equal Protection and right to travel); Shapiro, 394 U.S. at 641–42 (holding that the one-year residency requirement for Aid to Families with Dependent Children (AFDC) violated Equal Protection and right to travel).

37 Mathews v. Eldridge, 424 U.S. 319, 349 (1976) (holding that adequate due process was provided to person whose Social Security disability benefits were terminated); Goldberg v. Kelly, 397 U.S. 254, 264 (1970) (requiring due process before termination of benefits); see also Goss v. Lopez, 419 U.S. 565, 579 (1975) (requiring hearing before suspension or expulsion of public school students).

38 See Bd. of Regents v. Roth, 408 U.S. 564, 577–78 (1972) (requiring a “legitimate claim of entitlement” to create a property interest in continued employment after the expiration of a contract).

39 See Goldberg, 397 U.S. at 261 (finding the Due Process Clause required a pretermination hearing because welfare recipients are destitute, without funds, and in brutal need, and deprivation “without a prior hearing . . . is unconscionable”) (citation omitted).

istrative regulations.⁴⁰ Nor are lawmakers anxious to ascribe entitlement status to government services provided under federal statutes and allow remedies to individuals who are denied or lose government services.⁴¹ For example, no one can claim a right to pension or health insurance benefits upon reaching retirement age, despite paying mandatory payroll taxes to the Social Security Trust Fund,⁴² even if Congress repeals the Social Security Act.⁴³ The narrow Equal Protec-

40 See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 276 (2002) (narrowing the availability of the § 1983 action under federal statutes); see also *Bowen v. Michigan Acad. of Family Physicians*, 476 U.S. 667, 678 (1986) (allowing judicial review based on challenge to validity of Medicare regulations but not benefits calculation); Blumstein, *supra* note 30, at 1375 (noting limits on judicial review of benefits claims); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 416–17 (2008) (suggesting *Gonzaga* endangers fragile Medicaid entitlement); Kinney, *supra* note 3, at 360–61 & nn.171–72 (noting the threat to procedural due process by the “judicial sanction of the diminished status of benefits in government entitlement programs due to their statutory definition” and citing cases); cf. *United States v. Erika, Inc.*, 456 U.S. 201, 206 (1982) (barring judicial review of administrative determinations of the amount of Medicare payments).

41 See, e.g., *Colson v. Sillman*, 35 F.3d 106, 108, 110 (2d Cir. 1994) (holding that applicants for county’s physically handicapped children’s program had no “legally cognizable property-type interest in a government benefit” or “claim of entitlement” to state services); *White v. Moses Taylor Hosp.*, 763 F. Supp. 776, 788 (M.D. Pa. 1991) (denying uninsured patient’s claimed right to treatment based on defendant hospital’s acceptance of federal funds); JOST, *supra* note 3, at 24–51 (discussing constitutional issues with respect to federal health entitlement programs); Hershkoff, *supra* note 19, at 1173 (noting Congress’s 1996 decision to eliminate the Aid to Families with Dependent Children (AFDC) program, “devolving” instead to block grants to states, and the statute’s “purport[ing] to eliminate public assistance as a federal entitlement”); Kinney *supra* note 3, at 360 n.173 (citing statutes affirmatively stating that benefits are not entitlements). See generally Sidney A. Shapiro & Richard E. Levy, *Government Benefits and the Rule of Law: Toward a Standards-Based Theory of Due Process*, 57 ADMIN. L. REV. 107, 108–09 (2005) (discussing the Court’s entitlement approach to due process with respect to government benefits).

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

43 See *Flemming v. Nestor*, 363 U.S. 603 (1960) (upholding Social Security Act amendment terminating benefits of aliens who are deported on certain grounds); JOST, *supra* note 3, at 30–34 (noting the use of the word “entitlement” in Medicare and Medicaid statutes and Internal Revenue Code but a lack of meaningful, enforceable rights after ERISA).

tion and Due Process challenges to government health care services do not establish an affirmative federal constitutional right to health.

C. *Constitutional Allocation of Powers*

The federal structure of the U.S. Constitution provides additional support for turning to state constitutional provisions on health. Article I assigns certain enumerated powers to the federal government. All remaining powers are reserved to the states under the Tenth Amendment.⁴⁴ That allocation of power is constitutionally grounded and part of the Framers' design to facilitate centralized coordination at the federal level, on the one hand, and diffusion of power and respect for state sovereignty, on the other.⁴⁵ While the Constitution allows both federal and state governments to address health, the responsibility falls more squarely within states' reserved powers.

Federal enumerated powers include the power to tax and spend for the general welfare, commerce power, national security powers, and the catch-all necessary and proper clause.⁴⁶ Most federal health legislation is enacted under the spending or commerce powers, including Social Security and Medicare for the elderly and disabled, Medicaid for needy individuals, and the Children's Health Insurance Program (CHIP).⁴⁷ Congress can also use the spending power to en-

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

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

46 U.S. CONST. art. I, § 8.

47 See U.S. CONST. art. 1, § 8, cl. 1, 3; *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (recognizing Medicaid as spending power legislation); *Atkins v. Rivera*, 477 U.S. 154, 156–57 (1986) (describing Medicaid legislation); *Helvering v. Davis*, 301 U.S. 619, 640 (1937) (recognizing Social Security Act as valid exercise of spending power for the general welfare); Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334, 336, 342 (1970) (discussing the historical evolution of federal health laws and recognition of the Social Security Law of as a legitimate exercise of the spending power); Robert F. Rich & William D. White, *Fe-*

tics states to enact laws or implement programs by conditioning federal funds on states' compliance with broad federal program mandates.⁴⁸ Medicaid and SCHIP are prime examples of that sort of cooperative federalism.⁴⁹ States with approved programs receive a percentage-on-the-dollar match from the federal government for every state dollar spent.⁵⁰ Accordingly, states are incentivized to provide generous public benefits, while the federal government shifts a portion of the funding burden to states.⁵¹ The prominence of cooperative federalism in government health care programs demonstrates states' central role in that aspect of the U.S. health care delivery system.

States retain vast powers and broad discretion to carry out state policy objectives.⁵² The Framers recognized that states bear primary

deralism and Health Care Policy, 1998 U. ILL. L. REV. 861, 872 (1998) ("With the enactment of Medicare in 1965, the federal government assumed responsibility for acute care of the elderly.").

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

49 See 42 U.S.C. § 1396 (2006) (Medicaid); 42 U.S.C. § 1397aa (2006) (SCHIP); *Atkins*, 477 U.S. at 156–57 (describing Medicaid as a joint federal-state partnership); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36–37 (1981) (describing Medicaid similarly); *Harris v. McRae*, 448 U.S. 297, 308 (1980) ("Medicaid . . . is a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons."); Huberfeld, *supra* note 40, at 419 ("Medicaid is a classic example of cooperative federalism . . ."); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 10 (2004) ("Medicaid followed the tradition of federal grant-in-aid programs, enacted pursuant to Congress's spending clause powers, which condition the receipt of federal funds by states that elect to participate on compliance with a series of structural and operational conditions of participation."); see also William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor/Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1550 (2007) ("[C]ooperative federalism [programs] typically involve a federal statute that regulates a risk or addresses a social ill or need [but] do not depend solely on federal actors for their implementation and enforcement."); Frank R. Strong, *Cooperative Federalism*, 23 IOWA L. REV. 459, 479–82 (1938) (introducing a symposium on "cooperative federalism"). As one of his first acts in office, President Obama signed legislation expanding (and renaming, as CHIP) SCHIP. See Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111-3, 123 Stat. 8 (2009).

50 See Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 860–61 (1990) (providing a program overview); Elizabeth A. Weeks, *Cooperative Federalism and Health Care Reform: The Medicare Part D "Clawback" Example*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 79, 94–96 (2007) (describing the Medicaid program).

51 See Weeks, *supra* note 50, at 95 & n.132 (citing Strong, *supra* note 51, at 479–82).

52 See Rodriguez, *supra* note 44, at 278 ("[S]tate political entities may exercise all powers (except as limited by the national constitution) necessary to carry out state goals.").

responsibility for people's lives, liberties, and property.⁵³ Health, welfare, and safety fall squarely within states' traditional reserved police powers.⁵⁴ In addition, states' *parens patriae* powers encompass vulnerable members of society, including the mentally ill, children, and poor, who may have special health care needs.⁵⁵ States may also act within the sphere of enumerated federal powers as long as their actions are not prohibited by federal law and do not conflict with, impede the purpose of, or intrude upon an area of exclusive federal regulation, as a matter of preemption.⁵⁶

Most states have broadly exercised their reserved powers, enacting a wide range of regulations governing the practice of medicine and other health professions,⁵⁷ licensing and operation of medical facili-

⁵³ See THE FEDERALIST NO. 45, at 319 (James Madison) (E. Bourne ed. 1937); THE FEDERALIST NO. 17, at 113 (Alexander Hamilton) (E. Bourne ed. 1937); Stanley Mosk, *State Constitutionalism: Both Liberal and Conservative*, 63 TEX. L. REV. 1081, 1083 n.11 (1985) (citing same); see also Erwin Chemerinsky, *The Values of Federalism*, 47 FLA. L. REV. 499, 525 (1995) ("The Framers envisioned that the vast majority of governance would be at the state and local levels and that federal actions would be relatively rare and limited."); Hershkoff, *supra* note 19, at 1166 ("Federal rationality review also rests on the related assumption that states and localities are normatively superior to the national government in dealing with the everyday stuff of life: family relations, public schooling, and the like.").

⁵⁴ See *United States v. Lopez*, 514 U.S. 549, 564 (1995) (noting that "States historically have been sovereign" in areas such as "family law[,] "criminal law enforcement[, and] education"); *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905) ("The authority of the State to enact this [mandatory vaccination] statute is to be referred to what is commonly called the police power—a power which the State did not surrender when becoming a member of the Union under the Constitution. Although this court has refrained from any attempt to define the limits of that power, yet it has distinctly recognized the authority of a State to enact quarantine laws and 'health laws of every description;' indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people of other States.").

⁵⁵ See *infra* notes 238–42 and accompanying text (describing *parens patriae* power).

⁵⁶ See *Champion v. Ames (The Lottery Case)*, 188 U.S. 321, 347–53 (1903) (describing coexisting Federal Commerce Power and state police powers to regulate commerce); *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 436 (1819) (declaring as invalid state laws that "retard, impede, burden, or in any manner control[] the operations" of federal laws); Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 225 (2000) ("Although the Constitution makes a few of the federal government's powers exclusive, the states retain concurrent authority over most of the areas in which the federal government can act.") (citations omitted). See generally Stephen A. Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767 (1994) (examining standard views of preemption); Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727 (2008) (reviewing comparative institutional analysis through the lens of preemption).

⁵⁷ See *Williamson v. Lee Optical*, 348 U.S. 483 (1955) (upholding Oklahoma statute restricting performance of eye examinations and prescription to licensed optometrists and ophthalmologists); *Dent v. West Virginia*, 129 U.S. 114 (1888) (upholding state physician licensure requirements).

ties,⁵⁸ and the business of health insurance.⁵⁹ States establish public health departments and agencies dedicated to protecting the health and welfare of residents.⁶⁰ In addition, most states accept the conditional spending “carrot” and provide health care in cooperation with the federal government.⁶¹ Many states also enact their own initiatives funded and administered solely at the state level.⁶²

States’ reserved powers offer unique opportunities to address social welfare concerns.⁶³ Federal constitutional law establishes a floor,

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

59 See McCarran-Ferguson Act of 1945, 15 U.S.C. § 1012(a) (2006) (“The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”). The McCarran-Ferguson Act was Congress’s explicit reaffirmation of the primary role of states in insurance regulation, following the Supreme Court’s decision in *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533 (1944), upholding application of federal antitrust laws to interstate insurance contracts. The Act made clear that “regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.” 15 U.S.C. § 1011 (2006). State health insurance regulation of employer health plans is significantly restricted by the federal Employee Retirement and Income Security Act of 1974 (“ERISA”), Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified at 29 U.S.C. § 1001–1461).

60 See GOSTIN, *supra* note 27, at 149–55 (describing the history of state and local public health regulation).

61 See Kinney, *supra* note 50, at 855–57 (describing the current “magnitude of the Medicaid program” and federal and state financial and administrative commitments); Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 120 (1995) (noting many existing “cooperative federalism” health care programs); Weeks, *supra* note 50, at 79–80, 79 n.5 (discussing cooperative federalism, Medicare, and Medicaid).

62 JOEL F. HANDLER, *THE POVERTY OF WELFARE REFORM* 62–75 (1995) (describing state experimentation in the 1980s, including varying work programs under the Federal Aid to Families with Dependent Children (AFDC) program); Tammy Murray, Note, *State Innovation in Health Care: Congress’ Broad Spending Power Under a National Health Care System Will Stifle State Laboratories of Democracy*, 3 IND. HEALTH L. REV. 263, 271–72 (2006) (describing state health care financing and other reform efforts); Rich & White, *supra* note 47, at 872–74 (describing state initiatives).

63 See DANIEL J. ELAZAR, *THE AMERICAN CONSTITUTIONAL TRADITION* 113 (1988) (“[S]tate constitutions are important determinants of who gets what, when, and how in America”); G. ALAN TARR, *UNDERSTANDING STATE CONSTITUTIONS* 149 (1998) (describing states’ early recognition of responsibility for social welfare); Daniel Gordon, *Superconstitutions Saving the Shunned: The State Constitutions Masquerading as Weaklings*, 67 TEMP. L. REV. 965, 970 (1994) (“[S]tate constitutions serve as the predominant source of protection for individual rights in the United States”); Paul W. Kahn, *State Constitutionalism and the Problems of Fairness*, 30 VAL. U. L. REV. 459, 464 (1996) (observing that states have the opportunity to address fairness controversies not being resolved satisfactorily at the federal level).

requiring states to recognize at least that minimum level of protection to individual rights. But states may go above the federal floor and accord even greater protection.⁶⁴ While federal constitutional jurisprudence has rejected the notion of a constitutional right to health, states could recognize such a right under their own constitutions. Justice William Brennan, in a series of articles,⁶⁵ expressly urged that states could and should expand protection for individual rights, continuing the Warren Court's civil rights jurisprudence.⁶⁶ States have embraced that charge to varying degrees, as we shall see.

64 See, e.g., *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 280–82 (1990) (recognizing that Missouri is entitled to accord stronger protection to preservation of life than federal law by requiring clear and convincing evidence to terminate life support); see also Buzbee, *supra* note 49, at 1555 (“[F]ederal floors retain the benefits of multiple regulatory voices, protections, and diverse regulatory modalities.”); James A. Gardner, *The “States-As-Laboratories” Metaphor in State Constitutional Law*, 30 VAL. U. L. REV. 475, 483 (1996) (discussing *Cruzan*); Hans A. Linde, *Without “Due Process”: Unconstitutional Law in Oregon*, 49 OR. L. REV. 125, 182 (1970) (urging examination of civil rights claims arising under state constitutions before turning to federal protections); Justin Long, *Intermittent State Constitutionalism*, 34 PEPP. L. REV. 41, 51 (2006) (referring to “the truism that state courts are legally entitled to interpret their state constitutions as more protective of liberty than the Federal Constitution”); Thomas G. Saylor, *Prophylaxis in Modern State Constitutionalism: New Judicial Federalism and the Acknowledged, Prophylactic Rule*, 59 N.Y.U. ANN. SURV. AM. L. 283, 286–89 (2003) (“‘New judicial federalism’ generally refers . . . to the increased tendency of state courts to interpret state charters as sources of rights independent of the Federal Constitution and interpretations of the United States Supreme Court.”).

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

66 See James A. Gardner, *The Failed Discourse of State Constitutionalism*, 90 MICH. L. REV. 761, 762 (1992) (noting that Brennan urged states to look to “state constitutions as potentially more generous guarantors of individual rights than the U.S. Constitution as construed by the Burger Court” and others’ characterizing Brennan’s articles as “the ‘Magna Carta’ of state constitutionalism”); Kahn, *supra* note 63, at 464 (“[Brennan] was eager to preserve the judicial ideals of the 60s and 70s. State constitutionalism represented a kind of forum shopping for liberals.”); Mosk, *supra* note 53, at 1081 (“For the liberal, there is the prospect of continued expansion of individual rights and liberties; the work of the Warren Court can be carried on at the state level.”); Rodriguez, *supra* note 44, at 271 (describing Brennan’s “strategic effort . . . to highlight the value of plumbing the states for individual rights protections in the face of conservative retrenchment”); Robert A. Schapiro, *Identity and Interpretation in State Constitutional Law*, 84 VA. L. REV. 389, 420 (1998) (“The renewed interest in state constitutions was prompted by the desire to entrench and advance the accomplishments of the Warren Court at a time when the federal judiciary was becoming hostile to the expansion of certain claims of individual rights.”).

D. Federalism Policies

Several familiar federalism policy arguments further suggest that constitutional recognition of health is better grounded in state rather than federal law. State legislators may be more accessible and responsive to constituents' interests.⁶⁷ Local representatives also may represent the particular values and concerns of their communities, which may not be shared by the entire nation.⁶⁸ Some scholars reject the notion that community values can be defined strictly by reference to state boundaries.⁶⁹ Even if not aligned with state borders, giving voice to diverse views of the separate sovereign states is a core tenet of our federal system.⁷⁰ Different territories may have different tastes and needs, especially on social policy matters.⁷¹

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- 67 See *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 575 n.18 (1985) (Powell, J., dissenting) ("The Framers recognized that the most effective democracy occurs at local levels of government, where people with firsthand knowledge of local problems have more ready access to public officials . . ."); Chemerinsky, *supra* note 53, at 527 ("[T]o the extent the electorate is small, and elected representatives are thus more immediately accountable to individuals and their concerns, government is brought closer to the people, and democratic ideals are more fully realized."); Betsy J. Grey, *The New Federalism Jurisprudence and National Tort Reform*, 59 WASH. & LEE L. REV. 475, 511 (2002) (noting that one value of federalism is "foster[ing] governments that are more responsive than Congress to the needs of local citizens").
- 68 See Shirley S. Abrahamson, *Reincarnation of State Courts*, 36 SW. L.J. 951, 965 (1982) (suggesting that state constitutional interpretation should consider the state's "peculiarities," including "its land, its industry, its people, its history"); Peter D. Jacobson, *The Federalist Approach to Health Care and its Limitations: Introductory Remarks*, 29 HAMLINE J. PUB. L. & POL'Y vii, xiv (2007-08) ("The individual states are closer to the people, and hence better equipped to reflect their plurality of values."); Schapiro, *supra* note 66, at 403 (discussing the view that state constitutional interpretation "should be guided by various indicia of state distinctiveness").
- 69 See, e.g., Gardner, *supra* note 66, at 823 ("[W]e are a nation, which is to say that we constitute collectively a certain community."); James A. Gardner, *What is a State Constitution?*, 24 RUTGERS L.J. 1025, 1025-26 (1993) (considering the role of the state constitution in the United States); Long, *supra* note 64, at 59-61 (discussing Gardner's notion of "romantic subnationalism"); Schapiro, *supra* note 66, at 441 ("The mistake underlying the various theories of state constitutional interpretation . . . is the conflation of the political unit of the state with an assumed underlying organic community.").
- 70 See Abrahamson, *supra* note 68, at 966 (considering the positive advantages of having both federal and state constitutions); Judith S. Kaye, *Dual Constitutionalism in Practice and Principle*, 61 ST. JOHN'S L. REV. 399, 423 (1987) ("Many states today espouse cultural values distinctively their own."); Long, *supra* note 64, at 101 ("Diversity among the states also permits mobile Americans to vote with their feet.").
- 71 See Alan R. Weil & James R. Tallon, Jr., *The States' Role in National Health Reform*, 36 J.L. MED. & ETHICS 690, 690 (2008) ("[S]tate policies can be more closely tailored to local economic conditions and can reflect local values . . ."); cf. Gardner, *supra* note 66, at 816-17 (describing but later rebutting view that variations in state constitutions "reflect differences in the fundamental value choices and character of the people who made the constitutions").

Political judgments about particular reform proposals are products of personal experience, political ideology, and local economic and social conditions. These factors change substantially as one moves about the United States. If change is to be workable and acceptable, it must take account of the real differences between New York and Idaho, Wisconsin and Louisiana.⁷²

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

In addition, states serve as laboratories of democracy, experimenting and crafting solutions to problems, which can be borrowed by other states and the federal government.⁷³ One state's experience enshrining a constitutional, enforceable right to health care may counsel for or against similar enactments in other states or at the federal level. Massachusetts's 2006 comprehensive state health reform plan offers a recent example of a state experiment to which other states and federal policymakers are looking for ideas and lessons.⁷⁴ California attempted similar reforms but found the model difficult to

⁷² Mashaw & Marmor, *supra* note 61, at 116.

⁷³ *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."); see Chemerinsky, *supra* note 53, at 528–29 ("A final argument that is frequently made for protecting federalism is that states can serve as laboratories for experimentation."); Gardner, *supra* note 64, at 486–87 (suggesting that the states-as-laboratories approach produces potentially valuable information about policy alternatives); Grey, *supra* note 67, at 512 (noting "Justice Brandeis's famous observation about the states as laboratories for experimentation"); Long, *supra* note 64, at 56 (summarizing "laboratories of democracy" rationale for independent judicial interpretation of state constitutions); Rich & White, *supra* note 47, at 868 ("[S]tates have amply demonstrated an ability to come up with innovative new solutions and act as 'laboratories of democracy' in important social policy areas like health care."). *But see generally* David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541 (2008) (arguing that decentralized policymaking and "democratic experimentalism" has failed to produce effective antipoverty law).

⁷⁴ An Act Providing Access to Affordable, Quality, Accountable Health Care, 2005 Mass. H.B. 4479, ch. 58, 2006 Mass. Acts, (codified at Mass. Gen. Laws ch. 111M (2007)); see Christopher Lee, *Massachusetts Begins Universal Health Care*, WASH. POST, July 1, 2007, at A6 ("Massachusetts's new grand experiment could become a model for major changes in health care across the country—if it works."); John E. McDonough, *A Year Later, Health-care Experiment Has Strong Vital Signs*, BOSTON GLOBE, April 11, 2007, at A9; Kevin Sack, *With Health Care for Nearly All, Massachusetts Now Faces Costs*, N.Y. TIMES, March 16, 2009, at A1 (describing Massachusetts's 2006 health reform law as "perhaps the boldest state health care experiment" and noting that "[w]ith Washington watching, the state's leaders are again blazing new trails" with cost-containment efforts); see also Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1284–94 (2007) (outlining the Massachusetts plan); Robert Steinbrook, *Health Care Reform in Massachusetts—Expanding Coverage, Escalating Costs*, 385 NEW ENG. J. MED. 2757, 2757 (2008) (detailing the Massachusetts plan).

adapt.⁷⁵ President Obama's campaign proposals and congressional proposals included key components of the Massachusetts health reform initiatives,⁷⁶ as does the recently enacted federal statute.⁷⁷ Especially on controversial issues, it may be beneficial to allow public sentiment and judicial deliberation slowly to percolate up from the states, rather than rushing a broad, federal pronouncement that may generate backlash or ill-fitting solutions.⁷⁸

Arguments in favor of a federal approach to health reform include uniformity, universality, portability, comprehensiveness, and fiscal viability.⁷⁹ If health care is a right, or at least a significant public concern, it may be important that all citizens receive the same core

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- 75 Associated Press, *Arnold's Health Plan to Stir Debate*, WASH. TIMES, Jan. 9, 2007, at A3; Jim Carlton, *Schwarzenegger Embarks on Fight for Health Plan*, WALL ST. J., Jan. 9, 2007, at A2 (noting that Massachusetts's Republican governor "struck a bipartisan deal with his state's legislature last year"); Sonya Geis & Christopher Lee, *Schwarzenegger Proposes Universal Health Coverage*, WASH. POST, Jan. 9, 2007, at A3; Lee, *supra* note 74 at A6 ("Gov. Arnold Schwarzenegger (R) is pushing a similar plan in California, and other states are watching closely."); Sara Watson Arthurs, *Health Plan Brings Praise, Concerns*, TIMES-STANDARD (Eureka, Cal.), Jan. 10, 2007; *All Things Considered: The Massachusetts Health Plan, and California's* (National Public Radio broadcast Jan. 10, 2007), available at 2007 WLNR 547932; see Weeks, *supra* note 74, at 1299–1301 (comparing Massachusetts law and California proposal).
- 76 See Linda J. Blumberg & John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 NEW ENG. J. MED. 1, 6 (2009) (noting that Massachusetts is the only state to require individuals to obtain health insurance); Ceci Connolly, *Kennedy's Health-Care Measure to Require Employers to Chip In*, WASH. POST, May 29, 2009, at A3; Robert Pear, *Sweeping Health Plan is Drafted by Kennedy*, N.Y. TIMES, June 6, 2009, at A13 (describing key components of American Health Choices Act); Kevin Sack, *Massachusetts, Model for Universal Health Care, Sees Ups and Downs in Policy*, N.Y. TIMES, May 28, 2009, at A19; Kevin Sack, *One State's Lesson on Health Care*, N.Y. TIMES, March 29, 2009, at WK1, 4 (side-by-side comparison of Massachusetts Plan and Obama's proposals).
- 77 Patient Protection and Affordable Care Act, § 1501, Pub. L. No. 111-148, 124 Stat. 119 (2010) (individual mandate); *id.* §§ 1511–15 (employer mandate); *id.* § 1321 (state-based Exchanges).
- 78 See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (holding that the constitutional right of privacy encompasses a woman's decision to terminate pregnancy but that a state may have compelling justifications for limiting the right); Adam Liptak, *Gay Vows, Repeated from State to State*, N.Y. TIMES, April 12, 2009, at WK1 (suggesting that state-by-state recognition of same-sex marriage rights may be preferable a to U.S. Supreme Court decision because the Court's previous "decisions on issues like school desegregation, abortion and same-sex marriage can raise questions about the judicial branch usurping the democratic process," shut down developments in state law, and generate lasting backlash).
- 79 Mashaw & Marmor, *supra* note 61, at 118 (listing desirable federal standards for health reform); Rich & White, *supra* note 47, at 867 ("[T]he federal government can ensure equity through uniform national standards."); see also Robert L. Glicksman & Richard E. Levy, *A Collective Action Perspective on Ceiling Preemption by Federal Environmental Regulation: The Case of Global Climate Change*, 102 NW. U. L. REV. 579, 598–99 (2008) (discussing uniformity).

package of services.⁸⁰ Federal legislation and enforcement can effect uniform standards.⁸¹ Moreover, federal benefits are portable, allowing people to move from state to state without losing or having to change their health care benefits.⁸² The federal government may also have greater administrative capacity and financial resources than states to implement broad social policies.⁸³ To the extent that health reform requires subsidies or redistribution of resources, the federal government can achieve that objective on a national scale.⁸⁴

Federal programs also might avoid race-to-the-bottom and in-migration problems that could occur at the state level.⁸⁵ The race-to-the-bottom argument suggests that if one state offers generous gov-

80 Kinney, *supra* note 50, at 857 (“This lack of uniformity [in Medicaid] may arguably be undesirable from an equity perspective but it follows inevitably from Congress’s decision to . . . give[] states great authority to structure programs within federal constraints.”); Mashaw & Marmor, *supra* note 61, at 119 (“Citizens and resident aliens are the proper beneficiaries of guaranteed health insurance and no good case exists for permitting variation in this national standard.”); Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127, 132 (1995) (advocating that federal programs should be applied no matter how individual states’ health programs may differ).

81 See, e.g., Patient Protection and Affordable Care Act, § 1304 (defining “Qualified Health Plans”).

82 See Mashaw & Marmor, *supra* note 61, at 123 (suggesting that the “obvious solution” to individuals having to change insurers when they move is “a national requirement that states recognize the terms of other states’ health insurance programs”).

83 Jacobson, *supra* note 68, at xv (“Resource availability also favors federal implementation.”); Rich & White, *supra* note 47, at 867 (“The first is that the federal government has superior administrative capacity and greater will to implement social policy than the states.”); Super, *supra* note 73, at 558 (“To the extent that state and local governments lack the resources to fund important activities, democratic experimentalism assumes Congress will fund them to pursue broadly defined purposes.”).

84 Rich & White, *supra* note 47, at 867 (“[F]ederal government can redistribute resources on a national basis, whereas the states . . . are limited to internal redistribution.”); Super, *supra* note 73, at 577 (“Decentralization imposes the burden of redistributing to low-income people on narrow segments of society . . .”).

85 See Saenz v. Roe, 526 U.S. 489, 509–10 (1999) (“The Solicitor General also suggests that . . . ‘States might engage in a “race to the bottom” in setting the benefit levels in their [welfare] programs.’”) (citation omitted); Charles Barrilleaux & Paul Brace, *Notes from the Laboratories of Democracy: State Government Enactments of Market- and State-Based Health Insurance Reforms in the 1990s*, 32 J. HEALTH POL. POL’Y & L. 655, 670 (2007) (“[S]tates may engage in a race to the bottom in which they compete with their neighbors to provide the least generous benefits.”); Dennis C. Mueller, *Federalist Governments and Trumps*, 83 VA. L. REV. 1419, 1426 (1997) (describing “welfare effects of mobility across communities”); Jonathan Rodden & Susan Rose-Ackerman, *Does Federalism Preserve Markets?*, 83 VA. L. REV. 1521, 1549 (1997) (“Interjurisdictional competition . . . provides incentives for subnational units to produce externalities that favor local businesses and citizens and export costs onto others.”); Super, *supra* note 73, at 557 (suggesting that arguments in favor of democratic experimentalism assume the absence of factors such as “externalities from one state or locality’s actions that affect another state or locality”); cf. Glicksman & Levy, *supra* note 79, at 597–98 (describing race to the bottom concern with state environmental regulation).

ernment benefits while neighboring states do not, people may be tempted to move to the more generous state.⁸⁶ As more people move, the generous states' costs rise.⁸⁷ The negative incentive, then, is for the state to offer minimal government benefits in the first instance, thereby avoiding the undesired in-migration and increased cost burdens.⁸⁸ The concern is exacerbated because federal Equal Protection prohibits states from imposing durational residency requirements for government benefits.⁸⁹ Those economic incentive arguments against state benefits should not be given undue weight, however, as various sources rebut the "welfare magnet" notion that people move simply to obtain government services. In fact, those most in need of government assistance may be the least able to relocate.⁹⁰

86 As the Court recognized in *Memorial Hosp. v. Maricopa County*, considering a state law denying public hospital care to new immigrants:

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

415 U.S. 250, 257 (1974).

87 See *Saenz*, 526 U.S. at 506 ("California has instead advanced an entirely fiscal justification for its multitiered scheme. . . . [which] will save the State approximately \$10.9 million a year."); Mueller, *supra* note 85, at 1426 (discussing example of better schools and noting that the family that moves "may impose further costs on the community it enters by overcrowding its schools").

88 See, e.g., *Plyler v. Doe*, 457 U.S. 202, 228 (1982) (recognizing that "a State might have an interest in mitigating the potentially harsh economic effects of sudden shifts in population"); *Shapiro v. Thompson*, 394 U.S. 618 (1969) (noting that the state's justification for a waiting period was that if "people can be deterred from entering the jurisdiction by denying them welfare benefits during the first year, state programs to assist long-time residents will not be impaired by a substantial influx of indigent newcomers").

89 See, e.g., *Saenz*, 526 U.S. at 510–11 (holding that California durational residency requirement for Temporary Assistance to Needy Families (TANF) benefits violated Fourteenth Amendment right to travel); *Mem'l Hosp.*, 415 U.S. at 269 (Arizona one-year residency requirement for free medical care to indigents violated Equal Protection and right to travel); *Shapiro*, 394 U.S. at 641–42 (one-year residency requirement for Aid to Families with Dependent Children (AFDC) violated Equal Protection).

90 See *Saenz*, 526 U.S. at 506 ("[A]lthough it is reasonable to assume that some persons may be motivated to move for the purpose of obtaining higher benefits, the empirical evidence reviewed by the District Judge, which takes into account the high cost of living in California, indicates that the number of such persons is quite small"); Scott W. Alford & Sheldon Danziger, *Welfare Magnets: Myth or Reality?*, 62 J. POL. 350, 363 (2000) (concluding that single parents do not move frequently, and when they do it is for reasons other than taking advantage of a state's welfare benefits); F.H. Buckley & Margaret F. Brinig, *Welfare Magnets: The Race for the Top*, 5 SUP. CT. ECON. REV. 141, 162 (1997) (concluding that moving costs alone cannot explain the existence of payout differentials

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

II. STATE CONSTITUTIONAL PROVISIONS ON HEALTH

This Part surveys state constitutions that expressly refer to health and case law relying on those provisions. Thirteen state constitutions specifically mention health.⁹¹ Six of those provisions have been judicially interpreted.⁹² Another state's constitutional provision on "beneficent provision" for the needy has been interpreted to encompass health care.⁹³ One additional state judicially recognizes health care as a fundamental value, despite the absence of express constitutional reference.⁹⁴

A. Overview of State Constitutional Provisions

The year of adoption for state constitutional provisions on health varies widely.⁹⁵ The earliest provision dates back to 1869, along with two others enacted in the late 1800s. The last two states admitted to the Union, Alaska and Hawaii, have constitutional provisions on health. Alaska's, adopted in 1956, pre-dates its statehood by three years. Hawaii's is the most recently adopted, in 1978. Six others date to the 1970s. One state's constitutional amendments addressing health were added in the late 1930s, at the time of progressive federal reforms, including the Social Security Act, designed to promote re-

among the states); Super, *supra* note 73, at 582 ("[R]esearch is mixed [on whether individuals] respond to interstate differences in welfare policy . . ."); cf. PAUL E. PETERSON & MARK C. ROM, WELFARE MAGNETS: A NEW CASE FOR A NATIONAL STANDARD 82–83 (1990) (noting that welfare policies may affect geographic residency choices in the long-term, if not the short-term).

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

92 See *infra* Part II.B.

93 N.C. CONST. art. XI § 4 ("Beneficent provision for the poor, the unfortunate and the orphan is one of the first duties of a civilized and Christian state."); see *infra* Part II.B.3 (discussing North Carolina case law).

94 See *infra* Part II.B.7 (discussing New Jersey cases).

95 See *infra* Appendix A (chart listing text of provisions and dates of adoption).

covery after the Great Depression.⁹⁶ Another state's was adopted in the early 1960s Great Society era, which brought federal programs to address poverty and social injustice, including Medicare and Medicaid.⁹⁷

The text of state constitutions reveals certain trends. Some constitutions arguably create enforceable rights.⁹⁸ Others merely recognize health as an important value, public concern, or aspiration. Some contain mandatory language that the state or, specifically, state legislature, "shall pass suitable laws" or "shall provide" for the health of citizens. Other constitutions identify the state's power or authority over health but do not establish a duty. In addition to varying strength of rights-creating language, state constitutions differ in their inclusiveness. Some limit the right or duty to the indigent, insane, or other vulnerable members of society. Other constitutions specify types of services, such as public health or hospital care. All of the provisions fall well short of a broad guarantee of health.

B. Judicial Interpretation of State Constitutions

Judicial interpretation of the relevant provisions is relatively thin. Most cases rely on the constitutional provisions pertaining to health indirectly to support a conclusion on a different question. When state courts have enforced the provisions, the holdings have been deliberately narrow. State courts seem to draw careful lines to avoid recognizing broad, enforceable rights to health.

1. Michigan

Michigan is a useful starting point because it has seen the most direct attempt to enforce a right to health care. Article 1, section 51 of Michigan's Constitution provides: "The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for

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

97 STARR, *supra* note 96, at 367-74 (describing Great Society programs and Medicare and Medicaid enactment); Peter B. Edelman, *Toward a Comprehensive Antipoverty Strategy: Getting Beyond the Silver Bullet*, 81 *GEO. L.J.* 1697, 1710-18 (1993) (describing Great Society programs and aftermath).

98 *See infra* Appendix B (chart summarizing similarities and differences in the text of state constitutional provisions).

the protection and promotion of the public health.”⁹⁹ The first sentence is largely aspirational, expressing a shared value and concern for health as a primary responsibility of the state.¹⁰⁰ By its terms, the constitution recognizes “public health” and “general welfare,” not individual rights. The second sentence uses mandatory language, requiring the legislature to pass public health laws.

In *Michigan Universal Health Care Action Network v. State*,¹⁰¹ various advocacy groups brought a class action on behalf of uninsured and underinsured residents, seeking a declaratory judgment that Article I, section 51 requires the legislature to establish a state-wide health care plan.¹⁰² The court of appeals’ brief, unreported opinion affirmed the trial court’s dismissal for lack of standing.¹⁰³ The appeals court noted that section 51 is not self-executing and merely empowers the legislature to enact laws.¹⁰⁴ Despite the mandatory language in the second sentence, the court concluded that the provision did not “require the state to provide state-funded health care coverage.”¹⁰⁵ Accordingly, the plaintiffs could not show the requisite “causal connection between the State’s alleged failure to comply with the constitution by enacting a health care plan and the plaintiff’s injuries, allegedly caused by their lack of health coverage.”¹⁰⁶ The case was dismissed without reaching the merits.

The few other Michigan cases referring to section 51 involved malpractice or negligence suits against state or county health care facilities. The defendants claimed governmental immunity. In two of the cases, patients themselves were injured by hospital staff.¹⁰⁷ In the third case, a third-party in the community was injured by an inpatient on a grounds pass.¹⁰⁸ In all three cases, the courts held that the hospital entities and employees were immune from liability, noting that

99 MICH. CONST. art. 4, § 51 (2009).

100 See Gary A. Benjamin & Shaakirrah R. Sanders, *Michigan’s Duty to Provide Access to Health Care*, 6 J.L. SOC’Y. 1, 13 (2005) (“[A]t the very least, it means that health care is a governmental function.”).

101 No. 261400, 2005 WL 3116595 (Mich. App. 2005).

102 *Id.* at *1; see Benjamin & Shaakirrah, *supra* note 100, at 32–33 (discussing case background, with appellate review pending).

103 *Mich. Universal*, 2005 WL 3116595, at *1.

104 *Id.* at *2.

105 *Id.*

106 *Id.*

107 *Perry v. Kalamazoo State Hosp.*, 273 N.W.2d 421 (Mich. 1978) (patient was placed in restraints and asphyxiated on his own vomit); *Coen v. Oakland County*, 400 N.W.2d 614 (Mich. 1986) (patient was allegedly injured by prescription drugs).

108 *Hamilton v. Reynolds*, 341 N.W.2d 152 (Mich. 1983) (woman was killed in her home by patient released on grounds pass).

they were acting “in furtherance of the state’s constitutional mandate to protect and promote public health.”¹⁰⁹ With respect to enforceable health rights, the decisions give with one hand and take away with the other. They first acknowledged the state’s duty to provide care and treatment but then held the governmental actors immune for failing to properly carry out the duty.¹¹⁰ The relevance of the constitution was merely to establish that the defendants were carrying out a public function. As interpreted by Michigan courts, Article 1, section 51 does not create and, in fact, seems to negate, any enforceable claim with respect to state action or inaction.

2. *New York*

Another promising venue for constitutional protection of health is New York, which has been widely acknowledged as a bastion of social and economic rights.¹¹¹ Two constitutional provisions could be interpreted as establishing health rights. First, the “Aid to the Needy Provision,” Article 17, section 1: “The aid, care, and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.”¹¹² Second, the “Public Health Provision,” Article 17, section 3: “The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefore shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.”¹¹³ The provisions identify “aid, care, and support” and “health” as matters of “public concern.” Both provisions use mandatory “shall” language but ac-

109 *Id.* at 154 (citing section 51); *see also Coen*, 400 N.W.2d at 615–16 (citing section 51); *Perry*, 273 N.W.2d at 423 n.4 (quoting section 51);

110 In *Perry*, the claim was framed as a breach of the defendant hospital’s “duty to provide for the care, treatment and custody of its patients.” 273 N.W.2d at 422 n.1. *Coen* noted that “the provision of mental health services . . . involves an activity impliedly mandated by the state constitution.” 400 N.W.2d at 615.

111 *See TARR*, *supra* note 63, at 149 (suggesting that New York “pioneered” state efforts, “committing itself explicitly to providing for the social welfare of its residents”); Williams, *supra* note 17, at 25 (citing New York’s Constitutional provisions as examples of positive rights); Hershkoff, *supra* note 19, at 1144–45 (citing the New York Constitution as an example of a mandatory obligation on the state); Alan Jenkins & Sabrineh Ardalann, *Positive Health: The Human Right to Health Care Under the New York State Constitution*, 35 FORDHAM URB. L.J. 479, 483 (2008) (“New York’s Constitution is particularly protective of [education, shelter, and health care] rights.”); Sunstein, *supra* note 20, at 13–14 (describing New York as “exemplary” of state “constitutional declaration of social and economic rights”).

112 N.Y. CONST. art. 17, § 1 (2006).

113 *Id.* § 3.

cord discretion to the legislature to determine “in such manner and by such means” to provide state assistance.

In 1938, New York adopted five amendments, including the Aid to the Needy and Public Health Provisions, expressly recognizing welfare needs of citizens as matters of public concern. Other amendments addressed care and treatment for persons with mental illnesses¹¹⁴ and housing for low-income citizens.¹¹⁵ The Public Health Provision aimed primarily at public health and hygiene concerns of the era, such as sanitation and vaccination. But reports from the Constitutional Convention suggest that lawmakers also discussed important, then-recent medical advances and the eventual need for universal health care.¹¹⁶ Despite those aspirational beginnings, the New York constitutional provisions have not supported broad claims to health rights.

There is little, relevant case law on the Public Health provision. Most cases merely recognize local public health departments’ authority to promulgate rules and regulations.¹¹⁷ When plaintiffs have asserted individual claims under the Public Health Provision, courts have side-stepped the question. For example, in *Hope v. Perales*,¹¹⁸ plaintiffs charged that a state parental assistance program that did not cover abortions as medical services violated the Public Health Provision.¹¹⁹ The court held that the parental assistance program was not aimed at protecting the public’s health; therefore, the Public

114 *Id.* § 4 (“The care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by state and local authorities and in such manner as the legislature may from time to time determine.”).

115 N.Y. CONST. art. 18, § 1 (2006) (“Subject to the provisions of this article, the legislature may provide in such manner, by such means and upon such terms and conditions as it may prescribe for low rent housing and nursing home accommodations for persons of low income as defined by law . . .”).

116 See Martha F. Davis, *The Spirit of our Times: State Constitutions and International Human Rights*, 30 N.Y.U. REV. L. & SOC. CHANGE 359, 392 (2006); Helen Hershkoff, *Welfare Devolution and State Constitutions*, 67 FORDHAM L. REV. 1403, 1415–25 (1999) (discussing history of Article XVII); Jenkins & Ardalann, *supra* note 111, at 483–95 (discussing history of amendments); see also STARR, *supra* note 96, at 182–89 (describing New York’s early public health interventions); Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 75–85 (2003); R.L. Duffus, *Shall Medicine Be Socialized? A Big Issue Is Joined*, N.Y. TIMES, Dec. 4, 1932, at XX7; S.J. Duncan-Clark, Editorial, *Doctors and Laity in Row over Health*, N.Y. TIMES, Apr. 21, 1929, at 1 (“The mounting cost of medical care has become a most serious problem for many persons of moderate means.”).

117 See, e.g., *Conlon v. Marshall*, 59 N.Y.S.2d 52, 55–56 (1945) (regarding New York City tuberculosis regulation).

118 634 N.E.2d 183 (N.Y. 1994).

119 *Id.* at 188.

Health Provision was inapplicable.¹²⁰ Similarly, in *Aliessa v. Novello*,¹²¹ the court declined to rely on the Public Health Provision to uphold a challenge to the state's denial of Medicaid to undocumented immigrants. The court instead recognized a duty to provide Medicaid benefits to the plaintiffs based on the Aid to the Needy Provision.

The *Aliessa* court cited the U.S. Supreme Court's decision in *Memorial Hospital v. Maricopa County*,¹²² which identified health care as a "basic necessity of life."¹²³ *Maricopa* struck down a state durational residency requirement for publicly funded nonemergency hospitalization or medical care as violating the constitutional right of interstate travel by denying newcomers the "basic necessities of life."¹²⁴ The key point in both *Aliessa* and *Maricopa* was that state benefits must be available equally to both newly-arrived and longer-term residents. But the cases do not recognize any baseline right to state-provided medical care.

The Aid to the Needy Provision, while not expressly mentioning "health," has been more vigorously interpreted to create affirmative rights.¹²⁵ The New York court noted: "In view of this legislative history, as well as the mandatory language of the provision itself, it is clear that section 1 of article XVII imposes upon the State an affirmative duty to aid the needy."¹²⁶ In the Medicaid case, *Aliessa*, the New York court held that denying medical assistance based on criteria other than need, namely, immigration status, violated the letter and spirit of the Aid to the Needy Provision.¹²⁷ The court emphasized that "care

120 *Id.*

121 754 N.E.2d 1085, 1093 n.12 (N.Y. 2001).

122 *See Mem'l Hosp. v. Maricopa County*, 415 U.S. 250, 269 (1974) ("The Arizona durational residence requirement for eligibility for nonemergency free medical care creates an 'invidious classification' that impinges on the right of interstate travel by denying newcomers 'basic necessities of life.'").

123 *See Aliessa*, 754 N.E.2d at 1093 (quoting *Maricopa*, 415 U.S. at 259-61).

124 *Memorial Hosp.*, 415 U.S. at 259 (citing *Shapiro v. Thompson*, 394 U.S. 618, 641 (1969)) (striking durational residency requirement on welfare benefits); DEP'T. OF HEALTH, EDUC., AND WELFARE SUBMISSION TO THE H. COMM. ON WAY AND MEANS, 86TH CONG., REPORT ON MEDICAL RESOURCES AVAILABLE TO MEET THE NEEDS OF PUBLIC ASSISTANCE RECIPIENTS 74 (Comm. Print 1961).

125 *See, e.g., McCain v. Koch*, 511 N.E.2d 62, 62-63 (N.Y. 1987) (upholding injunction against New York City emergency homeless shelter to maintain minimum standards); *Tucker v. Toia*, 371 N.E.2d 449, 451-53 (N.Y. 1977) (finding affirmative state duty to provide home relief benefits to minor children living alone); *Wilkins v. Perales*, 487 N.Y.S.2d 961, 964 (Sup. Ct. 1985) (recognizing an Aid to the Needy provision as an individually enforceable fundamental right); Hershkoff, *supra* note 116, at 1425 (discussing individually enforceable right to welfare under New York Constitution).

126 *Tucker*, 371 N.E.2d at 452.

127 *See Aliessa*, 754 N.E.2d at 1098-99 ("We hold that section 122 violates the Equal Protection Clauses of the United States and the New York State Constitutions insofar as it denies

for the needy is not a matter of ‘legislative grace,’ it is a constitutional mandate.”¹²⁸ Even while recognizing a constitutional duty on the state, the New York court stopped short of telling the state legislature how to carry out its duty,¹²⁹ allowing considerable discretion to define the scope of its obligations and flexibility to adapt to changing circumstances.¹³⁰ The New York Court of Appeals was similarly hesitant to spell out the contours of the state’s duty to provide mental health treatment under that constitutional provision.¹³¹

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

3. North Carolina

Similar to New York’s Aid to the Needy provision, the North Carolina Constitution does not expressly mention health, but a provision on welfare has been the basis of several claims involving medical treatment. Article XI, section 4, provides: “Beneficent provision for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and Christian state. Therefore the General Assembly shall provide for and define the duties of a board of public welfare.”¹³² The

State Medicaid to otherwise eligible [New York residents] lawfully admitted . . . based on their status as aliens.”).

128 *Id.* at 1092; *see also* *Lovelace v. Gross*, 605 N.E.2d 339, 342 (N.Y. 1992) (noting “that the Legislature may not refuse to aid the needy”) (citing *Tucker*, 371 N.E.2d, at 452–53).

129 *See Lovelace*, 605 N.E.2d at 342 (noting that the New York “Constitution vests the Legislature with discretion ‘in determining the amount of aid, and in classifying recipients and defining the term ‘needy’”) (quoting *Tucker*, 371 N.E.2d at 452).

130 *See Hershkoff*, *supra* note 116, at 1427–28 (describing how an amendment to the New York state Constitution afforded the state broad power to meet the needs of the poor).

131 The court recognized minors’ due process right to treatment as a consequence of being deprived of their liberty by being placed in state training facilities but declined to address the adequacy of the treatment. Specifically, in *Lavette v. City of New York*, the court stated:

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

316 N.E.2d 314, 317 (N.Y. 1974).

132 N.C. CONST. art. XI, § 4.

provision expressly declares a state duty but limited to the “poor” and “unfortunate.”¹³³

An early North Carolina Supreme Court decision clearly turned on the indigent status of the patient. *State Hospital at Raleigh v. Security National Bank* involved a hospital collections action against the guardian of a deceased patient.¹³⁴ The patient, a U.S. Army veteran, was both insane and indigent when admitted to the hospital.¹³⁵ During his stay, the patient became eligible for Veterans’ Bureau financial assistance, sufficient to cover the cost of care that he had received.¹³⁶ The patient’s guardian claimed that the Veterans’ Benefits were exempt from any and all creditors and, therefore, the hospital could not collect. The Supreme Court of North Carolina observed that, “[t]he Constitution of North Carolina empowers the General Assembly to provide that indigent insane persons shall be cared for at the charge of the state.”¹³⁷ The court then noted that nothing in the constitution required or authorized the legislature “to provide for the care, treatment, or maintenance of nonindigent insane persons at the expense of the state.”¹³⁸ Accordingly, once the patient became non-indigent, he had no further right to state-provided care.¹³⁹

North Carolina affirmed that approach in *Graham v. Reserve Life Insurance Co.*,¹⁴⁰ holding that a state-operated tuberculosis sanatorium could collect payment from a nonindigent’s health and accident insurance policy.¹⁴¹ Rejecting the patient’s argument that providing free tuberculosis treatment to the indigent, while collecting payment

133 *Id.*

134 178 S.E. 487, 488 (N.C. 1935) (“This is an action to recover [from] the defendant the entire cost of the care, treatment, and maintenance of its ward . . . from the date of his admission as a patient in the State Hospital at Raleigh until the commencement of this action.”).

135 *Id.* (noting that “Earl N. Betts was an indigent person, without funds or property with which to pay for his support and treatment in said Hospital” and that he received compensation from the Veteran’s Bureau of the United States).

136 *See id.* (indicating that he had been awarded compensation by the Veteran’s Bureau of the United States).

137 *Id.* at 491; *see* N.C. CONST. of 1868, art. XI, § 10 (1868) (“The General Assembly shall provide that all deaf mutes, the blind, and the insane of the State, shall be cared for at the charge of the State.”); *see also* John L. Sanders, *Our Constitutions: A Historical Perspective, The North Carolina Constitution*, State Library of North Carolina (summarizing the history of North Carolina’s constitutional conventions and amendments), available at <http://statelibrary.ncdcr.gov/nc/STGOVT/PRECONST.HTM> (last visited May 6, 2010).

138 *State Hosp. at Raleigh*, 178 S.E. at 491.

139 *See id.* at 492 (“When he became a nonindigent patient of the hospital, he had no further right to its care, treatment, and maintenance at the expense of the state, because he had been admitted to the hospital as an indigent patient.”).

140 *See* 161 S.E.2d 485, 491 (S.C. 1968) (finding the plaintiff himself liable to the hospital).

141 *See id.* (“[D]efendant is liable to plaintiff for the sum of \$600.00, the policy limit.”).

at varying rates from the nonindigent and insured, violated equal protection, the court noted:

Germs attack both the affluent and the indigent. Therefore, in order to protect all its citizens, the State must—in the first instance, at least— provide treatment without cost to the indigent. It does not follow, however, that it must also furnish free treatment to those who are able to pay or who have had the forethought to purchase insurance to cover the cost of hospitalization.¹⁴²

The state's decision to allocate scarce resources to the indigent, while collecting payment from those who can afford to pay, did not operate as unconstitutional discrimination.¹⁴³

Two more recent decisions likewise narrowly define the constitutional duty. First, *Casey v. Wake County* considered whether a county health department family planning clinic was a governmental actor entitled to sovereign immunity.¹⁴⁴ The personal injury action was brought by a sixteen-year-old plaintiff who developed complications from insertion of an intrauterine device. In upholding the health department's immunity claim, the court cited Article XI, section 4, noting that "our State Constitution mandates care for those in need as a duty of the State."¹⁴⁵ The duty may be delegated to counties and local boards of health, authorized by statute to make rules and regulations "not inconsistent with law, as are necessary to protect and advance the public health."¹⁴⁶ The county family planning clinic, under such delegation, provided services "to all women, whether they can pay or not"¹⁴⁷ and as "a benefit to the general populous,"¹⁴⁸ consistent with the state's duty to provide for the "health and welfare of the citizens of the county."¹⁴⁹ Distributing free family planning and contraceptives, therefore, was a governmental function for which the hospital was entitled to immunity.¹⁵⁰ The decision did not explicitly turn on the plaintiff's lack of ability to pay or otherwise limit the definition of "need" to financial status. References to the "general populous"

142 *Id.*

143 *See id.* ("It seems entirely unnecessary to say that the law makes no unconstitutional discrimination between classes when it charges all tubercular patients the same rate but actually collects from only those who can pay.")

144 *See* 263 S.E.2d 360, 361 (N.C. Ct. App. 1980) (setting forth the main issue to be decided in the case).

145 *Id.*

146 *Id.* (citing N.C. GEN. STAT. § 130-17(b)(1983)).

147 *Id.*

148 *Id.*

149 *Id.*

150 *See id.* at 362 (indicating that the hospital is entitled to governmental immunity for these actions).

and suggestion of a duty “to all women” could be read to support a broader duty, not limited to the indigent. But there is no case law supporting that interpretation.

Craven County Hospital Corp. v. Lenoir County suggests that North Carolina courts likely would not accept the broader reading.¹⁵¹ *Craven County* involved an action by a private hospital against a city, county, and sheriff’s department to recover costs of medical care provided to an indigent, intoxicated person injured while in police custody. As a threshold matter, the court clarified that the intoxicated man was not under arrest but had merely been detained by the sheriff’s department, as authorized by statute, until he became sober.¹⁵² The court also clarified that the patient’s injury resulted from his own intoxicated state, not any conduct by the officers.¹⁵³ Had the patient been in police custody under arrest or conviction, the case would likely have come out differently, with federal constitutional implications.¹⁵⁴

On the issues raised, the court considered the hospital’s constitutional claim that Article XI, section 4 imposed a duty to provide medical care and, therefore, pay for the patient’s treatment.¹⁵⁵ The court noted that Article XI, section 4 makes clear that “care of the indigent sick and afflicted poor is a proper function of the Government of this State” and that the function may be delegated to local governments.¹⁵⁶ Carefully parsing the text, the court acknowledged that the state had properly delegated the “duty to provide local *public health* services” to counties but not the duty to provide hospital care or establish public hospitals.¹⁵⁷ Accordingly, the county had no duty to pay for hospital care. Therefore, the hospital could not collect payment from the

151 See 331 S.E.2d 690, 693 (N.C. Ct. App. 1985) (“No duty is imposed by statute upon the City [] to pay for medical services rendered to persons in the custody of its police officers; therefore there is no relationship implied by law which would obligate the City to pay the costs of such treatment.”).

152 See *id.* (citing N.C. GEN. STAT. § 122-65.13 (1983)) (describing the circumstances of the patient’s detention).

153 See *id.* at 693–94 (noting that the patient was not injured by the officers but rather as a result of his intoxicated condition).

154 See *infra* notes 260–69 and accompanying text (explaining Eighth Amendment implications).

155 See *Craven County*, 331 S.E.2d at 694 (describing plaintiff’s allegation that “defendant City has a constitutional obligation to provide necessary medical attention to those in the custody of its officers, including the obligation to pay for such treatment”).

156 *Id.* at 694 (citing *Martin v. Comm’rs of Wake*, 180 S.E. 777, 783 (N.C. 1935) (interpreting North Carolina Constitution of 1868)).

157 *Id.* at 695 (emphasis added).

county, city, or sheriffs' department for the cost of the intoxicated patient's care.¹⁵⁸

Craven County Hospital demonstrates the careful line that courts draw in declining to recognize an affirmative right to state-funded health care. The case specified that the patient was not under arrest in police custody, which would have created a duty to provide medical care. The decision also distinguished sharply between "public health" and "hospital care." Moreover, the case recognized that the state's duty does not extend to governmental subunits absent clear legislative delegation. The court seemed untroubled by the fact that the private hospital would be left bearing the cost of care for an indigent patient delivered to its doors by government authorities. Had the man wandered into the hospital on his own, the result presumably would have been the same: The hospital would have treated him and been unable to collect payment.¹⁵⁹

4. Mississippi

Mississippi's provision is one of the oldest on the books (adopted in 1869), and thus could be a source of well-developed judicial interpretation. Article IV, section 86 provides: "It shall be the duty of the legislature to provide by law for the treatment and care of the insane; and the legislature may provide for the care of the indigent sick in the hospitals in the State."¹⁶⁰ The text is clear that the mandatory, "shall provide" provision applies only to mental health care for "the insane." Otherwise, the state, seemingly in its discretion, "may provide" general hospital care to "the indigent sick."

Consistent with the constitutional text, Mississippi courts have not recognized a broad right to health care under Article IV, section 86.

158 *See id.* (finding that "no cause of action accrues in favor of a health care provider against a county to recover for the cost of hospital services rendered to an indigent resident of the county").

159 *Craven County* pre-dates the federal patient "anti-dumping" law, the Emergency Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd, enacted in 1986. Even had EMTALA been in effect at the time of the decision, it would not create a right to treatment for the patient or right to payment for the hospital. EMTALA requires hospitals that maintain emergency rooms and participate in the Medicare program to screen and stabilize patients regardless of their ability to pay but does not prohibit hospitals from attempting to collect payment after the fact. *See* 42 U.S.C. §1395dd(b)(1) (2000); Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222 (Sept. 9, 2003) (to be codified at 42 C.F.R. pts. 413, 482, 489) (summarizing EMTALA requirements).

160 MISS. CONST. art. IV, § 86.

In *Craig v. Mercy Hospital-Street Memorial*, a hospital sought to compel the state treasury to pay a requisitioned grant of state funds, which would then be matched by federal grants.¹⁶¹ The State Attorney General deemed the hospital ineligible for the state grant on two grounds: First, a state statute limited the federally matched grants to non-profit entities. Second, a different constitutional provision, section 66, prohibited the state from giving any “donation or gratuity” for “a sectarian purpose or use.”¹⁶²

The Mississippi Supreme Court rejected the Attorney General’s first argument, concluding that the hospital was, in fact, a non-profit organization.¹⁶³ On the second argument, the court acknowledged that the hospital was religiously affiliated but noted that it operated under a separate charter from the Sisters of Mercy and described itself as nonsectarian. Accordingly, the court held that the grant to the hospital did not violate section 66. The court also noted that section 86 of the Mississippi Constitution creates an “obligation . . . though not a mandatory duty” to provide hospital care for the indigent sick.¹⁶⁴ In carrying out that duty, the legislature could delegate to private entities, including those with religious affiliation.¹⁶⁵ A state “grant” to a private entity carrying out the public purpose of providing indigent hospital care would not be considered “a donation or gratuity” violating section 66.¹⁶⁶ Accordingly, the plaintiff-hospital was eligible for the grant.

A more recent case considered the state’s constitutional duty to provide care for the mentally ill. In *Attorney General v. Interest of B.C.M.*,¹⁶⁷ the Mississippi Supreme Court considered whether a statute authorizing the facility director to refuse admission under certain circumstances violated section 86.¹⁶⁸ The case involved a minor who was court-ordered for treatment at a local hospital. The director of the

161 See *Craig v. Mercy Hosp.* 45 So.2d 809, 810 (Miss. 1950) (discussing the hospital’s filing of a petition for writ of mandamus to compel the state treasury to pay the funds).

162 *Id.* at 810–11 (citing MISS. CONST. art. IV, § 66).

163 See *id.* at 814 (noting that the Commission on Hospital Care and the trial court established that the hospital qualified as a non-profit institution).

164 *Id.* at 817–18.

165 See *id.* at 818 (suggesting that a state may bestow a grant on a private, religiously-affiliated entity to assist in the carrying out of a public duty so long as the grant is was not used for sectarian purposes).

166 *Id.* at 822.

167 See *B.C.M.*, 744 So.2d 299, 299 (Miss. 1999) (considering whether conditioning judicially-ordered mental treatment on the availability of facilities and services is constitutional under state law).

168 See *id.* at 299–300 (citing MISS. CONST. art. IV, § 86) (“It shall be the duty of the legislature to provide by law for the treatment and care of the insane . . .”).

hospital refused to admit the patient, citing lack of space. The court noted that the state's "duty to care for the mentally ill is constitutionally mandated" but, as in *Craig*, allowed the state to delegate the public function to particular health care providers.¹⁶⁹ While the "Constitution mandates that the Legislature provide for the care of the insane, it places no restrictions on how the Legislature may allot that duty . . ." ¹⁷⁰ The Court concluded that the state fulfilled its constitutional duty by requiring the admitting institution to assume at least temporary responsibility for court-ordered patients, even if it lacks facilities to immediately admit patients for longer-term treatment.¹⁷¹ The refusal-to-admit provision, therefore, was constitutional.

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

5. *South Carolina*

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

The health, welfare, and safety of the lives and property of the people of this State and the conservation of its natural resources are matters of public concern. The General Assembly shall provide appropriate agencies to function in these areas of public concern and determine the activities, powers, and duties of such agencies.¹⁷²

There are no South Carolina cases interpreting the current provision, adopted in 1971, and case law on earlier versions is very limited. Al-

169 *Id.* at 302–03.

170 *Id.* at 303 (citation omitted).

171 *Id.* at 303 ("[T]he Mississippi Constitution clearly provides that the Legislature is to care for the insane. The Legislature has done so by . . . requir[ing] the director of the admitting facility to assume the responsibility of providing treatment and care for mentally ill minors even if they are not immediately admitted to the facility as soon as they are committed by the lower court.")

172 S.C. CONST. art. XII, § 1.

though the current text does not limit any state duty to mental health as opposed to general medical care, the constitution and courts historically made that distinction.

A 1941 South Carolina Supreme Court case, *Crouch v. Benet*,¹⁷³ involved a taxpayer petition to enjoin a state loan to a hospital and training center for the mentally ill.¹⁷⁴ The court noted the state's long history of providing care for "the unfortunate," dating back to 1822, with "probably the oldest building now standing in the United States built by a State for the insane."¹⁷⁵ The court cited an earlier version of Article XII, section 1, which provided that "[i]nstitutions for the care of the insane . . . and poor shall always be fostered and supported by this State,"¹⁷⁶ which the court deemed both "a wise provision of law" and "long established public policy."¹⁷⁷ Accordingly, the court recognized the state's role in assisting "helpless members of society who because of mental infirmities cannot care for themselves" as a "mandate of the Constitution of the State."¹⁷⁸ State loans to the defendant hospital comported with that duty, and the taxpayer's challenge was rejected.¹⁷⁹

Crouch hardly stands as a judicial declaration of an individual right to health care, providing merely that "appropriation[s] shall be made as often as may be necessary to carry out [the purpose of Article XII, section 1]."¹⁸⁰ Also, the court limited the state's duty to care for the mentally ill, even though the constitutional provision referred to "helpless members of society" more broadly.¹⁸¹

6. Montana

Montana's 1972 constitution contains an express "inalienable rights" provision that includes "health," suggesting a promising venue for clear judicial recognition. Article II, section 3, provides:

173 See 17 S.E.2d 320 (S.C. 1941) (describing a proceeding to test the constitutionality of a hospital issuing certificates of indebtedness to the state under a certain South Carolina Act where the funds obtained by the hospital would be used to provide additional facilities and buildings).

174 See *id.* at 321, 324 (discussing taxpayer efforts to prevent the state from providing these funds to the hospital).

175 *Id.* at 323.

176 *Id.*

177 *Id.*

178 *Id.*

179 *Id.* at 324.

180 *Id.* at 323-24.

181 *Id.* at 323.

All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life's basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and seeking their safety, health and happiness in all lawful ways.¹⁸²

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

For example, a recent Montana Supreme Court opinion, *Simms v. Montana Eighteenth Judicial District Court*, relied on Article II, section 3 in deciding a procedural issue in a medical malpractice case.¹⁸³ The issue was whether the trial court exercised proper supervisory control over the litigation by ordering the plaintiff-patient to undergo an invasive independent medical evaluation in Oregon at the defendant-hospital’s request. The Montana Supreme Court held that the trial court abused its discretion in ordering the examination, noting: “When a proposed examination risks unnecessary, painful or harmful procedures, the scale must favor protecting individual rights.”¹⁸⁴ Accordingly, the state, or trial court judges, cannot compel individuals to submit to unnecessary medical examinations. *Simms* identifies health as a fundamental right¹⁸⁵ but hardly establishes an affirmative, enforceable right to health care. At most, the decision recognizes the negative right to be free from burdensome, painful intrusions on individual health and bodily integrity.

The Montana Supreme Court similarly recognized the inalienable right to health as a negative right in other contexts. *Armstrong v. State* struck down a statute providing that only physicians could lawfully perform pre-viability abortions.¹⁸⁶ Non-physician health care provid-

182 MONT. CONST. art II, § 3 (1972).

183 See 68 P.3d 678, 682 (Mont. 2003) (citing MONT. CONST. art. II, § 3, providing a right to safety, health, and happiness, and § 10, affording a right to privacy).

184 *Id.*, at 683.

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

186 See 989 P.2d 364, 384 (Mont. 1999) (striking down Montana’s statutory prohibition on pre-viability abortions as unconstitutional in violation of individual privacy under Article II, section 10, of the Montana Constitution).

ers challenged the statute on state constitutional grounds. The decision turned primarily on Montana's constitutional privacy provision, Article II, section 10.¹⁸⁷ But the court buttressed its holding, noting that:

Article II, section 3, guarantees each person the inalienable right to seek safety, health and happiness in all lawful ways—i.e., in the context of this case, the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference.¹⁸⁸

The decision echoes *Simms's* recognition of individual rights of bodily integrity and medical decision making. *Armstrong* specified that the fundamental right of privacy includes a “personal autonomy component” that “broadly guarantees each individual the right to make medical judgments affecting his or her bodily integrity and health in partnership with a chosen health care provider free from the interference of the government.”¹⁸⁹

Another recent case, *In the Matter of C.R.O.*, sounds a similar note. The Montana Supreme Court reversed a decision terminating parental rights of a father who was undergoing treatment for mental illness.¹⁹⁰ The majority declined to terminate parental rights, finding the evidence lacking that the father's condition was unlikely to change within a reasonable time, which would allow him to assume the role of parent.¹⁹¹ The holding did not turn on Article II, section 3. But Justice Nelson in dissent noted that “the Court's decision trammels the inalienable constitutional rights of [the child] to pursue life's basic necessities, to enjoy a safe, healthy, and happy life” and “basic human dignity,” presumably through adoption or foster care in a “permanent, stable and loving family.”¹⁹² Justice Nelson's passionate dissent, reminiscent of Justice Blackmun in *DeShaney*, concluded: “Once again, the biological parent wins a court case and the child

187 See MONT. CONST. art. II, § 10 (“The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.”).

188 *Armstrong*, 989 P.2d at 383.

189 *Id.* at 384.

190 See 43 P.3d 913, 919 (Mont. 2002) (reversing the lower court's decision).

191 See *id.* at 919 (“We hold that substantial evidence does not exist to support the District Court's finding that [the doctor] believed that the condition preventing [the father] from assuming the role of parent is unlikely to change within a reasonable time.”).

192 *Id.* at 921 (Nelson, J., dissenting) (citing MONT. CONST. art. II, § 3); *id.* at 922 (paraphrasing same).

loses a shot at a decent life. How sad. Indeed, how tragic.”¹⁹³ Certainly, the constitutional provision played no role in the majority’s decision to uphold parental rights. But *C.R.O.* suggests that at least one justice would give constitutional weight to certain basic necessities, including health. Moreover, Justice Nelson seemed willing to recognize the need for affirmative state action, such as, removing the child from parental custody, in order to protect the inalienable health right.

Even more revealing of Montana’s strong preference for negative rights is its willingness to imply certain fundamental rights, bootstrapping from the express inalienable rights provision. *Wadsworth v. State* involved a state worker’s claim for wrongful termination under a regulation that prohibited state employees from moonlighting.¹⁹⁴ The court held that the anti-moonlighting law violated the plaintiff’s fundamental right to pursue employment under Article II, section 3. The court quoted the inalienable rights provision and acknowledged that employment was not one of the enumerated rights.¹⁹⁵

[N]evertheless, we have held a right may be ‘fundamental’ under Montana’s constitution if the right is either found in the Declaration of Rights or is a right ‘without which other constitutionally guaranteed rights would have little meaning.’ The inalienable right to pursue life’s basic necessities is stated in the Declaration of Rights and is therefore a fundamental right.¹⁹⁶

The court further noted that employment enables the worker to obtain “the most basic of life’s necessities, such as food, clothing, and shelter” and “other essentials of modern life, *including health and medical insurance*, retirement, and day care.”¹⁹⁷ Having concluded that Article II, section 3, contains an implied fundamental right to employment, the court then applied strict scrutiny, requiring “the State [to] show a compelling state interest” and that the “legislative action is the

193 *Id.* at 922; *see also* *DeShaney v. Winnebago County Dep’t of Soc. Servs.*, 489 U.S. 189, 213 (1989) (Blackmun, J., dissenting) (exclaiming, “Poor Joshua!” and noting that as a result of the Court holding no constitutional duty to protect the child from his father’s abuse, “this child, Joshua DeShaney, now is assigned to live out the remainder of his life profoundly retarded”).

194 *See* 911 P.2d 1165, 1171 (Mont. 1996) (discussing the worker’s claim that “the conflict-of-interest rule unconstitutionally infringed upon his fundamental right to the opportunity to pursue employment.”).

195 *See id.* at 1172 (“While not specifically enumerated in the terms of Article II, section 3 . . . the opportunity to pursue employment is, nonetheless, necessary to enjoy the right to pursue life’s basic necessities.”).

196 *Id.* at 1172 (citation omitted).

197 *Id.* (emphasis added).

least onerous path that can be taken to achieve the state objective.”¹⁹⁸ The state failed to meet that burden; therefore, the plaintiff was wrongfully discharged.¹⁹⁹ *Wadsworth* recognizes only a negative right to be free from government intrusion in the lawful pursuit of employment as a means to obtaining health insurance, not a positive right to government-provided health care. To wit, Montana courts have declined to recognize other implied fundamental rights, in particular, to government benefits.²⁰⁰

By contrast to the equivocal stance on health, Montana courts are much more inclined to enforce environmental rights under the state constitution. The same inalienable rights provision that includes health also lists “a clean and healthy environment.” The environmental right is the first in the list and is not limited to an individual’s own “seeking,” “possessing,” “pursuing,” “acquiring,” or “defending,” as the other inalienable rights are.²⁰¹ Montana courts have allowed individual claims to enforce the environmental provision and squarely hold that the right is fundamental.

In *Montana Environmental Information Center v. Department of Environmental Quality*, environmental groups sought to enjoin a state-issued exploration license that would have allowed discharge of groundwater containing high levels of arsenic and zinc into two river aquifers.²⁰² The constitutional challenge to the statute authorizing the license was based on Article II, section 3, which provides that “[a]ll persons are born free and have certain inalienable rights. . . . [including] the right to a clean and healthful environment,”²⁰³ and Article IX, section 1, which expressly requires the state to “maintain and improve a clean and healthful environment,” protect “environmental life . . . from degradation,” and “prevent unreasonable depletion and degradation of natural resources.”²⁰⁴ Together, those two constitutional provisions create a judicially enforceable right.

198 *Id.* at 1174.

199 *See id.* at 1175 (“We hold that, because the State did not demonstrate a compelling interest for applying the conflict-of-interest rule at issue here, the State wrongfully terminated [the workers’] employment.”).

200 *See Zempel v. Uninsured Employers’ Fund*, 938 P.2d 658, 664 (Mont. 1997) (finding no constitutional violation in excluding businesses operating exclusively on Indian reservations from workers compensation benefits); *Butte Cmty Union v. Lewis*, 712 P.2d 1309, 1311 (Mont. 1986) (finding no implied fundamental right to state general assistance).

201 MONT. CONST. art II, § 3.

202 *Mont. Envtl. Info. Ctr. v. Dep’t of Envtl. Quality*, 988 P.2d 1236, 1237 (Mont. 1999) (describing plaintiffs’ request for suspending the exploration license).

203 *Id.* at 1243 (citing MONT. CONST. art.II, § 3).

204 *Id.* (citing MONT. CONST. art. IX, § 1, paras. 1, 3) (emphasis omitted).

The court first held that the environmental organizations had standing to bring the challenge.²⁰⁵ Moreover, the constitutional right was self-executing, without any legislative enactment, in noted contrast to the *Michigan Universal Health Care Action Network* decision in Michigan, which struck the plaintiffs' claim for lack of standing and lack of an enforceable right.²⁰⁶ Under the two constitutional provisions, the *MEIC* court, citing *Wadsworth*,²⁰⁷ recognized a fundamental right to a clean and healthful environment, any interference with which would be subject to strict scrutiny.²⁰⁸ The decision further relied on a detailed historical record of Montana's 1972 Constitutional Convention on state environmental protection, suggesting the drafters' intent that "healthful" modify the term "environment."²⁰⁹ Other Montana decisions have similarly recognized a fundamental right to a "healthful environment" under the state constitution.²¹⁰ While the State of Montana may have a duty to guarantee a clean and healthful environment, it has no duty to guarantee individual health or access to health care or health insurance.

205 *See id.* ("[W]e conclude that the allegations in the Plaintiffs' complaint which are uncontroverted, established their standing to challenge conduct which has an arguably adverse impact . . .").

206 *See Michigan Universal Health Care Action Network v. State*, No. 261400, 2005 WL 3116595, at *1 (Mich. Ct. App. 2005) (affirming the lower court's dismissal of the case on lack of standing grounds); *see also supra* notes 101–106 (discussing this case further).

207 *See Wadsworth v. State*, 911 P.2d 1165, 1167 (Mont. 1996) (affirming a finding of wrongful termination).

208 *See Mont. Envtl. Info. Ctr.*, 988 P.2d at 1246.

[T]he right to a clean and healthful environment is a fundamental right... and... any statute or rule which implicates that right must be strictly scrutinized and can only survive scrutiny if the State establishes a compelling state interest and that its action is closely tailored to effectuate that interest and is the least onerous path that can be taken to achieve the State's objection.

(emphasis omitted) (citing *Wadsworth*, 911 P.2d at 1174).

209 *Id.* at 1247–49; *see also* Cameron Carter & Kyle Karinen, Note, *A Question of Intent: The Montana Constitution, Environmental Rights, and the MEIC Decision*, 22 PUB. LAND & RESOURCES L. REV. 97, 98 (2001) ("MEIC is the first decision by the Montana Supreme Court to delineate the nature and scope of the environmental provisions contained in Montana's Constitution."); John L. Horwich, *Montana's Constitutional Environmental Quality Provisions: Self-Execution or Self-Delusion?*, 57 MONT. L. REV. 323, 323 & n.1 (1996) (providing historical background on Montana's 1972 Constitution).

210 *See, e.g., Cape-France Enters. v. Estate of Peed*, 29 P.3d 1011, 1016–17 (Mont. 2001) (noting that a clean environment is a "fundamental right that may be infringed only by demonstrating a compelling state interest" and allowing plaintiff to drill a well "may cause significant degradation of uncontaminated aquifers and pose serious public health risks").

7. *New Jersey*

The lessons of Montana's implied fundamental rights decisions apply more broadly to New Jersey. The New Jersey constitution contains no specific provision on health, but New Jersey courts have consistently indentified "preservation of health" as an implied constitutional right.²¹¹

Beginning with *Tomlinson v. Armour & Co.*, an early products liability suit over canned ham,²¹² the New Jersey Court of Appeals maintained that "[a]mong the most fundamental of personal rights, without which man could not live in a state of society, is the right of personal security, including the preservation of a man's health from such practices as may prejudice or annoy it."²¹³ Accordingly, the court upheld the plaintiff's action against the tainted meat vendor, despite the presence of a contractual agreement and absence of scienter. As described in *Tomlinson*, the right pertains to freedom *from* interference with health, rather than a right *to* state-provided health care, much like the Montana cases. The *Tomlinson* language has been carried forward and applied more broadly in recent New Jersey decisions, most notably, abortion cases.

In *Right to Choose v. Byrne*, the New Jersey Supreme Court struck down a state statute on Medicaid funding for abortions.²¹⁴ New Jersey's Medicaid program covered abortions only when the life of the mother was in danger. The court recognized that a woman's right to choose an abortion is a fundamental right of all residents, "including those entitled to Medicaid reimbursement for necessary medical treatment."²¹⁵ The decision rested on two implied rights in the New Jersey Constitution: privacy and health. The right to privacy,

211 See Helen Hershkoff, *The New Jersey Constitution: Positive Rights, Common Law Entitlements, and State Action*, 69 ALB. L. REV. 553, 553-55 (2006) (lauding the New Jersey Supreme Court as "a jurisprudential entrepreneur . . . on decisions that involve social and economic life" and noting that "[n]ot all important social welfare rights are enumerated in the New Jersey text"); Judith S. Kaye, *Foreward: The Common Law and State Constitutional Law as Full Partners in the Protection of Individual Rights*, 23 RUTGERS L.J. 727, 738-50 (1992) (describing examples, including New Jersey, of judicial recognition of new individual rights, outside express constitutional provisions and characterizing trend as "a common law infused with constitutional values").

212 See 70 A.314, 316-17 (N. J. 1908), *overruled in part by* *Henningsen v. Bloomfield Motors, Inc.*, 161 A.2d 69 (N.J. 1960) (creating a precedent that privity of contract was no longer required for implied warranty claim).

213 *Id.* at 317 (quotations omitted).

214 See 450 A.2d 925, 914 (N.J. 1982).

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

deemed fundamental, derived from the New Jersey constitution's express recognition of "certain natural and unalienable rights," including "life, liberty and the pursuit of safety and happiness."²¹⁶ The trial court also recognized an implied, fundamental right to health, but the Supreme Court did not go quite that far. The Supreme Court cited *Tomlinson* as recognition "that New Jersey accords a high priority to the preservation of health."²¹⁷ Then, applying strict scrutiny to the abortion-funding law, the *Byrne* court held that "[i]n balancing the protection of a woman's health and her fundamental right to privacy against the asserted state interest in protecting potential life, we conclude that the governmental interference is unreasonable."²¹⁸

In another case, *Horizon Health Center v. Felicissimo*,²¹⁹ a family planning clinic sought to enjoin anti-abortion protesters from picketing on the public sidewalk in front of the clinic.²²⁰ The court upheld the injunction even though it restricted the protestors' free speech rights.²²¹ Citing both *Tomlinson* and *Byrne*, the Court noted that "[t]he New Jersey Constitution does not guarantee explicitly a fundamental right to health" but does accord a "high priority to the preservation of health."²²² After recognizing that the state "has a significant interest in insuring unrestricted access to . . . medical services," the Supreme Court held that the trial court did not err in issuing the injunction against interference with that interest.²²³ *Felicissimo* thus affirms New Jersey's recognition of a significant interest, if not fundamental right, to health care. *Byrne* comes closer to saying that the state must affirmatively provide certain medically necessary treatment once it establishes a medical assistance program.²²⁴ *Felicissimo* does not compel government action but recognizes the state's legitimate interest in ensuring access to medical services, including abortion.

The abortion decisions recognizing health care as a "high priority" were cited in a different context, prisoner health care, and for a different result, to conclude that the state is not obligated to pay for

216 *Byrne*, 450 A.2d at 933 (citing N.J. CONST. of 1947, art 1, ¶ 1).

217 *Id.* at 934.

218 *Id.* at 937; see Hershkoff, *supra* note 211, at 555 (discussing *Byrne*, 450 A.2d at 941 (N.J. 1982)).

219 638 A.2d 1260, 1265 (N.J. 1994).

220 *Id.* at 1263–64.

221 *Id.* at 1270 ("The trial court therefore had the power to issue injunctive restrictions to preserve health even if those restrictions affected defendants' First Amendment rights.").

222 *Id.* at 1269.

223 *Id.*

224 *See* *Right to Choose v. Byrne*, 450 A.2d 925, 936–37 (N.J. 1982) (declining to rest decision solely on equal protection or due process grounds).

medical services. In *Mourning v. Correctional Medical Services of St. Louis*, inmates challenged a New Jersey law requiring prison inmate copayments for medical treatment.²²⁵ A prisoner challenged the copayment statute as violating “his right under the New Jersey State Constitution to reasonable healthcare.”²²⁶ The court acknowledged that “prison officials have an absolute duty to provide medical care during a term of imprisonment” but that “it is up to the Legislature to determine who should bear the cost.”²²⁷ Citing *Byrne* for the proposition that the New Jersey Supreme Court declined to recognize health as a “fundamental right,” the court proceeded to consider the copayment requirement under rational relation scrutiny.²²⁸ The court concluded that the state had a “legitimate interest in defraying the cost of health care provided to inmates . . . and in reducing the alleged abuse of the sick-call policy.”²²⁹ Accordingly, the copayment law was upheld.²³⁰

Mourning purported to rely on *Byrne*, but the holdings are difficult to reconcile. *Mourning* suggested that the state must provide health care to prisoners but is not required to pay for all of the services.²³¹ *Byrne* suggested that, in order to protect a woman’s right to medical care, the state must pay. *Tomlinson* and *Felicissimo* recognize the importance of health and take steps to protect that interest from interference by others. Even *Byrne*, recognizing that the state must fund all medically necessary abortions for Medicaid beneficiaries, does not establish an affirmative right for all persons to state-funded medical care. The decision is consistent with federal equal protection cases, recognizing that once the government elects to provide certain benefits, it must do so even-handedly.

III. TRENDS IN STATE CONSTITUTIONAL HEALTH LAW

The preceding survey of constitutions and judicial decisions reveals common limits, exceptions, and distinctions in state constitutional recognition of health. States seem generally reluctant to iden-

225 692 A.2d 529, 530–33 (N.J. Super. Ct. App. Div. 1997).

226 *Id.* at 535.

227 *Id.* at 536–37 (quoting *Cooper Med. Ctr. v. Johnson*, 497 A.2d 909 (Law Div. 1985), *aff’d*, 504 A.2d 1199 (N.J. Super. Ct. App. Div. 1986)).

228 *Id.* at 538 (noting that the “plaintiff forthrightly admits” there is no fundamental right to health under the New Jersey Constitution).

229 *Id.*

230 *Id.* at 539–40.

231 *Id.* at 538 (“Although the government must provide medical care, the Supreme Court has never held that the government must pay for it.”).

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

State constitutions, for all of their arguable shortcomings, represent the views of a wide range of stakeholders on some of their most fundamental concerns.²³² It is significant that several states enshrine health explicitly in their constitutions, unlike the U.S. Constitution. Understanding the ways in which states extend greater constitutional protection to health and the reasons underlying those decisions should inform both state and federal policymakers' approaches to health care rights, duties, and responsibilities. Although attention is currently focused on federal reform, states remain central to the health care system through cooperative state-federal health care programs, like Medicaid, and regulation of health care providers and insurers operating within their borders. States are poised to play an even greater role in the health care delivery under new federal laws, with the establishment of state-based health insur-

²³² See Gardner, *supra* note 66, at 831 (noting that state constitutions represent distinct community values, defined by state boundaries, and demonstrate "clumpy, irregular variations of a single national character" and that "the views of any subgroup of the community, such as the people of a state, might yield a profile somewhat different from the national one"); Paul W. Kahn, *Interpretation and Authority in State Constitutionalism*, 106 HARV. L. REV. 1147, 1168 (1993) ("[American constitutionalism] is enriched whenever new voices are added to the debate over the meaning of the rule of law within a democratic polity. It is especially enriched because fifty different courts will talk with each other, as well as with the federal courts, about the meaning of a common enterprise."); Rodriguez, *supra* note 44, at 271 (highlighting that state constitutions are "intrinsically important as legal frameworks for the implementation of public policy throughout all fifty of the states"); Schapiro, *supra* note 66, at 393 (arguing that state constitutions represent "the collection of those particular values that various electoral supermajorities have seen fit to enshrine in the constitution") (citation omitted); see also Hans A. Linde, *E Pluribus—Constitutional Theory and State Courts*, 18 GA. L. REV. 165, 195 (1984) ("The presence or absence of a clause in a constitution—an equal rights amendment, for instance, or a right of privacy—may or may not be evidence of societal values, but it is unmistakable evidence of societal action, of the choice whether to enact an idea into law.").

ance marketplaces,²³³ Medicaid expansion,²³⁴ and state-operated health insurance consumer protections²³⁵ and administrative simplification.²³⁶ State political processes, including proposals to amend state constitutions to add health rights, foster the democratic process and development of novel approaches to health reform.

A. *Vulnerable Groups*

Of the states that identify a duty to provide or protect health, some limit the duty to certain vulnerable groups of individuals, including the mentally insane, indigent, and prisoners. States' willingness to recognize affirmative duties to provide care and treatment for those groups may be explained by the tradition of states as *parens patriae*. The duty may also derive from the U.S. Constitution and common law of torts. Some state law protections for vulnerable groups parallel federal law. In other instances, states' constitutional protections exceed the federal floor.

1. *Mentally Ill*

Mississippi, New York, and Arkansas, by constitutional text, and South Carolina, by judicial interpretation, recognize a duty to provide care and treatment for the mentally ill or insane.²³⁷ Several other state decisions involve state-funded psychiatric hospitals. The special concern for the mentally ill may derive from the tradition of states acting as *parens patriae*, or "government as parent." *Parens patriae* is often invoked to justify government protection for the mentally insane, children, and others who are legally incompetent to manage their own affairs.²³⁸ Mentally ill persons, in particular, have been

233 See Patient Protection and Affordable Care Act, § 1321, Pub. L. No. 111-148, 124 Stat. 119 (2010) (regarding state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges).

234 *Id.* § 2001 (creating new mandatory Medicaid eligibility category for non-elderly, non-pregnant individuals at or below 133% federal poverty level).

235 *Id.* § 1002 (providing grants to state to establish office of health insurance consumer information or health insurance ombudsman programs) (amending Public Health Service Act, § 2793).

236 *Id.* § 1413 (streamlining of procedures for enrollment through Exchanges, Medicaid, CHIP, and health subsidy programs).

237 See *infra* Appendices A (listing current constitutional text) and B (summarizing similarities); see also N.Y. CONST., art. XVII, § 4 (regarding "[c]are and treatment of persons suffering from mental disorder or defect").

238 See *Addington v. Texas*, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves . . ."); *Late Corp. of the Church of Jesus Chr-*

deemed proper objects of state *parens patriae*.²³⁹ Likewise, the blind, disabled, and children may warrant special protection.²⁴⁰ Children would seem particularly appropriate objects, but none of the state constitutions specify health care rights or special concern for children.²⁴¹ One conclusion from the trend among states is that states' paternalistic concern for the health of citizens does not extend to people needing general medical care, as distinct from those needing mental health care.²⁴²

The historically greater concern for the mentally ill in some state constitutions and case law stands in marked contrast to the practice of commercial health insurers, which tend to cover treatment for physical health problems more generously than mental health problems. Recent federal mental health parity legislation aimed to cor-

ist of *Latter-Day Saints v. United States*, 136 U.S. 1, 57 (1890) (noting that the *parens patriae* authority of the crown "devolved upon" the state legislatures); *Fontain v. Ravenel*, 58 U.S. 369, 384 (1854) ("The State, as a sovereign, is the *parens patriae*."); *Fontain*, 58 U.S. at 393 (Taney, C.J., concurring) ("These prerogative powers, which belong to the sovereign as *parens patriae*, remain with the States."); *W. Va. v. Chas. Pfizer & Co.*, 440 F.2d 1079, 1089 (2d Cir. 1971) ("*Parens patriae*, literally 'parent of the country,' refers traditionally to the role of the state as sovereign and guardian of persons under a legal disability to act for themselves such as juveniles, the insane, or the unknown."); WILLIAM BLACKSTONE, 3 COMMENTARIES ON THE LAW OF ENGLAND 47 (1765–1769) (describing the state's role as "the general guardian of all infants, idiots, and lunatics"); GOSTIN, *supra* note 27, at 95–97 (describing state *parens patriae* powers).

²³⁹ See *Addington*, 441 U.S. at 425–27 (recognizing state's legitimate interest under *parens patriae* power in confining mentally ill persons who have dangerous tendencies); Antony B. Klapper, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 819 (1993) (listing six states with constitutional provisions recognizing affirmative rights of the mentally ill). But see Michael L. Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A. L. REV. 1249, 1292–93 (1987) (concluding that no state, save two "ambiguous" decisions, has recognized an affirmative right to treatment for mentally disabled persons).

²⁴⁰ See, e.g., ARK. CONST., art. XIX, § 19 (describing duties to the "deaf and dumb and blind persons," and also for treatment of the "insane"); MISS. CONST., art. IV, § 86 (providing for "treatment and care of the insane"); N.C. CONST., art. XI, § 4 (recognizing the duty of "[b]eneficent provision for the poor, the unfortunate and the orphan").

²⁴¹ See *In re Gault*, 387 U.S. 1, 16 (1967) (describing origins of juvenile justice system, in which the idea was rehabilitation, not punishment, and the "proceedings were not adversary, but that the state was proceeding as *parens patriae*"); Gilbert T. Venable, Note, *The Parens Patriae Theory and Its Effect on the Constitutional Limits of Juvenile Court Powers*, 27 U. PITT. L. REV. 894, 895 (1966) (describing origin of *parens patriae* as English King's power to protect children and "idiots").

²⁴² See, e.g., *State v. Copeland*, 765 P.2d 1266, 1271 (Utah 1988) (noting that because *parens patriae* is premised on state caring for those who cannot care for themselves, power is implicated only when individual cannot make own evaluation of need for treatment); cf. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (holding that states' civil commitment power does not extend to a "nondangerous [mentally ill] individual who is capable of surviving safely in freedom by himself").

rect that disparity.²⁴³ The federal law certainly does not establish any constitutional duty or even a statutory obligation on commercial health plans, much less federal or state governments, to provide care to the mentally ill. But commercial insurance plans that cover mental health must provide coverage and terms comparable to general health care policies.²⁴⁴ The law effectively serves as a federal statutory equal protection law for commercial insurance companies. But it creates no affirmative right to state-funded mental health care, treatment, or coverage.

State constitutions, by contrast, traditionally have been more generous to mental health needs than physical health needs of individuals. *Parens patriae* may be one justification inasmuch as the mentally ill were deemed incompetent to care for themselves. But state police powers also justify civil confinement of “dangerous” mentally ill individuals.²⁴⁵ It may be that state constitutions recognizing mandatory duties to care for the mentally ill were not motivated by progressive notions of parity or special compassion but rather the desire to incapacitate or control “the insane.” Nevertheless, states that constitutionalize a duty to provide treatment, and not merely control and confinement, for the mentally ill, exceed the federal constitutional floor. The U.S. Supreme Court has not recognized a broad right to treatment for mentally ill individuals as a constitutional requirement of

243 See 42 U.S.C. § 300gg-5 (2008) (affording an example of mental health provisions); Mental Health Parity Act of 1996, Pub. L. No. 104-204, 702(a), 110 Stat. 2944 (Sept. 26, 1996), codified at 29 U.S.C.A. § 1185a (2008) (including mental health provisions); Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (Oct. 3, 2008) (codified as amended in scattered sections of 26, 29, and 42 U.S.C.) (including mental health provisions); Mental Health Parity and Addiction Equity Act of 2008, S. 558, 110th Cong. § 712a(a) (2007) (including a mental health parity provision).

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

245 See *Kansas v. Hendricks*, 521 U.S. 346, 363 (1997) (“The State may take measures to restrict the freedom of the dangerously mentally ill. This is a legitimate nonpunitive governmental objective and has been historically so regarded.”); *Addington v. Texas*, 441 U.S. 418, 426 (1979) (“[T]he state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.”); *State v. Post*, 541 N.W.2d 115, 133 (Wis. 1995) (“[T]he state has a compelling interest in protecting the public from dangerous mentally disordered persons”); Elizabeth A. Weeks, Note, *The Newly Found “Compassion” for Sexually Violent Predators: Civil Commitment and the Right to Treatment in the Wake of Kansas v. Hendricks*, 32 GA. L. REV. 1261, 1283–85 (1998) (discussing police power justification for civil commitment).

civil commitment.²⁴⁶ State constitutions that specify even a limited duty to the mentally ill, therefore, are more protective of health care rights than federal law.

2. Indigent

Indigency is another limit that appears in some state constitutions. Mississippi, for example, explicitly limits the constitutional recognition of health to the poor.²⁴⁷ Other states, such as New York and North Carolina, do not recognize health as a distinct constitutional right but address health care as a component of constitutional provisions on welfare or aid to the needy.²⁴⁸ States that limit the duty to provide health care to financially needy individuals may be operating under *parens patriae* justification inasmuch as impoverished persons are considered vulnerable.²⁴⁹ But there are myriad other justifications

²⁴⁶ See *Hendricks*, 521 U.S. at 365–66 (holding that civil confinement, without treatment, “may be a legitimate end of the civil law”); *Youngberg v. Romeo*, 457 U. S. 307, 322 (1982) (recognizing involuntarily committed mentally disabled individual’s right to such “minimally adequate” or reasonable training to ensure “safety and freedom from unreasonable restraints”); *O’Connor v. Donaldson*, 422 U.S. 563, 573 (1975) (declining to decide “whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State”); see also *Compagnie Francaise de Navigation a Vapeur v. La. State Bd. of Health*, 186 U.S. 380, 388 (1902) (cited by majority in *Hendricks*, 521 U.S. at 366, for proposition that states can civilly detain such persons even in the absence of treatment); Burgett, *supra* note 32, at 213 n.32 (clarifying that “right to treatment” does not suggest affirmative right to state services, but rather a condition on a state’s rights to confine its citizens). See generally MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY 166–213 (1994) (discussing right to treatment). But see Morton Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499, 499 (1960) (advocating right to treatment for individuals confined in public institutions); Weeks, *supra* note 245, at 1276–83 (discussing Supreme Court precedent that could support a right to treatment).

²⁴⁷ MISS. CONST. art. IV, § 86 (granting legislature discretion to provide “care of the indigent sick”); see also HAW. CONST. art. IX, § 3 (regarding “financial assistance, medical assistance and social services for persons who are found to be in need of . . . such assistance and services”).

²⁴⁸ See *infra* Appendices A (listing state constitutional provisions on health) and B (noting provisions referencing the indigent); see also Hershkoff, *supra* note 19, at 1135 (estimating that “more than a dozen state constitutions provide explicit protections for the poor”); Rory Weiner, *Universal Health Insurance under State Equal Protection Law*, 23 W. NEW ENG. L. REV. 327, 336 (2002) (“[T]wenty-three states . . . have some form of constitutional provision for assisting the poor,” suggesting that “this strategy offers more potential than relying on explicit health-related state constitutional provisions.”); cf. Stacy, *supra* note 3, at 85 (suggesting judicial approaches to a federal welfare right to health care).

²⁴⁹ Edelman, *supra* note 97, at 1703–04 (1993) (“[T]he blind, the deaf, and the incurably insane were treated fairly consistently as deserving—objects of state assistance not subject to discretionary judgments about their individual morality or worth.”); see, e.g., *Higdon v. Boning*, 296 A.2d 569, 572 (N.J. Juv. & Dom. Rel. Ct. 1972) (enforcing municipality’s duty under state statute to aid the needy to prevent “unnecessary” suffering from “sickness,” including payment for cerebral palsy patient’s physical therapy and other services).

underlying government welfare programs, including moral,²⁵⁰ economic,²⁵¹ political,²⁵² historical,²⁵³ and social.²⁵⁴

The history of federal welfare policy does not suggest a general concern for the poor; thus, state constitutions may accord greater protections. Rather than provide broad, government assistance, federal programs elaborately distinguish between the “deserving” and “undeserving” poor.²⁵⁵ Typically, people who became impoverished through conditions beyond their control are considered more deserving than those perceived to be poor simply because they failed to work hard enough to support themselves.²⁵⁶ That view is widely reflected in federal health care programs for the elderly, disabled, and other “blameless” poor.²⁵⁷

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

251 See, e.g., VICTOR R. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 17–30 (expanded ed., 1999) (discussing economic considerations underlying health care resource allocation); RICHARD A. POSNER, ECONOMIC ANALYSIS OF THE LAW 508 (1998) (“Poverty imposes costs on the nonpoor that warrant, on narrowly economic (i.e., wealth-maximizing) grounds and so without regard to ethical or political considerations, incurring some costs to reduce it.”).

252 See, e.g., STARR, *supra* note 96, at 235–89 (describing political contours of social insurance reform movement in U.S. history); Super, *supra* note 73, at 593–98 (listing and describing “Political Sources of Antipoverty Law”).

253 See, e.g., *Goldberg v. Kelly*, 397 U.S. 254, 264–65 (1970) (“From its founding the Nation’s basic commitment has been to foster the dignity and well-being of all persons within its borders. . . . This perception, against the background of our traditions, has significantly influenced the development of the contemporary public assistance system.”).

254 See Handler, *supra* note 96, at 936–38 (“Much of welfare policy is driven by the belief that the poor pose silent, insidious threats to dominant ideologies and social order.”).

255 See Edelman, *supra* note 97, at 1703 (“America has always had a regard for the ‘deserving’ among its poor, and the categories of deserving poor have broadened as time has passed, a salutary development that must be noted positively.”); Handler, *supra* note 96, at 906 (“Thus, the heart of poverty policy centers on the question of who is excused from work. Those who are excused are the ‘deserving poor’; those who must work are the ‘undeserving.’”); see also RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 412 (1997) (suggesting that English and American Poor Laws “distinguished the ‘worthy’ from the ‘unworthy’ poor, i.e., those who had a socially legitimate reason for poverty and not working (such as advanced age, illness and physical disability) versus those who did not” and suggesting that the Social Security Act of 1935 reflected that tradition); Moon, *supra* note 250, at 48 (suggesting that welfare programs “rely largely upon selective programs in which eligibility is determined by means-testing, rather than the principles of universality and social insurance”).

256 See *Goldberg*, 397 U.S. at 265 (“We have come to recognize that forces not within the control of the poor contribute to their poverty.”); CHARLES MURRAY, LOSING GROUND: AMERICAN SOCIAL POLICY 1950–1980 197–99 (1984) (distinguishing between a laid-off factory worker and a healthy “drone,” who merely refuses to work).

257 See, e.g., 42 U.S.C. § 1395c (describing eligibility for Medicare, including persons over age 65, disabled, and with end-stage renal disease); 42 U.S.C. § 1396a(a)(10)(a) (listing cate-

By contrast, state constitutions that recognize duties to provide health care to the poor, generally, without the finer distinctions typical under federal programs, take a broader view of health rights. On the other hand, state constitutions' indigency distinctions may simply reflect the reality of scarce resources, necessity of line-drawing, and concerns about the appearance of "socialized medicine."²⁵⁸ Nevertheless, at least some states expressly acknowledge that people unable to pay for health care warrant some level of government assistance. That view only recently began to resonate at the federal level with proposals and legislation to provide government subsidies and plans to those who cannot afford commercial health insurance coverage.²⁵⁹

3. Prisoners

A few state constitutional decisions suggest that criminals and others in state custody may be entitled to health care. Those cases, for the most part, closely track federal constitutional law. The U.S. Supreme Court has held that denying medical care to prisoners constitutes cruel and unusual punishment under the Eighth Amendment.²⁶⁰ States typically interpret their duty to provide prisoner med-

gories of recipients eligible for Medicaid); ROSENBLATT, *supra* note 255, at 425 (citing ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 262–64 (1974)) (discussing market-based justifications for Medicaid categories); WELFARE: A DOCUMENTARY HISTORY OF U.S. POLICY AND POLITICS 1 (Gwendolyn Mink & Rickie Solinger eds., 2003) ("Nevertheless, many of the negative assumptions about the poor that powered the politics and policy of relief also powered the politics and policy of welfare, both at its origins and in the present day"); Edelman, *supra* note 97, at 1703–09 (summarizing U.S. welfare programs for the "deserving" poor); Handler, *supra* note 96, at 909–10 (describing welfare programs "for particular categories of the poor," including Aid to Dependent Children (ADC)).

258 See *Graham v. Reserve Life Ins. Co.*, 161 S.E.2d 485, 491 (N.C. 1968) (rejecting nonindigent patient's equal protection argument, noting that "[s]uch a contention is least expected from those who, under other circumstances, decry the expansion of the welfare state and urge medical and hospital insurance with private corporations as a bulwark against socialized medicine").

259 See Blumberg & Holahan, *supra* note 76, at 7 (discussing individual mandate and subsidies); Jacob S. Hacker, *Healthy Competition—The Why and How of "Public-Plan Choice,"* 360 NEW ENG. J. MED. 2269, 2269 (2009); Robert Pear, *Reach of Subsidies is Critical Issue for Health Plan*, N.Y. TIMES, July 27, 2009, at A1; see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2001, 124 Stat. 119 (2010) (Medicaid expansion); *id.* § 1402 (premium credits and cost-sharing subsidies to eligible individuals between 100 and 400% of federal poverty level).

260 See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (plurality opinion) ("[D]eliberate indifference to serious medical needs of prisoners" [violates] the Eighth Amendment); see *Substantive Rights Retained by Prisoners*, 36 GEO. L.J. ANN. REV. CRIM. PROC. 948, 969 n.2914 (2007) (listing Supreme Court cases applying "deliberate indifference" standard); see also *West v. Atkins*, 487 U.S. 42 (1988) (contracting out prison medical care does not relieve state of its constitutional duty to provide adequate medical treatment to those in its cus-

ical care in lockstep with federal law, providing no more than the minimal requirement.²⁶¹ For example, New Jersey recognized prisoners' right to medical care but upheld a state law requiring them to pay a portion of their care.²⁶² North Carolina declined to impose a duty on local governments to pay for private hospital care for an individual who was in police non-arrest custody.²⁶³

Others in state custody, such as juveniles²⁶⁴ and mentally disabled persons,²⁶⁵ may be entitled to health care on similar grounds.²⁶⁶ If *DeShaney's* "Poor Joshua" had been in state protective custody, rather

tody); *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983) ("The Due Process Clause . . . require[s] the responsible government or governmental agency to provide medical care to persons . . . who have been injured while being apprehended by the police."); Blumstein, *supra* note 30, at 1381 ("The irony of *Gamble* rests on the fact that an indigent in need of medical treatment becomes constitutionally entitled to it only if he is incarcerated.").

261 See Brennan, *The Bill of Rights*, *supra* note 65, at 550–51 ("Some state courts and commentators have taken umbrage at the suggestion that proceeding in lockstep with the Supreme Court is the only way to avoid irrational law enforcement."); Gardner, *supra* note 66, at 791 ("[L]ockstep analysis of the state constitution discourages the development of an independent state constitutional discourse."); Schapiro, *supra* note 66, at 421 ("Interpreting the state constitution to mean the same as the federal represents a kind of middle position between the duty to apply federal law and the ability to engage in independent interpretation of the state constitution.").

262 See *supra* notes 225–231 and accompanying text (discussing *Mourning v. Correctional Med. Servs. of St. Louis*, 692 A.2d 529 (N.J. Super. Ct. App. Div. 1997)).

263 See *supra* notes 151–158 and accompanying text (discussing *Craven County Hosp. Corp. v. Lenoir County*, 331 S.E.2d 690 (N.C. Ct. App. 1985)).

264 Compare *Santana v. Collazo*, 714 F.2d 1172, 1177 (1st Cir. 1983) (juveniles have no right to rehabilitative treatment under the Constitution) with *Nelson v. Heyne*, 491 F.2d 352, 360 (7th Cir. 1974) (juveniles have a right to rehabilitative treatment under the Fourteenth Amendment), and *Stevens v. Harper*, 213 F.R.D. 358, 375–76 (E.D. Cal. 2002) (acknowledging conflicting case law on juveniles' constitutional right to treatment), and *Alexander S. ex rel. Bowers v. Boyd*, 876 F. Supp. 773, 790 (D.S.C. 1995) (juveniles have a right to rehabilitative treatment under the Fourteenth Amendment), and *Lavette v. City of New York*, 316 N.E.2d 314, 317 (1974) (describing the right to treatment for children under state custodial supervision, premised on due process liberty deprivation).

265 See *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982) ("When a person is institutionalized—and wholly dependent on the State[,] . . . a duty to provide certain services and care does exist . . ."); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 31–32 (1981) (declining to decide whether mentally retarded individuals residing at a state institution are entitled to treatment); *Wyatt v. Aderholt*, 503 F.2d 1305, 1315 (5th Cir. 1974) (holding that mentally handicapped patients civilly committed at state institutions have a constitutional right to treatment).

266 See *Wing*, *supra* note 3, at 163 ("The Supreme Court has recognized that government has some affirmative responsibility to provide for the needs, including the medical needs, of mental patients, the institutionalized retarded, prisoners, and, presumably, other wards of the state or federal governments.").

than his father's care, it seems likely that the case would have been decided differently, at least as a matter of federal constitutional law.²⁶⁷

The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.²⁶⁸

Under similar reasoning, federal decisions recognize states' constitutional duty to protect children placed in state foster care.²⁶⁹

States are bound only to the federal constitutional minimum and could extend greater protection to prisoners and others in custody.²⁷⁰ So far, none have accepted the invitation with respect to health care rights.²⁷¹ By comparison, all but two states adopted explicit constitutional provisions limiting the severity of punishment for convicted criminals, and thirty-five of those provisions differ substantially from

267 *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 200–01 (1989) (“The [right to treatment] analysis simply has no applicability in the present case. Petitioners concede that the harms Joshua suffered occurred not while he was in the State’s custody, but while he was in the custody of his natural father . . .”). *But see id.* at 206–09 (Brennan, J., dissenting) (faulting the Court for failing to consider other, non-physical ways in which the state took control over Joshua).

268 *Id.* at 200; *see also* Currie, *supra* note 33, at 874 (suggesting that prisoner medical treatment cases do not establish an affirmative right but merely demonstrate a due process violation because “by locking an individual up without providing such services, the government has deprived him of them in the most traditional sense”).

269 *See, e.g.*, *Berman v. Young*, 291 F.3d 976, 982 (7th Cir. 2002) (“Recognizing the ‘special relationship’ exception to the general *DeShaney* rule, we have held that once a state removes a child from her parents’ custody, it has sufficiently restrained the liberty of the child and therefore assumes a duty of safekeeping.”); *Burton v. Richmond*, 276 F.3d 973, 978–79 (8th Cir. 2002) (distinguishing *DeShaney* because child was clearly in state custodial foster care); *see also DeShaney*, 489 U.S. at 201 n.9 (recognizing that several lower courts held “that the State may be held liable under the Due Process Clause for failing to protect children in foster homes from mistreatment at the hands of their foster parents”); Wing, *supra* note 3, at 163 (suggesting that when the Supreme Court recognized an affirmative duty to provide medical care for “mental patients, the institutionalized retarded, prisoners,” and other wards of the state, “the Court has premised its reasoning on the fact that the protected individual was in the custody, in the most literal sense, of the government”).

270 *See Brennan, State Constitutions, supra* note 65, at 502 (“[D]ecisions of the [U.S. Supreme] Court are not, and should not be, dispositive of questions regarding rights guaranteed by counterpoint provisions of state law.”).

271 *Cf. PERLIN, supra* note 246, at 195–96 (“[T]here has been virtually no case law on the question of a state constitutional right to treatment on behalf of mentally disabled persons.”); Klapper, *supra* note 239, at 739 (suggesting possibilities for recognizing right to treatment under state constitutions).

the U.S. Constitution's Eighth Amendment.²⁷² The New Jersey and North Carolina decisions on health care rights of those in custody suggest that states acknowledge the constitutional duty but resist bearing the full financial burden of providing the care.

A duty to provide medical care to persons in state custody would also be consistent with common-law torts principles. As a general rule, there is no duty to provide affirmative care, protection, aid, or warning.²⁷³ But if the defendant takes the plaintiff into custody or otherwise deprives him of access to care, then a duty arises.²⁷⁴ Some states have recognized affirmative duties on law enforcement officers under state tort law, if not state constitutional law.²⁷⁵

B. *Types of Services*

In addition to limiting constitutional protection to particular vulnerable groups, states also limit the types of those services they are obligated to provide. Several constitutions recognize public health, distinguished from individual health care or medical treatment.²⁷⁶

²⁷² See Richard S. Frase, *Limiting Excessive Prison Sentences Under Federal and State Constitutions*, 11 U. PA. J. CONST. L. 39, 64–69 (2008) (summarizing state constitutional provisions and defendant-favorable case law).

²⁷³ See DAN B. DOBBS, *THE LAW OF TORTS* § 227, 578–79 (2000) (describing general “no duty” rule); RESTATEMENT (SECOND) OF TORTS § 314 (1965); see, e.g., *Union Pacific Ry. v. Cappier*, 72 P. 281, 283 (Kan. 1903) (denying recovery to trespasser killed by train and distinguishing cases allowing recovery, in which “the person injured was in the custody and care of those who were at fault in failing to give him proper treatment.”); *Harper v. Herman*, 499 N.W.2d 472, 475 (Minn. 1993) (holding private boat owner not liable for injuries to passenger who dove into shallow water); *Yania v. Bigan*, 155 A.2d 343, 346 (Pa. 1959) (“The mere fact that Bigan saw Yania in a position of peril . . . imposed upon him no legal, although a moral, obligation or duty to go to his rescue . . .”).

²⁷⁴ See RESTATEMENT (SECOND) OF TORTS § 314A(4) (1965); see, e.g., *People v. Wong*, 588 N.Y.S.2d 119, 124 (1992) (discussing the legal duties created by a contractual babysitting agreement and the “voluntary assumption of complete and exclusive care of a helpless child”); *Mirand v. City of New York*, 637 N.E.2d 263, 264–266 (N.Y. 1994) (holding the school board liable for harm sustained when two sisters were assaulted by another student, recognizing “[t]he duty owed derives from the simple fact that a school, in assuming physical custody and control over its students, effectively takes the place of parents and guardians”).

²⁷⁵ See, e.g., *Wilson v. City of Kotzebue*, 627 P.2d 623, 628–29 (Alaska 1981) (discussing the possibility that custodial officers might owe a heightened duty of care to intoxicated prisoners or arrestees to see that they are protected from harming themselves or from harm by others); *Clemets v. Heston*, 485 N.E.2d 287, 291 (Ohio Ct. App. 1985) (noting an affirmative duty on a law officer to protect those the officer has arrested and has in custody).

²⁷⁶ See *infra* Appendix B (identifying eight states’ provisions).

Other constitutions specify environmental rights.²⁷⁷ One state's constitution is expressly limited to hospital care.²⁷⁸ Several states recognize constitutional rights to a particular medical procedure, abortion, but not health care more generally.²⁷⁹

1. *Public Health*

State police powers have long been recognized to encompass protection and promotion of public health.²⁸⁰ Until the New Deal, the power to act in the interest of public health was exclusively the province of states.²⁸¹ Consistent with the historical role of states in public health, more than half of the constitutions surveyed and several judicial decisions distinguish between the states' duty with respect to the public's health, as opposed to individual health.²⁸² "Health care" focuses on individual wellness or freedom from pathology, whereas "public health" is concerned with promoting optimal health of the population as a whole.²⁸³ The goal of public health is not simply im-

277 See, e.g., MONT. CONST. art. II, § 3 (stating that inalienable rights include "the right to a clean and healthful environment" and "health"); S.C. CONST. art. XII, § 1 (describing health and the conservation of natural resources as "matters of public concern").

278 See MISS. CONST. art. IV, § 86.

279 See *infra* Part III.B.4.

280 *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) ("According to settled principles, the police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety."); *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 203 (1824) (stating that it is within states' powers to enact "[i]nspection laws, quarantine laws, health laws of every description").

281 James G. Hodge, Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93, 94 (1997) ("[A]s the states' exclusive power to regulate in the interests of public health was limited judicially and politically, public health law began to shift from states to the federal government, largely during the New Deal."); see also GOSTIN, *supra* note 27, at 91 ("The states and localities have had the predominant public responsibility for population-based health services since the founding of the republic."); Parmet, *supra* note 19, at 272 ("Public health actions lay within the core of the police power.").

282 See *infra* Appendix B.

283 Nancy M. Baum et al., *Looking Ahead: Addressing Ethical Challenges in Public Health Practice*, 35 J.L. MED. & ETHICS 657, 658-59 (2007) (distinguishing "public health from individually oriented health care" and urging that "public health ethics is a field of inquiry in its own right"); Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 AM. J. PUB. HEALTH 1607, 1608 (1997) (defining "health" as a "personal, medical matter, a state of freedom from pathology achieved by an individual through the mediation of a doctor" and characterizing "[p]ublic health, by contrast . . . as an attribute of communities in social and physical environments"); Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101, 112-15, 121-24 (2005) (distinguishing "health" and "public health" rights); Andrew W. Siegel, *The Jurisprudence of Public Health:*

proving individual health outcomes but the common good.²⁸⁴ According to some, public health, welfare, and security were the very reasons for establishing government in the origin of society.²⁸⁵

By contrast, there is no long-standing tradition of state involvement in individual medical care. Consistent with the negative rights orientation and free-market tradition, individuals, through their own efforts, are left to secure necessary health care for themselves and their families.²⁸⁶ Health care is viewed as a matter of individual, not collective, responsibility.²⁸⁷ Individuals privately contract with health care providers and insurers, as they would for any other good or service.²⁸⁸ That libertarian view is exemplified in Montana's decisions recognizing a fundamental right to employment as means to obtain-

Reflections on Lawrence O. Gostin's Public Health Law, 18 J. CONTEMP. HEALTH L. & POL'Y 359, 361-62 (2001) ("Public health law is concerned with the state's role in advancing the health of the community, whereas health care law is concerned with the 'microrelationships between health care providers and patients.'" (quoting LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 15 (2000))).

284 WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 9 (2009) ("[T]he focus of public health is on the health or well-being of people, not individuals."); Baum, *supra* note 283, at 657 (noting "public health's emphasis on population health rather than issues of individual health"); Lawrence O. Gostin, *Health of the People: The Highest Law?*, 32 J.L. MED. & ETHICS 509, 510 (2004) ("The field of public health would profit from a vibrant conception of 'the common' that sees public interests as more than the aggregation of individual interests.").

285 See PARMET, *supra* note 284, at 15 (quoting the maxim "*salus populi suprema lex*" ("The well being of the public is the supreme law") as meaning that attainment of public safety "was the rationale for civil society"); Richard A. Epstein, *In Defense of the "Old" Public Health*, 69 BROOK. L. REV. 1421, 1427 (2004) (describing the same maxim as having "powerful roots . . . in the American political tradition"); James A. Tobey, *Public Health and the Police Power*, 4 N.Y.U. L. REV. 126, 126 (1927) (suggesting that government is "organized for the express purpose, among others, of conserving the public health").

286 See DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE 7-9 (2000) (tracing the demise of "Marcus Welby medicine" and the rise of market-based health care); ROSENBLATT ET AL., *supra* note 255, at 32-33 (explaining market-competition view of health care); Jonathan Oberlander, *The Political Economy of Unfairness in U.S. Health Policy*, 69 L. & CONTEMP. PROBS. 245, 252 (2006) ("American political culture values liberty over equity, cherishes markets and individual responsibility over government and social solidarity . . ."); Arnold S. Relman & Uwe E. Reinhardt, *Debating For-Profit Health Care and the Ethics of Physicians*, 5 HEALTH AFF. 16 (1986) ("If one looked for die-hard champions of free enterprise and libertarian thought, one could always find them among our physicians.").

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

288 See, e.g., *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) (rejecting patient's personal injury claim for physician's "refusal to enter into a contract of employment").

ing individual health care but not a fundamental right to state unemployment or health care benefits. For similar reasons, state courts upheld challenges to various obstacles to obtaining individual health care.²⁸⁹

Public health, by contrast, largely rejects market theory.²⁹⁰ Traditional public health objectives, including sanitation,²⁹¹ infectious disease control, nuisance abatement, public safety, and pure food and drinking water,²⁹² cannot be secured through individual effort and call for coordination through centralized government. Collective action and public benefit are hallmarks of public health interventions.²⁹³ Public health, for example, may justify a state paying to treat infectious disease because otherwise the infected individual would endanger the health and safety of all.²⁹⁴ There is some tradition of

289 See, e.g., *Armstrong v. State*, 989 P.2d 364, 384 (Mont. 1999) (striking down restriction on choice of provider); *Horizon Health Ctr. v. Felicissimo*, 638 A.2d 1260 (N.J. 1994) (upholding injunction on abortion clinic protesters as obstructing access to medical care).

290 See PARMET, *supra* note 284, at 15–16 (explaining but rebutting traditional market-theory view that government intervention is required only when private markets are flawed or fail); STARR, *supra* 96, at 180–89 (describing historical tension between medical profession and public health); BURRIS, *supra* note 283, at 1608 (“[T]o accept the rhetorical structure of market individualism is to accept a political language that has no words for public health.”).

291 See STARR, *supra* note 96, at 181 (“In mid-nineteenth-century America, public health was mainly concerned with sanitary reform and affiliated more closely with engineering than with medicine.”); Elizabeth Fee, *The Origins and Development of Public Health in the United States*, reprinted in LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW & ETHICS: A READER*, at 27, 28 (from 1 OXFORD TEXTBOOK OF PUBLIC HEALTH (3d ed. 1997)) (“In the colonies, public health consisted of activities deemed necessary to protect the population from the spread of epidemic diseases, by the enactment of sanitary laws and regulations governing such matters as the construction of toilets, the disposal of wastes, and the disposition of dead animals.”); Parmet, *supra* note 19, at 290 (“[P]ublic sanitation regulations in Massachusetts go back as far as 1634 . . .”).

292 GOSTIN, *supra* note 27, at 95 (listing various state public health powers).

293 *Id.* at 9 (“[N]o single individual or group of individuals can ensure his or her health. Meaningful protection and assurance of the population’s health require communal effort.”); INSTITUTE OF MEDICINE, *THE FUTURE OF PUBLIC HEALTH* 19 (1988) (“Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”); STARR, *supra* note 96, at 180 (“[P]ublic health [is] ‘the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts . . . and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.’”); Michael Walzer, *Security and Welfare*, reprinted in GOSTIN, *supra* note 291, at 69, 75 (from *Spheres of Justice: A Defense of Pluralism and Equality* (1983)) (“Dealing with tuberculosis, cancer, or heart failure, however, requires a common effort. Medical research is expensive, and the treatment of many particular diseases lies far beyond the resources of any ordinary citizens. So the community must step in . . .”).

294 See, e.g., *Graham v. Reserve Life Ins. Co.*, 161 S.E.2d 485, 491 (N.C. 1968) (upholding provision of free tuberculosis treatment to the indigent, noting [i]t is within the police

federal public health regulation, but the federal role is not constitutionally recognized or as broad as states' authority.²⁹⁵

The scope of public health recognized in state constitutions is consistent with the negative rights orientation. The traditional scope of public health was limited to collective action problems in which individual efforts cannot secure the desired outcome. The "new" public health takes a broader view, addressing seemingly individual health habits or conditions, such as obesity, smoking, domestic violence, firearms, and socioeconomic disparities.²⁹⁶ In the traditional public health view, states avoid interfering with individual rights unless necessary to protect the community.²⁹⁷ If the broader, "new" public health view gains wider acceptance, the implications could be dramatic. States that constitutionally recognize a duty to protect and promote the public health may be required to intervene more directly and affirmatively in a wide range of individual preferences, habits, and activities.

power of the State to provide treatment for infectious and contagious disease, which—if untreated—can become epidemic"); *Kirk v. Wyman*, 65 S.E. 387, 389 (S.C. 1909) (holding that it "is a reasonable exercise of the police power" to establish boards of health and pesthouses); GOSTIN, *supra* note 291, at 24 (suggesting that within the context of the industrial revolution and increased urbanization "citizens began to think of the control of disease as being properly within the sphere of government control").

295 See GOSTIN, *supra* note 27, at 155–61 (describing and cataloging history of federal public health regulation).

296 See THEODORE H. TULCHINSKY & ELENA A. VARAVIKOVA, *THE NEW PUBLIC HEALTH: AN INTRODUCTION FOR THE 21ST CENTURY*, 106–09 (2000) (describing World Health Organization definition of the "New Public Health (NPH)" as "a philosophy which endeavors to broaden the older understanding of public health so that, for example, it includes the health of the individual in addition to the health of populations, and seeks to address such contemporary health issues as are concerned with equitable access to health services, the environment, political governance and social and economic development."); Epstein, *supra* note 285, at 1423 (distinguishing "old" and "new" public health and listing examples of inspection, quarantine, and vaccination for the former, and tort reform, access to health care, and relieving wealth disparity for the latter); Lawrence O. Gostin & M. Gregg Bloche, *The Politics of Public Health: A Response to Epstein*, 46 *PERSP. IN BIOLOGY & MED.* S160, S162 (2003) (responding to Epstein's and other "conservatives" attacks on public health but agreeing that "there is a 'new' public health, broader in its reach than . . . control of infectious disease"); Meier & Mori, *supra* note 283, at 119 ("[M]odern public health programs can be framed expansively as part of a social justice movement . . .").

297 See *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) ("But the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good."); see, e.g., GOSTIN *supra* note 27, at xxv (summarizing "the dominant liberal position that individual freedom is by far the preferred value to guide ethical and legal analysis in matters of physical and mental health").

2. *Environmental Health*

Just as there is no federal constitutional right to health, there is no federal constitutional right to a clean environment.²⁹⁸ Montana and several other states have expressly extended protection of environmental rights above the federal floor. Some state constitutional provisions are framed in terms of environmental health.²⁹⁹ The environmental provisions are supported by reasoning similar to the public health provisions and do not provide support for a broader, individual right to health care.

Montana's constitutional environmental rights are particularly robust, with two constitutional provisions and judicial recognition of a self-executing, individually enforceable right.³⁰⁰ Other states' constitutions identify the environment or natural resources, but do not interpret them as broadly as Montana.³⁰¹ Montana's judicial enforce-

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

299 See, e.g., HAW. CONST. art. XI, § 9 ("Each person has the right to a clean and healthful environment. . . ."); ILL. CONST. art. XI, § 1 ("The public policy of the State and the duty of each person is to provide and maintain a healthful environment for the benefit of this and future generations."); LA. CONST. art. IX, § 1 ("The natural resources of the state, including air and water, and the healthful, scenic, historic, and esthetic quality of the environment shall be protected, conserved, and replenished insofar as possible and consistent with the health, safety, and welfare of the people."); MONT. CONST. art. IX, § 1, ¶ 1 ("The state and each person shall maintain and improve a clean and healthful environment in Montana for present and future generations."); PENN. CONST. art. 1, § 27 (The people have a right to clean air, pure water, and to the preservation of the natural, scenic, historic, and esthetic values of the environment."). See generally Barton H. Thompson Jr., *The Environment and Natural Resources*, in 3 STATE CONSTITUTIONS FOR THE TWENTY-FIRST CENTURY: THE AGENDA OF STATE CONSTITUTIONAL REFORM 307 (G. Alan Tarr & Robert F. Williams eds., 2006) (discussing state constitutional provisions protecting natural resources and the environment, suggesting that "[a] majority of state constitutions seek to protect the public's interest in natural resources and the environment"); Mary Ellen Cusack, Comment, *Judicial Interpretation of State Constitutional Rights to a Healthful Environment*, 20 B.C. ENVTL. AFF. L. REV. 173, 182 & nn.60, 62 (1993) (listing seven states' environmental provisions); Horwich, *supra* note 209, at 325 n.13 (listing eight states, including Montana); A.E. Dick Howard, *State Constitutions and the Environment*, 58 VA. L. REV. 193 (1972) (describing the then-recent trend of states adopting constitutional environmental provisions).

300 See *Montana Env'tl. Info. Ctr. v. Dep't. of Env'tl. Quality*, 988 P. 2d 1236, 1237 (Mont. 1999); Horwich, *supra* note 209, at 323 & n.1 (quoting public land law scholar Charles Wilkinson, and describing Montana's Constitution as "the single strongest statement of conservation philosophy in the constitution of any state and, very likely, of any nation in the world").

301 See, e.g., *Glisson v. City of Marion*, 720 N.E.2d 1034, 1044 (Ill. 1999) (limiting state constitutional protection to pollution, explicitly excluding biodiversity conservation); Machi-

ment of environmental rights, like its strong negative rights orientation to health, is consistent with themes of rugged individualism and the frontier American West.³⁰² Under that view, the government generally should refrain from interfering with individual rights unless necessary to secure communal wants and needs. Clean air and water, like public health, are classic nonexcludable, nonexclusive “public goods,” requiring collective action to secure, protect, and promote.

The community as a whole has a stake in environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. These collective goods, and many more, are essential conditions for health. Yet these benefits can be secured only through organized action on behalf of the people.³⁰³

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

pongo Land & Coal Co. v. Commonwealth, 799 A.2d 751, 774–75 (Pa. 2002) (allowing state to defend takings claim against coal mine by showing that proposed mine had high potential to pollute stream); Margaret J. Fried & Monique J. Van Damme, *Environmental Protection in a Constitutional Setting*, 68 TEMP. L. REV. 1369 (1995) (urging stronger recognition of environmental rights under Pennsylvania’s constitution); Cusack, *supra* note 299, at 182–91 (discussing enforcement challenges); Howard, *supra* note 299, at 202–04 (listing states’ constitutional provisions declaring environmental “rights” and statutes allowing citizens’ suits).

302 See Gardner, *supra* note 66, at 817 (“The founders of a populist frontier state with a tradition of ferocious individualism, like Washington or Oregon, probably intended to carve out a larger sphere of rights, a larger arena of activity into which the government could not intrude” (quoting David Schuman, *Advocacy of State Constitutional Law Cases: A Report from the Provinces*, 2 EMERGING ISSUES IN STATE CONSTITUTIONAL LAW 275, 285 (1989))); Thompson, *supra* note 299, at 307 (describing new Western states’ approaches to natural resources and the environment, including constitutional protections).

303 GOSTIN, *supra* note 27, at 9; see Brett M. Frischmann, *An Economic Theory of Infrastructure and Commons Management*, 89 MINN. L. REV. 917, 942–56, 981–83 (2005) (defining terms and applying them to the environment); John S. Harbison, *Waist Deep in the Big Muddy: Property Rights, Public Values, and Instream Waters*, 26 LAND & WATER L. REV. 535, 547–48 (1991) (describing instream water as a public good that is both nonrival and nonexclusive); see also MANCUR OLSON, *THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS* (1971) (describing collective action problems in providing public goods); Ronald H. Coase, *The Lighthouse in Economics*, 17 J.L. & ECON. 357 (1974) (defining public goods as nonexclusive, nonexcludable goods, such as a lighthouse beacon).

3. *Hospital Care*

At least one state, Mississippi, expressly limits the state's constitutional authority to provide health care to the indigent in hospitals.³⁰⁴ Other states' constitutions, not surveyed above, expressly authorize the state to build public hospitals.³⁰⁵ Those provisions reflect states' traditional, limited role in providing health care to residents through almshouses, public hospitals, pesthouses, or sanatoria.³⁰⁶ Similarly, early private and quasi-governmental health insurance programs typically covered only the catastrophic risk of hospitalization, not a full array of routine and preventative medical care.³⁰⁷ Often, access to state hospitals was limited to the poor.³⁰⁸

Thus, the hospital-only limit on state constitutional recognition of health may be simply a subset of the indigency limit.³⁰⁹ The provisions may also fall under the public health duty. To the extent that state hospitals were established to treat infectious diseases, they fall within the scope of public health, rather than individual medical care.³¹⁰ If nothing else, the constitutional provisions on hospitals reflect an attempt to define narrowly any state responsibility and allocate scarce resources to the specific service of inpatient, acute care.

304 MISS. CONST. art. IV, § 86.

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

306 STARR, *supra* note 96, at 150 ("By making the almshouse the only source of governmental aid to the poor, legislatures hoped to restrict expenditures for public assistance."); Sara Rosenbaum, *supra* note 49, at 26 ("Prior to 1965 of course, the bulk of local spending on indigent health care took the form of direct investments in health care facilities such as public hospitals and clinics.").

307 See ROSENBLATT ET AL., *supra* note 255, at 10 (describing the history of Blue Cross, covering hospital but not physician services); *id.* at 369–70 (describing the political background of the original Medicare program, which began as Part A, hospital insurance); STARR, *supra* note 96, at 295–96 (describing the emergence of Blue Cross and other early insurance plans to cover hospital care).

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

309 See *supra* Part III.A.2.

310 See *supra* Part III.B.1.

4. Abortion

Several decisions construing state constitutions' protection for health arose in the context of abortion. New York found that refusing to fund abortions under a state parental assistance program did not violate the Public Health provision because the program was not aimed at protecting public health.³¹¹ Montana struck down restrictions on abortion providers because the law violated, among other rights, the inalienable right to health.³¹² New Jersey required the state Medicaid program to cover all medically necessary abortions³¹³ and upheld an injunction against abortion protesters found by the trial court to have obstructed access to medical services.³¹⁴

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

The New Jersey Medicaid decision, *Right to Choose v. Byrne*, came the closest to establishing an affirmative right to publicly funded abortions. The court declined to recognize a fundamental right to health but noted that the state places a "high priority" on health.³¹⁵ The decision rested primarily on the implied fundamental right to privacy and sounded in equal protection. The *Byrne* court made clear that the state is not constitutionally required to fund all abortions for all people in the state but "may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from a system providing all other medically necessary care for the indigent."³¹⁶

³¹¹ *Hope v. Perales*, 634 N.E.2d 183, 188 (N.Y. 1994).

³¹² *Armstrong v. State*, 989 P. 2d 364, 383–84 (Mont. 1999) (resting its holding primarily on the right to privacy, the court noted the "overlapping . . . guarantee[]" of "the inalienable right to . . . health. . . i.e., in the context of this case, the right to seek and obtain medical care from a chosen health care provider and to make personal judgments affecting one's own health and bodily integrity without government interference").

³¹³ *Right to Choose v. Byrne*, 450 A.2d 925 (N.J. 1982).

³¹⁴ *Horizon Health Ctr. v. Felicissimo*, 638 A.2d 1260, 1264, 1274 (N.J. 1994).

³¹⁵ *Byrne*, 450 A.2d at 934.

³¹⁶ *Id.*

By contrast, the U.S. Supreme Court had held two years earlier that states are not constitutionally obligated to fund abortions at all under Medicaid.³¹⁷ Federal abortion funding cases, even while recognizing a fundamental privacy right in the decision to have an abortion,³¹⁸ do not limit states' authority "to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds."³¹⁹ The Court subsequently backed down from the fundamental rights approach, replacing "close scrutiny" with the "undue burden" test for government regulation of a woman's interest in abortion.³²⁰

But even under the more rigorous standard of review, lack of government funding was not considered to interfere with a woman's right to an abortion.³²¹ Denial of state funding or access to public facilities leaves a woman "no worse off" than if the state had done nothing at all.³²² Moreover, poverty is not a suspect class that warrants heightened scrutiny for equal protection purposes.³²³ Thus, states are not required to pay for abortions, even though some women's lives may be at risk.³²⁴ The federal abortion funding cases express the same negative rights view as *DeShaney*: The state's failure to intervene to protect the child from his abusive father left him no worse off.³²⁵

³¹⁷ *Harris v. McRae*, 448 U.S. 297, 325–26 (1980).

³¹⁸ *Roe v. Wade*, 410 U.S. 113, 153–55 (1973).

³¹⁹ *Maher v. Roe*, 432 U.S. 464, 474 (1977).

³²⁰ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 876–77 (1992).

³²¹ *Harris*, 448 U.S. at 314–15, 322–23; see *Maher*, 432 U.S. at 473–78; Weiner, *supra* note 249, at 353–54 (explaining Court's decisions that restrictions on state funding for abortions do not constitute government interference with the right to abortion); Wing, *supra* note 3, at 168–69 (explaining that exclusions or limitations on government health programs are not subject to heightened review).

³²² *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 509 (1989) (upholding state law that prohibits use of state employees or facilities to perform abortions not necessary to save the mother's life); see also *Rust v. Sullivan*, 500 U.S. 173, 198 (1991) (extending rationale to uphold federal statute prohibiting public funding to health care facilities that counsel abortions); *Harris*, 448 U.S. at 316–17 (while a state "may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls into the latter category.").

³²³ *Maher*, 432 U.S. at 470–71 (stating that "[a]n indigent woman desiring an abortion does not come within the limited category of disadvantaged classes" and finding no discrimination against a suspect class).

³²⁴ *Harris*, 448 U.S. at 316–18; Blumstein, *supra* note 30, at 1378–79 (noting that the Court distinguished a woman's interest in protecting her own health from claimed constitutional entitlement to public funds for abortions); Wing, *supra* note 3, at 169–70 (discussing *Harris*).

³²⁵ Blumstein, *supra* note 30, at 1379 ("Freedom from governmental intrusion in a private realm does not automatically establish 'an entitlement to such funds as may be necessary to realize all the advantages of that freedom.'" (quoting *Harris*, 448 U.S. at 318)); Wing, *supra* note 3, at 168 (drawing a similar comparison to *DeShaney*).

Likewise, a state's failure to intervene to protect a woman whose health or life is in danger if she cannot obtain an abortion leaves her no worse off.

Federal law, although recognizing abortion rights, requires no affirmative state action to protect the right. States may, of course, give greater protection to individual rights than federal law.³²⁶ *Byrne* establishes New Jersey's decision to elevate women's abortion rights above the constitutionally mandated federal floor.³²⁷ Montana and New Jersey also seem to recognize a broader notion of "interference" than federal precedents by striking down restrictions on choice of medical provider and limiting free speech of abortion protesters.

But the enhanced protection that some states accord to abortion does not extend to health care, more broadly defined. Abortion is a singular, ideologically charged issue that encompasses much more than a medical procedure.³²⁸ There is no basis for assuming that state courts would apply the same principles in the same way to other health care services or government-funded medical care. The state abortion cases tell more about the state constituencies' religious beliefs, moral values, political ideologies, and medical standards than the value they place on health as a constitutional right.

C. State Constitutional Amendments

In evaluating the role of state constitutional provisions on health reform debates, it is useful to consider, at least briefly, not only what state constitutions include but also what amendments states have rejected. Several states recently considered constitutional amendments expressly recognizing broad, individually enforceable rights to

326 See *Right to Choose v. Byrne*, 450 A.2d 925, 931–32 (N.J. 1982) (noting that "the individual states may accord greater respect than the federal government to certain fundamental rights"); see also *supra* notes 64–66 (discussing Justice Brennan's articles and "new federalism").

327 See *Weiner*, *supra* note 248, at 354 & n.142 (discussing and citing state abortion cases, including *Byrne*, that "have gone beyond the Supreme Court's narrow interpretation of what constitutes government 'interference'").

328 Describing the abortion cases as *sui generis*, the *Casey* Court noted:

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

Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 852 (1992); see also *Harris*, 448 U.S. at 325 ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.").

health.³²⁹ In all cases, the proposals failed. In some states, the amendment debates served as catalysts for comprehensive legislative enactments. Even states typically considered progressive in many areas of health care reform have declined to constitutionalize universal health care rights. Like the adopted provisions, the proposed state constitutional amendments share certain common features.

Notably, the rights-creating language in the proposed amendments is much more explicit than the provisions currently in effect in some states. All of the proposed amendments affirmatively require state action and adequate financing for health care. Also, the amendments typically suggest a universal right, not limited to the mentally ill, indigent, helpless, in-custody, or other particular groups. The scope of the right would also be more comprehensive, including not just hospital or public health but a package of essential, comprehensive medical care. In addition, affordability is a key component of the proposed amendments, suggesting not just social or welfare rights but an economic right to health care. Overall, the proposals are much more detailed and explicit than existing state constitutions that mention health, coming closer to legislative enactments than general statements of public values or aspirations.³³⁰

In both Massachusetts³³¹ and Minnesota,³³² the proposed constitutional amendments were not adopted, but the state legislatures

³²⁹ See generally Kathrin Rüegg, *Embedding the Human Right to Health Care in U.S. State Constitutions: A Progress Review and Lessons for Advocates*, (Human Right to Health Program, Working Paper, 2009) (tracking history of attempts to amend constitutions in Massachusetts, Minnesota, Michigan, and Oregon, and mentioning additional proposals in North Carolina and Florida), available at http://www.nesri.org/programs/Constitutional_Amendment_Report_2-09.pdf.

³³⁰ See Gardner, *supra* note 66, at 819 (“[S]tate constitutions differ from the federal constitution in the level of detail in which they describe, and therefore the extent to which they constrain, governmental action with respect to subjects covered by the constitution.”); G. Alan Tarr, *Understanding State Constitutions*, 65 TEMP. L. REV. 1169, 1181–83 (1992) (explaining the prominence of “statutory” provisions in state constitutions, compared to the U.S. Constitution).

³³¹ See Health Care for Massachusetts Campaign, The Health Care Amendment (“Upon ratification of this amendment and thereafter, it shall be the obligation and duty of the Legislature and executive officials, on behalf of the Commonwealth, to enact and implement such laws, subject to approval of the voters at a statewide election, as will ensure that no Massachusetts resident lacks comprehensive, affordable, and equitably finance health insurance coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices.”) (footnotes omitted), available at <http://healthcareformass.org/about/amendment.shtml>.

³³² See, e.g., Minn. H.F. No. 683 (“Every Minnesota resident has the right health care. It is the responsibility of the governor and the legislature to implement all necessary legislation to ensure affordable health care.”), available at <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H0683.0.html&session=ls85>.

passed comprehensive health reform packages in the same year as the proposals were introduced.³³³ Key lobbyists behind the Minnesota proposal acknowledged that the amendment was a starting point for health reform and a way to gather and demonstrate public support for comprehensive legislation.³³⁴ In Massachusetts, sponsors of the Health Care Reform Act urged their colleagues to support the legislation instead of the proposed amendment. The Massachusetts constitutional amendment, they suggested, “would restrict legislators from quickly making inevitable tweaks” to the reform without going to a referendum vote for every change.³³⁵ In Michigan,³³⁶ the ballot proposal failed to gather the requisite signatures, getting lost in the Democratic Presidential Primary kerfuffle.³³⁷ Oregon,³³⁸ hailed as a leader in health reform innovation,³³⁹ has seen three, failed attempts

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

334 See Rüeegg, *supra* note 329, at 8 n.18 (summarizing statement of Jennifer Schaubach, Legislative Director of AFL-CIO, Minnesota).

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

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

337 See Rüeegg, *supra* note 329, at 11 (explaining how the lack of Democratic campaigning in Michigan impeded fundraising for the ballot initiative); Associated Press, *Dems Punish Michigan for Early Primary*, MSNBC, Dec. 1, 2007, available at <http://www.msnbc.msn.com/id/22054151/>.

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

339 See, e.g., Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL’Y & L. 161, 161 (1999) (“The Oregon Health Plan (OHP) has been widely heralded as an important innovation in medical care policy.”); Eric Lamond Robinson, *The Oregon Basic*

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

One can only speculate about the reasons that the proposed amendments failed to be adopted.³⁴⁰ But the experiences demonstrate that highly specific, rights-creating constitutional provisions on health have not gained popular political support, even in seemingly progressive states. Even if states are not willing to amend their constitutions to enshrine a health right, it would not be accurate to infer that states do not value health care, especially because states rejecting amendments subsequently enacted broad legislative health care reforms. The breadth and specificity of the proposed amendments that failed to pass provide a useful contrast to the narrowly defined, non-mandatory tone of the currently enacted state constitutional provisions examined above. That contrast suggests reluctance by states to provide broad constitutional guarantees of health care or to bind themselves to affirmative obligations and specific guarantees that may be difficult to uphold or modify.

IV. LESSONS FROM STATE CONSTITUTIONS

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

Health Services Act: A Model for State Reform?, 45 VAND. L. REV. 977, 1013 (1992) (describing how the Oregon Basic Health Services Act delivers better and more equitable health care than the federal system); Kathryn L. Tucker, *Federalism in the Context of Assisted Dying: Time for the Laboratory to Extend Beyond Oregon, to the Neighboring State of California*, 41 WILLAMETTE L. REV. 863, 865-71 (2005) (discussing Oregon's innovative physician-assisted suicide program); Casey Kaufman, Note, *Oregon v. Ashcroft: The Attorney General's Attempt to Override State Controlled Medical Practice*, 37 U.S.F. L. REV. 1065, 1065-66 (2003) (describing the Oregon Death with Dignity Act).

³⁴⁰ See generally Rüegg, *supra* note 329 (discussing penalties for violating party rules).

A. Assessment

The existing diversity of state constitutional approaches to health reflects diverse views on state constitutionalism and states' roles with respect to individuals' health. More than a dozen states give constitutional imprimatur to health.³⁴¹ Judicial decisions in the seven states examined demonstrate a general reluctance to recognize affirmative, enforceable health rights.³⁴² Indeed, there is not a single provision or case supporting a universal right to publicly funded health care. The clearest assertion of that sort of claim was soundly rejected before reaching the merits.³⁴³ Several states recognize health as a fundamental or inalienable right and protect individuals' right to obtain their own health insurance or medical care, free from interference by the state or others. Many expressly require legislative action to protect and promote the vital interest in health.³⁴⁴

In a few cases, claims to health rights fare better under state than federal law. State constitutions that contain aspirational statements, guarantee freedom to seek individual health care, or recognize state authority (if not obligation) for public health are more protective of health than the U.S. Constitution. Treatment for mentally ill or indigent persons, or for abortion or hospital care, may be required in some states. But even those situations are limited to particular groups of individuals and particular types of services for reasons that do not support a universal right to health care.³⁴⁵ Other constitutions mention health expressly but follow the federal preference for negative rights, declining to impose any affirmative duty on the state or recognize individually enforceable rights. States' recent attempts to adopt constitutional provisions enshrining clear, comprehensive health care rights and specific state duties have not received political support.³⁴⁶

States' reluctance to recognize judicially constitutional claims to individual health care rights should not be read as rejection of health as an essential human interest or insensitivity to the health, welfare, and safety of citizens. Rather, states may address those concerns through the coordinate branches of government. The urge to elevate health to an enforceable "right" seems to derive from the United

³⁴¹ See *infra* Appendix B (summarizing state constitutional provisions).

³⁴² See *supra* Part II.B.

³⁴³ Michigan Universal Health Care Action Network v. State, No. 261400, 2005 WL 3116595 (Mich. App. 2005).

³⁴⁴ See, e.g., WYO. CONST. art 7, § 20 (describing health as a "vital interest").

³⁴⁵ See *supra* Part III.A–B.

³⁴⁶ See *supra* Part III.C.

States tradition of according special prominence to constitutional rights³⁴⁷ and granting courts, the Supreme Court in particular, a virtual monopoly on constitutional interpretation.³⁴⁸ Accordingly, there is a sense that any right worthy of attention must be subject to judicial enforcement.³⁴⁹ But the legislative and executive branches are similarly compelled to abide by the constitution in carrying out their tasks. Legislators are expected prophylactically to consider the constitutionality of proposed legislation as much as courts rule retrospectively on the enacted laws.³⁵⁰ Moreover, courts may be ill-equipped to carry out the task of enforcing affirmative rights to adequate food, shelter, clothing, employment, and health care.³⁵¹ Provision of gov-

³⁴⁷ See *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819) (“In considering this question, then, we must never forget that it is a *constitution* we are expounding.”); Gardner, *supra* note 66, at 814 (“This cryptic phrase aptly captures the judicial view, embraced consistently ever since, that a constitution is different from other types of documents that courts may be called upon to interpret . . .”).

³⁴⁸ See *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803) (“It is emphatically the province and duty of the judicial department to [s]ay what the law is.”); Michelman, *supra* note 9, at 682 (discussing the “currently entrenched reliance on judicial review as an indispensable guarantor of the rule of constitutional law”); see also Gary Jeffrey Jacobsohn, *The Permeability of Constitutional Borders*, 82 TEX. L. REV. 1763, 1771 (2004) (noting Americans’ “predominant inclination has been to view the judiciary as exercising a monopoly over constitutional interpretation”); Linde, *supra* note 232, at 168 (suggesting that the “legitimacy” of judicial review “to set[] aside unconstitutional laws” is “the issue to which every law student is introduced by Chief Justice Marshall’s opinion in *Marbury v. Madison*.”).

³⁴⁹ See Sunstein, *supra* note 20, at 14 (“[I]n the American culture, constitutions are seen as pragmatic instruments—suited for, and not inextricable from, judicial enforcement.”); Tushnet, *supra* note 19, at 1211 (“[M]any appear to believe that, at least in advanced constitutional systems, civil rights must be enforceable through some sort of judicial proceeding.”).

³⁵⁰ Paul Brest, *Who Decides?*, 58 S. CAL. L. REV. 661, 670–71 (1985) (rebutting judicial exclusivity and placing responsibility on all branches to consider constitutional issues); Michelman, *supra* note 9, at 671, 685 (concluding that constitutional recognition of socioeconomic rights as a moral imperative on lawmakers may be separated from judicial review of constitutional law); Sager, *supra* note 11, at 435 (proposing an understanding that we are “constitutionally obliged . . . to address the injustice of poverty and entrenched racial disadvantage, but see the primary addresses of this obligation as elected officials rather than judges.”); Sunstein, *supra* note 20, at 16 (refuting institutional explanation for lack of social and economic rights, suggesting that “courts could take steps to ensure that basic needs receive a degree of legislative priority, and to correct conspicuous neglect.”).

³⁵¹ See Michelman, *supra* note 9, at 669 (“The choices needing to be made are subtle, technical, interactive, uncertain, subject-to-experience, and endlessly debatable. It is far from clear how courts of law can inject themselves into such matters with much credibility or authority.”); Mark Tushnet, *Social Welfare Rights and the Forms of Judicial Review*, 82 TEX. L. REV. 1895, 1896 (2004) (suggesting that a common argument against constitutional recognition of social welfare rights is that they “cannot be enforced in the courts because their enforcement requires the courts to make decisions that have large-scale consequences for government budgets”); see also Kinney, *supra* note 3, at 300 (“A more useful observation about individual enforcement of economic and social rights is that the de-

ernment services and implementation of social programs may be better handled legislatively than judicially.³⁵²

The role of the political branches in state constitutionalism is particularly salient. Although not as nimble as statutes, state constitutions are amended much more frequently and with much greater political involvement than the federal Constitution.³⁵³ Given the politics of state constitutionalism, it is appropriate that legislative and administrative roles figure prominently in state constitutional theory and interpretation.³⁵⁴ Many states that include health in their constitutions mandate legislative action or allow delegation to local authorities and agencies, as well as private actors, to address health or public health needs.³⁵⁵ Ironically, some of those provisions have the effect of reducing protection for individuals by cloaking state actors with im-

termination of their content involves facts and issues that are not appropriate for courts or other adjudicative tribunals to decide.”).

352 Bork, *supra* note 11, at 700 (stating that “[c]ourts simply are not equipped, much less authorized, to make . . . decisions” regarding the repeal of welfare statutes); Michelman, *supra* note 9, at 669–71 (discussing the widely-held view that courts “are ill-equipped for fine-tuned appraisals of governmental efforts” toward socioeconomic guarantees); Sager, *supra* note 11, at 420 (noting that implementation of social programs involves “immensely complex questions of social strategy and social responsibility . . . that seem far better addressed by the legislative and executive branches of government, questions that seem virtually out of the reach of the judiciary”); Sunstein, *supra* note 20, at 16 (“American courts have been reluctant to recognize social and economic rights, in part because of a belief that enforcement and protection of such rights would strain judicial capacities.”); Tushnet, *supra* note 19, at 1211 (“[C]ourts . . . are ill-suited to enforce social rights; courts cannot devise effective methods of ensuring that shelter, food or jobs are available to citizens.”).

353 TARR, *supra* note 63, at 23 (noting that “the federal Constitution has been amended less than once per decade,” compared to states, which regularly amend and revise their constitutions); Daniel B. Rodriguez, *State Constitutionalism and the Domain of Normative Theory*, 37 SAN DIEGO L. REV. 523, 527 (2000) (“[A] key distinction between the federal and state constitutions concerns the frequency of amendments over time.”); Lawrence G. Sager, *The Incurable Constitution*, 65 N.Y.U. L. REV. 893, 895 (noting that the U.S. “Constitution is markedly obdurate to textual change”); Schapiro, *supra* note 66, at 429–30 (noting the “greater ease of amending state constitutions and the greater electoral accountability of state judges”); Albert L. Sturm, *The Development of American State Constitutions*, 12 PUBLIUS: J. FEDERALISM 57, 57 (1982) (noting that “Since 1776, the fifty states have operated under no fewer than 145 constitutions” and tracing history of various amendments and changes).

354 Rodriguez, *supra* note 353, at 529–30 (“[A] difference between federal and state constitutionalism is a shift in focus from courts as the ultimate audiences for normative constitutional theory to the legislature and administrative agencies.”); *cf.* Kahn, *supra* note 63, at 471 (“An easily amended constitution may represent only a temporary resting place in an unsettled debate over public values. Such a constitution does not stand dramatically apart from ordinary politics.”).

355 See *supra* Part II.B.1–5 (discussing Michigan, New York, North Carolina, Mississippi, South Carolina); see also *infra* Appendices A (listing text of provisions) and B (summarizing similarities).

munity from liability. In sum, state constitutional law suggests ambivalence about health as an enforceable individual right but not a total lack of state concern for the health of individuals and populations.

B. Prescription

State constitutionalism does not provide a roadmap for health reform but does suggest certain trends that federal and state lawmakers should consider as they debate the future of the health care system. Perhaps the clearest message that can be derived from state constitutionalism is that any proposal for a universal, government-provided right to health care would not be widely supported. Indeed, Congress's recent federal reforms never seriously considered a single-payer proposal and ultimately rejected even a more modest "public option."³⁵⁶ States that constitutionally recognize the importance of health and limited state duties to provide health care do not guarantee health care to all residents. Attempts to litigate those sorts of claims or enact amendments guaranteeing universal health care rights have not succeeded. States, although raising the federal floor on protection of health in small degrees, generally adhere to the negative rights view that health is a matter of individual responsibility. To the extent that health is enshrined as a right in state constitutions, the provisions suggest merely that states cannot interfere with individual health care decisions or access, not that states must provide health care to all.

The survey of state constitutions demonstrates that states embrace their traditional reserved police powers to regulate public safety, public health, insurance companies, medical professions, and the environment to varying degrees. Federal reforms that intrude on traditional state powers will draw strong resistance.³⁵⁷ States will jealously

³⁵⁶ See Shailagh Murray, *House Health Care Reform Bill to Include Public Option*, WASH. POST, Oct. 29, 2009, at A7, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/28/AR2009102804756.html>; Robert Pear & David M. Herszenhorn, *Public Option Push in Senate Comes with Escape Hatch*, N.Y. TIMES, Oct. 27, 2009, at A1, available at http://www.nytimes.com/2009/10/27/health/policy/27health.html?_r=1&hp; see, e.g., Henry J. Kaiser Family Foundation, *Side-by-Side Comparison of Major Health Care Reform Proposals*, at 31 (describing H.R. 676 proposal to create federal health insurance program for all U.S. residents and comparing other bills) (updated April 7, 2010), available at http://www.kff.org/healthreform/upload/healthreform_sbs_full.pdf.

³⁵⁷ See, e.g., *Complaint, State of Florida v. Sebelius*, (N.D. Fla., March 23, 2010), available at [http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/\\$file/HealthCareReformLawsuit.pdf](http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/$file/HealthCareReformLawsuit.pdf). (asserting various constitutional arguments by 13 states, including Tenth Amendment, against Patient Protection and Affordable Care Act); see also Kirk Johnson, *States' Rights is Rallying Cry Of Lawmakers*, N.Y. TIMES, Mar. 17, 2010, at A1 available at

guard both their power to regulate in those areas as well as their choice to not regulate. States regulate medical professionals, health care facilities, and health insurance companies, but generally leave patients free to control and arrange payment for their own medical treatment. State constitutional law suggests a strong negative rights orientation, leaving individuals to pursue their own health care but not obligating the state to provide for them.

States may exercise greater powers in the areas of environmental and public health in order to promote the common good. Those examples suggest that if health care reform can be reframed as a collective action or public goods problem, the proposals may gain better traction. Mandatory vaccination intrudes on personal autonomy and medical decision making, but serves the common good by protecting society from infectious diseases. Similarly, mandatory health insurance, while arguably intruding on individual economic rights,³⁵⁸ may serve the common good by effecting broader risk pools and making health insurance more affordable for all.³⁵⁹ Recognizing states' greater receptivity to strong public health powers and framing health reform in those terms may be a way to overcome resistance.

Another approach would be to draw on states' recognition of a constitutional duty to provide health care to the indigent, in some cases, more generously than federal law. That state law trend evidences the view of a significant portion of the population that health care is not entirely a matter of individual responsibility, at least when it comes to people who are unable to obtain health care on the private market through their own efforts. Brought into the health reform debate, those opinions suggest support for government subsi-

<http://www.nytimes.com/2010/03/17/us/17states.html>; Timothy S. Jost, *Can the States Nullify Health Care Reform?*, 362 *NEW ENG. J. MED.* 869, 869 (2010) (describing trend of state resolutions aimed at nullifying federal health reform); Lisa Rosetta, *Most Say Opt Out of Health Reform*, *SALT LAKE TRIB.*, Jan. 26, 2010 (reporting poll results that majority of Utahans favor state level reform to federal reform), available at http://www.sltrib.com/news/ci_14265496; Richard Cauchi, National Conference of State Legislatures, *State Legislation Challenging Certain Reforms*, 2010, <http://www.ncsl.org/default.aspx?tabid=18906> (identifying thirty-nine states with pending legislation objecting to various provisions of federal health reform, including the public option and individual mandate).

358 See Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, 37 *J.L. MED. & ETHICS* 38, 44-45 (2009) (discussing how mandated health coverage would affect the economic rights of individuals and employers).

359 See Blumberg & Holahan, *supra* note 76, at 6.

dies for those unable to afford private health insurance and expansion of existing government health care programs.³⁶⁰

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

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

Similarly, state constitutions that more vigorously protect abortion rights than federal law reflect a host of moral, religious, political, and scientific views having little to do with health care more broadly speaking. The abortion rights debate has its own political discourse, which, if interjected into the health reform debate, would likely undermine support for health care rights. Indeed, federal proposals to require any new government health care benefit to cover abortions drew acrimonious responses,³⁶¹ and the final law expressly excepts abortion from any federal funding.³⁶²

States that limit their duty to inpatient hospital care may represent nothing more than an outdated view of medicine that undervalues

³⁶⁰ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 1402, 124 Stat. 119 (2010) (subsidies); *id.* § 2001 (Medicaid expansion),

³⁶¹ See, e.g., Dan Eggen & Rob Stein, *Abortion Opponents Criticize Health Reform Bills*, WASH. POST, July 23, 2009, at A5, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/22/AR2009072201583.html>; *Mandated Abortion Coverage Threatens Health Care Reform, U.S. Bishops' Official Says*, CATHOLIC NEWS AGENCY, Aug. 8, 2009, available at <http://www.catholicnewsagency.com/new.php?n=16798>; Karen Tumulty, *Could Abortion Coverage Sink Health-Care Reform?*, TIME, July 8, 2009, available at <http://www.time.com/time/politics/article/0,8599,1909178,00.html>.

³⁶² Exec. Order No. 13535, 75 Fed. Reg. 15599 (Mar. 24, 2010) ("Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act").

the importance of routine, preventative care. Modern health insurance plans and government health care programs encourage early diagnosis and prevention of health conditions that become more expensive to treat later rather than sooner.³⁶³ The hospital-only and other attempts by states to narrowly circumscribe their health care duties reflect the unavoidable reality that health care resources are scarce and must be rationed to some degree.³⁶⁴ That tension persistently underlies much of the health reform debate. States' constitutions offer little guidance for lawmakers making those difficult resource-allocation choices.

Setting aside the specific constitutional provisions and judicial decisions, the larger lesson of this survey and analysis of state constitutional law is recognition of the vital role that states play in health care delivery and reform. State constitutions offer a composite of views and approaches to guide reform at the federal and state levels. Even if differing political norms align only incidentally with state borders,³⁶⁵ state constitutions and state politics offer more accessible fora for expressing individual, even dissenting, opinions.³⁶⁶ Coalitions organized

³⁶³ See Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489, 502–05 (1995); Utz, *supra* note 80, at 132; Robert S. Gold, Editorial, *An Ounce of Prevention for the Debate on Health Care Reform*, BALTIMORE SUN, Aug. 6, 2009, at 15A, available at <http://www.baltimoresun.com/news/opinion/oped/bal-op.prevention06aug06,0,5754911.story>.

³⁶⁴ See Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES MAG., July 19, 2009, MM38, available at <http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html?pagewanted=all>. But see David B. Rivkin, Jr. & Lee A. Casey, *Is Government Health Care Constitutional?*, WALL ST. J., June 22, 2009, at A15.

³⁶⁵ See Gardner, *supra* note 66, at 818 (“[W]hatever currency the notion of local variations in character and values might once have had, it is a notion that no longer describes in any realistic way the politics of the present day states.”); Kahn, *supra* note 232, at 1150, 1168 (stating that “[i]f states are no longer the locus of a vibrant, community experience, then a state constitutionalism that looks to the unique state community for its sources of decisionmaking promises to remain a marginal factor in American public life,” urging instead state constitutionalism as “a process of giving voice to the state court’s understanding of the values and principles of the national community”); Hans A. Linde, *supra* note 232, at 194 (“Federalism divides our laws along state lines, but those lines do not match divisions in American society. . . . What national theory treats as a minority often is a majority in part or all of a state.”); Schapiro, *supra* note 66, at 428–40 & n.148 (reviewing and rebutting state identity arguments but nevertheless identifying a role for independent interpretation of state constitutions).

³⁶⁶ See Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256 (2009) (suggesting potential benefits for policymaking as a result of state resistance and dissent to federal reforms); Ernest A. Young, *Welcome to the Dark Side: Liberals Rediscover Federalism in the Wake of the War on Terror*, 69 BROOK. L. REV. 1277, 1311 (2004) (“Federalism is about dividing power . . . [and] providing institutional space for a diversity of political views.”).

around state politics to address state-level concerns may have stronger voices than they would at the federal level. States, as subunits of the federal government, offer greater access to the political process and opportunities to affect policy.³⁶⁷

The proposals for health care rights constitutional amendments demonstrate the value of state constitutionalism as opportunities to vet ideas and highlight policy concerns, even if, and perhaps because, the proposed amendments failed to be adopted.³⁶⁸ In those debates, lawmakers and voters were squarely compelled to consider whether health is a “constitutional” value or, at least, a pressing public concern demanding legislative action. Despite the failed constitutional amendment in Massachusetts, for example, that state’s reform package now serves as a comprehensive model.³⁶⁹ Watching the results of that experiment, other states and federal policymakers can develop proposals that encompass the successes and avoid the pitfalls.³⁷⁰

Moreover, if health care is to be enshrined as a constitutional right at all, it is more appropriately recognized at the state level. If a state ultimately does manage to enact a rights-creating constitutional amendment, other states could observe, evaluate, and perhaps follow. By contrast, a federal constitutional right would raise the minimum floor, narrowing the space for experimentation.³⁷¹

Scholars have comprehensively identified the many challenges associated with constitutional recognition of affirmative, enforceable rights.³⁷² Nevertheless, there is still something to be said for constitu-

367 See Kahn, *supra* note 232, at 1166 (noting “a longstanding justification of federalism under which state governments provide a forum for discussion, disagreement, and opposition to actions of the national government”); Long, *supra* note 64, at 46 (“States will probably never be the primary community or source of identity for most Americans. On the other hand, states may play some small part, at least once in a while, for nearly all Americans. Intermittent state constitutionalism recognizes and encourages this polyvalent sense of cultural identity.”); Rodriguez, *supra* note 44, at 271 (observing that state constitutions are “intrinsically important as legal frameworks for the implementation of public policy”).

368 See *supra* Part III.C.

369 See *supra* notes 74–76 and accompanying text (describing Massachusetts 2006 Health Reform Plan and proposals under President Obama’s administration).

370 See, e.g., Robert Steinbrook, *The End of Fee-for-Service Medicine? Proposals for Payment Reform in Massachusetts*, 361 NEW ENG. J. MED. 1036 (2009); Abby Goodnough, *Massachusetts Adjusts a Cut, Providing Some Health Care for 30,000 Immigrants*, N.Y. TIMES, July 30, 2009, at A19; *The Massachusetts Model*, N.Y. TIMES, Aug. 9, 2009, at wk 7.

371 Gardner, *supra* note 64, at 490 (arguing that if the purpose of state experimentation “is to influence the Court’s development of federal constitutional law, the effect of success can only be to persuade the Court to raise the federal floor—thereby depriving the states of a measure of their autonomy”).

372 See, e.g., Bades, *supra* note 19, at 2327–42 (discussing arguments against recognition of affirmative rights in section on “The Fear of Chaos: Floodgates, Slippery Slopes, and

tionalizing certain values and bestowing with them that weight of importance. Individual health is undeniably fundamental in the common parlance, non-constitutional sense of the word. Without a healthy body and mind, an individual cannot fully participate in many other aspects of society. Including health in state constitutions serves as “a constant headline,” guiding lawmakers and reminding the public of its importance.³⁷³ State constitutions that provide even weak protection for health serve that headlining function, even if they do not create robust, individually enforceable rights. Several nations’ constitutions contain similar nonjusticiable “directive principles” expressing fundamental values and requiring legislative action.³⁷⁴

Nonjusticiable constitutional expressions of health are not legally irrelevant,³⁷⁵ as demonstrated by the state judicial decisions surveyed in this Article. The state constitutional provisions on health were not always decisional but certainly instructive to the courts’ opinions, even when merely granting governmental immunity or approving state funding for health care. The right, duty, concern, or other constitutional reference to health at the very least called on courts to consider the impact of their decisions on the health of individuals in the state. As the cases reveal, health bears on many other substantive areas of law, including criminal, disability, family, environmental, torts, poverty, and abortion. Health is central to state governance, whether explicitly recognized in the constitution or inextricably intertwined with other state laws and values. Therefore, ardent advocates of health care rights should not be troubled by the absence of

Judicial Incapacity”); Cross, *supra* note 19, at 878–93 (discussing various arguments from critics of positive rights, including cost, judicial competence, and politics); Michelman, *supra* note 9, at 668–72 (listing “instrumental reasons” for the American constitutions’ failure to include socioeconomic rights); Sunstein, *supra* note 20, at 15 (suggesting a litany of questions that would arise if the Constitution included affirmative rights).

³⁷³ See Jacobsohn, *supra* note 348, at 1770 (quoting framers of Irish Constitution on inclusion of nonjusticiable Directive Principles (Ir. CONST., 1937, art. 45 (Social Policy))).

³⁷⁴ See, e.g., INDIA CONST. art. 37 (“The provisions contained in this Part [IV] shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.”); Ir. CONST., 1937, ch. XIII, art. 45 (announcing “principles of social policy . . . intended for the general guidance of [Parliament]” and specifying that they “shall not be cognizable by any Court under any of the provisions of this Constitution”); NIG. CONST., art 17 (providing for nomination of candidates for election into public offices); PAPUA N.G. CONST. pmbl. para. 2 (declaring independence and sovereignty).

³⁷⁵ See Kinney & Clark, *supra* note 20, at 301 (“[T]he right as policy imperative requires bound states to take legislative action and array national budgetary priorities in ways that fulfill that policy imperative.”); Tushnet, *supra* note 351, at 1898 (“Nonjusticiable rights . . . can be used to interpret ambiguous statutes [or to] explain why the courts refuse to recognize *other* rights . . .”).

enforceable constitutional guarantees of health in the federal or separate state constitutions. The multiple deficiencies in the United States' health care system to provide essential health care to individuals already are receiving considerable attention. State constitutions are admittedly imperfect, incongruent, and politicized.³⁷⁶ But the realpolitik of state constitutional law does not undermine its value as an essential collection of voices in the health reform conversation.

CONCLUSION

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

³⁷⁶ See, e.g., Gardner, *supra* note 66, at 763 (“[S]tate constitutional law today is a vast wasteland of confusing, conflicting, and essentially unintelligible pronouncements.”); Linde, *supra* note 232, at 196 (“Most state constitutions are dusty stuff – too much detail, too much diversity, too much debris of old tempests in local teapots, too much preoccupation with offices, their composition and administration, and forever with money, money, money.”)

Appendix A

| Provision | Year of Adoption | Current Text |
|---------------------------------|------------------|---|
| ALA. CONST. ART. IV, § 93.12 | 1946 | The state ... may acquire, build, establish, own, operate and maintain hospitals, health centers, sanatoria and other health facilities. The legislature for such purposes may appropriate public funds and may authorize counties, municipalities and other political subdivisions to appropriate their funds, and may designate or create an agency or agencies to accept and administer funds appropriated or donated for such purposes by the United States government to the state upon such terms and conditions as may be imposed by the United States government. |
| ALASKA CONST. ART. VII, § 4 | 1956 | The legislature shall provide for the promotion and protection of public health. |
| ARK. CONST. ART. 19, § 19 | 1874 | It shall be the duty of the General Assembly to provide by law for the support of institutions for the education of the deaf and dumb and the blind, and also for the treatment of the insane. |
| HAW. CONST. ART. IX, § 1 | 1978 | The State shall provide for the protection and promotion of the public health. |

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| HAW. CONST. ART. IX, § 3 | 1978 | The State shall have the power to provide financial assistance, medical assistance and social services for persons who are found to be in need of and are eligible for such assistance and services as provided by law. |
| ILL. CONST. PMBL. | 1970 | We, the People of the State of Illinois — grateful to Almighty God for the civil, political and religious liberty which He has permitted us to enjoy and seeking His blessing upon our endeavors — in order to provide for the health, safety and welfare of the people... |
| LA. CONST. ART. XII, § 8 | 1974 | The legislature may establish a system of economic and social welfare, unemployment compensation, and public health. |
| MICH. CONST. ART. 4, § 51 | 1963 | The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health. |
| MISS. CONST. ART. IV, § 86 | 1869 | It shall be the duty of the Legislature to provide by law for the treatment and care of the insane; and the Legislature may provide for the care of the indigent sick in the hospitals in the State. |
| MO. CONST. ART. 4, § 37 | 1972 | The health and general welfare of the people are mat- |

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| | | <p>ters of primary public concern; and to secure them there shall be established a department of social services in charge of a director appointed by the governor, by and with the advice and consent of the senate, charged with promoting improved health and other social services to the citizens of the state as provided by law, and the general assembly may grant power with respect thereto to counties, cities or other political subdivisions of the state.</p> |
| <p>MONT. CONST. ART II, § 3.</p> | <p>1972</p> | <p>All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life's basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and seeking their safety, health and happiness in all lawful ways. In enjoying these rights, all persons recognize corresponding responsibilities.</p> |
| <p>N.C. CONST. ART. XI § 4</p> | <p>1970</p> | <p>Beneficent provision for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and a Christian state. Therefore the General Assembly shall provide for and define the</p> |

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

Appendix B

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