Maryland Law Review

Volume 81 | Issue 1 Article 5

Equality and Sufficiency in Health Care Reform

Gabriel Scheffler

EQUALITY AND SUFFICIENCY IN HEALTH CARE REFORM

GABRIEL SCHEFFLER*

Most Americans believe that health care is a right, not a privilege. Yet debates over health care reform frequently fail to distinguish between two distinct conceptions of the right to health care: one which focuses on sufficient access to health care—what I refer to as the Right to a Decent Minimum—and a second which focuses on equality in access to health care—what I refer to as the Right to Equal Access. These two conceptions of the right to health care in turn support two distinct categories of proposals for expanding health insurance coverage. The Right to Equal Access justifies a more radical set of reforms, such as Medicare for All, whereas the Right to a Decent Minimum justifies a more incremental approach to health care reform, such as by building on the Patient Protection and Affordable Care Act. Comparing these two conceptions of the right to health care to Medicare for All and the incremental reforms clarifies what it as stake in the debate over health care reform: not just concerns about political feasibility, but also different moral or political values. At the same time, it reveals that there are some surprising areas of convergence between these two conceptions of the right to health care, and accordingly, that there is room for greater convergence between these two types of reform proposals.

* Associate Professor of Law, University of Miami School of Law. I thank the organizers and participants at the 2020 Health Law Scholars Workshop, hosted by Saint Louis University School of Law and the American Society of Law, Medicine & Ethics (ASLME); the 2021 ASLME Health Law Professors Conference, hosted by Northeastern University School of Law; the Harvard Health Law Policy, Bioethics, and Biotechnology Workshop; and the Florida International University College of Law Faculty Workshop. In particular, I am grateful for helpful feedback from Jessica Adler, Elizabeth Bast, Heather Bednarek, I. Glenn Cohen, Nathan Cortez, Greer Donley, Tamar Ezer, Leslie Francis, Robert Gatter, Jesse Goldner, Frances Hill, Allison Hoffman, Seema Mohapatra, JoNel Newman, Jim Nickel, Jennifer Oliva, Elizabeth Pendo, Anya Prince, Ana Santos Rutschman, Samuel Scheffler, Steve Schnably, Stacey Tovino, Howard Wasserman, Sidney Watson, Ruqaiijah Yearby, and Carly Zubrzycki. I thank Bailey Beauchamp for helpful editorial assistance. Finally, I am grateful to the *Maryland Law Review* editorial team, in particular Carly Brody, Will Gallagher, and Darcy Wood.

INTRODUCTION

Most Americans today believe that health care is a right, not a privilege.[1] In other words, they believe that all Americans are entitled to have health care, and that it is the government's responsibility to ensure that that is the case.[2] Yet the notion that health care is a right lacks specificity: What, concretely, is the kind of health care to which people have a right?

Viewing health care as a right apparently does not entail support for one specific health care reform plan.[3] Both President Joe Biden and Senator Bernie Sanders have described health care as a right, yet the latter made a single-payer Medicare for All plan the centerpiece of his 2016 and 2020 presidential campaigns,[4] whereas the former endorsed a more incremental approach that would expand the coverage provisions in the 2010 Patient Protection and Affordable Care Act (ACA), lower the eligibility age for Medicare, and establish a public option.[5] More generally, although Democrats tend to be strongly supportive of the notion that health care is a right, they have largely clustered into two main camps: those who support Medicare for All, and those who take a more incremental approach to health care reform, such as the Biden plan.[6] These two camps' preferred health care reform proposals differ in various ways, including in terms of the benefits

1. *Healthcare System*, GALLUP, https://news.gallup.com/poll/4708/healthcare-system.aspx (last visited Oct. 26, 2021).

2. *See* Leif Wenar, *Rights*, *in* STAN. ENCYC. OF PHIL. 1, 1 (Edward N. Zalta et al., 2021), https://leibniz.stanford.edu/friends/preview/rights/ (defining rights as "entitlements (not) to perform certain actions, or (not) to be in certain states; or entitlements that others (not) perform certain actions or (not) be in certain states").

3. *See* NORMAN DANIELS, JUST HEALTH CARE 8 (1985) [hereinafter DANIELS, JUST HEALTH CARE] ("Talk about a 'right to health care' can . . . imply quite different things, both with regard to the *scope* of what is being claimed and with regard to the type of justification it needs.").

4. Sen. Bernie Sanders, *An Economic Agenda for America: 12 Steps Forward*, HUFFINGTON POST: BLOG (Dec. 1, 2014, 12:13 PM), https://www.huffpost.com/entry/an-economic-agenda-for-am_b_6249022 ("The United States must join the rest of the industrialized world and recognize that health care is a right of all, and not a privilege. Despite the fact that more than 40 million Americans have no health insurance, we spend almost twice as much per capita on health care as any other nation. We need to establish a Medicare-for-all, single-payer system.").

5. *READ: Joe Biden's Remarks on Civil Unrest and Nationwide Protests*, CNN (June 2, 2020, 12:00 PM), https://www.cnn.com/2020/06/02/politics/biden-philadelphia-transcript/index.html ("[H]ealth care . . . should be a right not a privilege. The quickest route to universal coverage in this country is to expand Obamacare."); *Health Care*, BIDEN HARRIS, https://joebiden.com/healthcare/ (last visited Oct. 29, 2021).

6. Abby Goodnough & Trip Gabriel, *'Medicare for All' vs. 'Public Option': The 2020 Field Is Split, Our Survey Shows*, N.Y. TIMES (June 23, 2019), https://www.nytimes.com/2019/06/23/us/politics/2020-democrats-medicare-for-all-public-option.html.

that they would guarantee, the amount of cost-sharing borne by patients, and the role played by private insurance.[7]

Most of the public debate between these different camps has revolved around two fault lines: political feasibility and economic costs. Incrementalists object to Medicare for All as politically impossible and excessively costly.[8] Supporters of Medicare for All counter that the incrementalists are misinterpreting the lessons of history,[9] and that Medicare for All will lower costs by improving administrative efficiencies and reducing health care prices.[10] Which of these positions is correct is an empirical question. Both sides are making predictions about the future, while drawing on historical experience, data, and assumptions.[11]

What is less clear is whether these two positions also reflect different normative positions regarding the kind of health care benefits to which people are entitled. Many incrementalists deny that they object to Medicare for All in principle, but instead claim that they object to it on other grounds, such as that it is too politically difficult, or that there are other more important policy priorities (such as reforming our electoral system or addressing climate change).[12] Some health scholars have portrayed the debate between

7. *See infra* Part I. Of course, a substantial fraction of the American public does not view health care as a right at all, but rather as a privilege or a market commodity. *See Healthcare System*, *supra* note 1. This Article does not focus on that position, but it has been widely discussed elsewhere. *See, e.g.*, RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997); Atul Gawande, *Is Health Care a Right?*, NEW YORKER (Sept. 25, 2017), https://www.newyorker.com/magazine/2017/10/02/is-health-care-a-right.

8. *See, e.g.*, Paul Starr, *Rebounding with Medicare: Reform and Counterreform in American Health Policy*, 43 J. HEALTH POL., POL'Y & L., 707, 724 (2018); Emmarie Huetteman, *Democrats Debate Whether 'Medicare For All' is 'Realistic*,*'* KAISER HEALTH NEWS & POLITFACT HEALTHCHECK (Dec. 20, 2019), https://khn.org/news/democrats-debate-whether-medicare-for-all-is-realistic/.

9. *See* Adam Gaffney, *Medicare For All: If Not Now, When?*, HEALTH AFFS. BLOG (Mar. 9, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200309.156440/full/.

10. *See, e.g.*, *id*.; Shefali Luthra, *Sanders Embraces New Study That Lowers 'Medicare For All's' Cost, But Skepticism Abounds*, KAISER HEALTH NEWS (Feb. 26, 2020), https://khn.org/news/bernie-sanders-embraces-a-new-study-that-lowers-medicare-for-alls-price-tag-but-skepticism-abounds/; Meagan Day & Bhaskar Sunkara, *Why America Needs Medicare for All*, N.Y. TIMES (Aug. 10, 2018), https://www.nytimes.com/2018/08/10/opinion/medicare-for-all-health-costs.html.

11. *See* Josh Katz, Kevin Quealy & Margot Sanger-Katz, *Would 'Medicare for All' Save Billions or Cost Billions?*, N.Y. TIMES (Oct. 16, 2019), https://www.nytimes.com/interactive/2019/04/10/upshot/medicare-for-all-bernie-sanders-cost-estimates.html (cataloging different economists' and think tanks' estimates of how Medicare for All would affect American health care expenditures).

12. *See, e.g.*, Bobby Clark, *The Peril of Medicare for All*, HEALTH AFFS. BLOG (Oct. 22, 2019), https://www.healthaffairs.org/do/10.1377/hblog20191018.763821/full/; John E. McDonough, *Medicare For All: What History Can Teach Us About its Chances*, HEALTH AFFS. BLOG (Feb. 21, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200218.541583/full/; Matthew Yglesias, *Democratic Priorities For 2021: What's Most Important?*, VOX (Oct. 26, 2018), https://www.vox.com/policy-and-politics/2018/10/26/18027000/democratic-priorities-2021.

the two camps as one about means rather than ends, and have emphasized that both sides share the common goal of achieving universal health insurance coverage.[13] Along similar lines, others have suggested that implementing either Medicare for All or a more incremental health care reform proposal would secure the right to health care.[14] By contrast, some advocates of Medicare for All have framed it as morally distinctive because of its emphasis on reducing inequality, and have framed it as the only health care reform that can secure the right to health care.[15] Yet it is not clear from these accounts *why* inequality in access to health care is objectionable, and whether these objections extend to all forms of inequality in access.

This Article argues that there is in fact an important normative difference between these two positions: namely, that the incremental and Medicare for All proposals are supported by two different conceptions of the right to health care.[16] At base, these two conceptions reflect different views about what kind of health care we owe to each other.[17] These are not disagreements about political feasibility or empirical projections, but rather about moral or political values. Failure to recognize these conflicting values means that health care reform advocates frequently talk past one another, without confronting the underlying normative differences in their visions of

13. *See, e.g.*, Harold Pollack, *Single Payer Is Not a Principle*, DEMOCRACY: J. OF IDEAS (Fall 2017), https://democracyjournal.org/magazine/46/single-payer-is-not-a-principle/; *see also* JONATHAN COHN, THE TEN YEAR WAR 329 (2021) ("[T]he distinctions between versions of national health insurance aren't so important in the grand scheme of things."); Ronald Dworkin, *Justice in the Distribution of Health Care*, 38 MCGILL L.J. 883, 894 (1993) (venturing that "whether the United States ultimately chooses a single-payer scheme . . . or . . . a scheme that includes private competition, is more likely to depend on considerations other than justice.").

14. *See, e.g.*, Jeneen Interlandi, *Employer-Based Health Care, Meet Massive Unemployment*, N.Y. TIMES (June 29, 2020), https://www.nytimes.com/2020/06/29/opinion/coronavirus-medicare-for-all.html.

15. *See, e.g.*, Adam Gaffney, *Single-Payer or Bust*, DISSENT MAG., Spring 2018, https://www.dissentmagazine.org/article/single-payer-or-bust-two-souls-universal-healthcare ("[S]ingle-payer provides a distinct—and more egalitarian—vision of universality."); Tim Higginbotham & Chris Middleman, *"Medicare-for-All" Means Something. Don't Let Moderates Water It Down.*, VOX (July 13, 2018, 9:50 AM), https://www.vox.com/the-big-idea/2018/7/13/17567952/medicare-for-all-centrists-copycat-plans-water-down-left-center-sanders ("If we are truly committed to the idea of health care as a right, then we will eliminate the profit motive and guarantee that all patients receive the same standard of treatment and breadth of coverage.").

16. To be clear, I do not mean that the proponents of Medicare for All and the incremental reforms actually have these conceptions of the right to health care in mind, but rather that these conceptions provide at least some degree of justificatory support for their respective positions.

17. *See* NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 15 (2008) [hereinafter DANIELS, JUST HEALTH] ("[W]e may claim a right to health or health care only if it can be harvested from an acceptable general theory of distributive justice or from a more particular theory of justice for health and health care.").

health care reform. The goal of this Article is to bring to light these normative differences.[18]

In brief, Medicare for All is supported by a conception of the right to health care that is focused on equality in access to health care. This first conception of the right to health care, which I term the *Right to Equal Access*, is egalitarian, reflecting a concern with "the difference between what some have and what others have, and for reducing this difference."[19] The Right to Equal Access implies that unequal access to health care is objectionable, at least to some extent. By contrast, the incremental vision of health care reform is supported by a conception of the right to health care that is focused on sufficient access to health care. This second conception, which I term the *Right to a Decent Minimum*, is an example of what philosopher Harry Frankfurt refers to as the "doctrine of sufficiency," the idea that "what is morally important . . . is that everyone should have enough."[20] The Right to a Decent Minimum implies a right to access some fixed set of health care benefits, and that inequality in health care access is not itself objectionable.[21]

There are different theories of justice in health care that have been invoked to support the Right to Equal Access, and these theories have different justifications and implications for health care reform. At one end of the spectrum, what is sometimes referred to as the "insulation ideal" implies that health care should be distributed on a completely equal basis to all those who need it.[22] A much more nuanced and comprehensive theory, developed by philosopher Norman Daniels, posits that health care institutions should be governed so as to ensure what John Rawls refers to as "fair equality of opportunity."[23]

Similarly, there are multiple theories of justice in health care that support the Right to a Decent Minimum. Ronald Dworkin has developed what he refers to as a "prudent insurance" ideal, which implies that the

18. In this effort, I follow in the footsteps of other health scholars who have explored different ways that various features of the U.S. health care system reflect conflicting moral or political values. *See generally* Avedis Donabedian, *Social Responsibility for Personal Health Services: An Examination of Basic Values*, INQUIRY, June 1971, at 3; Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873 (2011).

19. T.M. SCANLON, WHY DOES INEQUALITY MATTER? 1 (2018).

20. HARRY G. FRANKFURT, ON INEQUALITY 7 (2015).

21. The divide between those who view rights as requiring a sufficient distribution of goods and those who view rights as requiring some degree of material equality has a long history and extends well outside of the health care context. *See generally* SAMUEL MOYN, NOT ENOUGH: HUMAN RIGHTS IN AN UNEQUAL WORLD (2018) (critiquing the human rights movement for focusing on sufficiency and failing to address material inequality).

22. RONALD DWORKIN, SOVEREIGN VIRTUE: THE THEORY AND PRACTICE OF EQUALITY 311 (2000) [hereinafter DWORKIN, SOVEREIGN VIRTUE].

23. *See generally* DANIELS, JUST HEALTH CARE, *supra* note 3.

government should provide insurance coverage for those health care services for which people would choose to purchase insurance coverage under certain idealized conditions.[24] A second influential account is a modified market approach, which justifies providing a basic package of health care benefits through market mechanisms on the basis that doing so will improve societal welfare.[25] Although these accounts do not explicitly invoke the language or framework of "rights," they each provide justifications for enacting a legal right to health care.[26] In particular, they each provide reasons in favor of extending health insurance coverage to all Americans.

This Article examines these distinct conceptions of the right to health care and their underlying distributional justifications, as well as the practical differences in terms of what they mean for the future of health care reform. Although there is not a single philosophical consensus about what kind of health care we owe one another, we can learn something from examining the different conceptions of the right to health care. Doing so shows that key policy differences between the two categories of reforms reflect different moral or political values. Yet it also shows that there is more room for convergence among these two types of reforms than might otherwise be expected, and it reveals that both categories of reforms fall short in at least one important respect from the perspective of either conception of the right to health care.

The divide between the Medicare for All and the incrementalist camps seems likely to be a subject of political disagreement for years to come. It dates back to the 1940s, when Democratic members of Congress first introduced a bill that would have created a national universal health insurance program.[27] Nor has the ACA forged a consensus on this issue. Although the implementation of the ACA appears to have increased public support for universal health insurance coverage, it has not resolved the debate over the form that coverage should take.[28]

---

24. *See* DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 311.

25. *See generally* ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICARE CARE (1980).

26. *See generally* Jennifer Prah Ruger, Theodore W. Ruger & George J. Annas, *The Elusive Right to Health Care Under U.S. Law*, 372 N. ENG. J. MED. 2558, 2558 (2015) (explaining how there is currently no universal constitutional right to health care, but that "Congress and the Supreme Court have incrementally crafted an incomplete web of health care rights during the past 50 years").

27. *See* Jonathan Oberlander, *Lessons from the Long and Winding Road to Medicare for All*, 109 AM. J. PUB. HEALTH 1497, 1498 (2019); Richard Sorian, *Democrats' Feud Over Health Care Has Deep Roots*, HEALTH AFFS. BLOG (Aug. 19, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190815.209963/full/.

28. *See* Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495, 558–66 (2020) (unearthing various ways that the legal and political battles over the ACA have shifted Americans' expectations surrounding health care); Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10*, 20 HOUST. J. HEALTH

It is important, therefore, to understand the normative stakes of this disagreement. Health care reform is not only an economic issue and a political issue, but also a moral one.[29] That is not to say that most people subscribe to a particular theory of justice in health care, but rather that they believe there are important moral reasons to support health care reform.[30] Examining some of the more prominent accounts of justice in health care can help to bring these reasons into sharper focus, to scrutinize them, and to better understand their implications.

This Article proceeds as follows: Part I describes Medicare for All and the incremental proposals in more detail and outlines their approach to three key policy areas: the scope of covered benefits, cost-sharing, and private insurance. Part II describes two variants each of the Right to Equal Access and the Right to a Decent Minimum and offers a brief sketch of the types of justifications these accounts rely on, as well as some of the objections to them. Part III examines the implications of these accounts with respect to the three aforementioned key policy issues, and then compares these implications to the actual approaches taken by Medicare for All and the incremental proposals.

L. & POL'Y 69, 71 (2020) [hereinafter Huberfeld, *Is Medicare for All the Answer?*] ("The ACA changed the American baseline principle from exclusion to inclusion—as I have called it elsewhere, a principle of universality—and effectively kick-started a conversation about health care expectations, which now appear to include universal coverage."); Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L., & ETHICS 67, 68 (2015) ("The ACA shifted the law away from state-based private law to federally-based public law, shunned exclusion, and began to embrace a concept of health care as a public good, one that is inclusive and leveling.").

29. *See* UWE E. REINHARDT, PRICED OUT: THE ECONOMIC AND ETHICAL COSTS OF AMERICAN HEALTH CARE 1 (2019) ("[A]t the heart of the debate [over health care reform] is a long-simmering argument over the following question on distributive *social ethics: To what extent should the better-off members of society be made to be their poorer and sick brothers' and sisters' keepers in health care?*"); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287, 290 (1993) ("The politics of health insurance can only be understood as a struggle over the meaning of sickness and whether it should be a condition that automatically generates mutual assistance.").

30. *See, e.g.*, *Most Americans View Access to Health Care as a Moral Issue*, HARRIS POLL, https://theharrispoll.com/healthday-news-an-overwhelming-majority-of-americans-believes-that-access-to-health-care-is-a-moral-issue-and-that-the-united-states-should-be-able-to-afford-universal-health-care-if-other-develop/ (finding that 84% of U.S. adults agree with the statement that "having a system that ensures that sick people get the care they need is a moral issue.").

I. TWO VISIONS OF HEALTH CARE REFORM

A. America's Twin Access Problems

During the 2020 election cycle, even before the COVID-19 pandemic, polls showed that health care had risen to the top of voters' priorities.[31] To some extent, it is surprising that there would be such a groundswell of popular support to revisit the issue of health care reform only ten years after the passage of the Patient Protection and Affordable Care Act ("ACA"), the most important health care legislation to be passed since the 1965 Medicare/Medicaid Act.[32] The ACA has had dramatic impacts on the health care system: It drove the uninsured rate to record low levels;[33] it led to significant increases in access to health care, improvements in financial security, and reductions in mortality;[34] and it helped to reduce racial and economic disparities in access to health care.[35]

Yet despite the progress made under the ACA, many Americans today still lack adequate access to health care. The most glaring barrier is a lack of affordability: Overall, around 1 in 10 Americans report delaying or forgoing care because of its cost.[36] The problem is even more acute for low-income adults, over half of whom report skipping doctor visits, recommended tests, or treatments due to cost.[37]

The affordability problem is in turn attributable in large part to the fact that the United States still does not have universal health insurance coverage.

---

31. Tess Bonn, *Poll: Voters Name Health Care as Top Issue Going into 2020*, HILL (Dec. 12, 2019), https://thehill.com/hilltv/rising/474327-voters-name-health-care-as-top-issue-going-into-2020.

32. *See* Isaac D. Buck, *The Meaning of "Medicare-for-All"*, 20 HOUS. J. HEALTH L. & POL'Y 159, 161 (2020); Huberfeld, *Is Medicare for All the Answer?*, *supra* note 28, at 71. *See generally* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020) (examining the ACA's political, legal, and policy legacies).

33. *See* WHITE HOUSE COUNCIL OF ECONOMIC ADVISERS, THE ECONOMIC RECORD OF THE OBAMA ADMINISTRATION: REFORMING THE HEALTH CARE SYSTEM 7 (2016).

34. *See generally* Benjamin D. Sommers, Atul A. Gawande & Katherine Baicker, *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586 (2017) (summarizing the empirical literature on the effects of the ACA on access to health care, financial security, and health outcomes).

35. *See, e.g.*, Kevin Griffith, Leigh Evans & Jacob Bor, *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFFS. 1503, 1508 (2017); Thomas C. Buchmueller & Helen G. Levy, *The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care*, 39 HEALTH AFFS. 395, 399–400 (2020).

36. Krutika Amin et al., *How Does Cost Affect Access to Care?*, PETERSON-KFF HEALTH SYSTEM TRACKER (Jan. 5, 2021), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/#item-about-1-in-10-adults-report-that-they-delayed-or-did-not-get-care-because-of-its-cost_2017.

37. Michelle M. Doty et al., *Income-Related Inequality in Affordability and Access to Primary Care in Eleven High-Income Countries*, 40 HEALTH AFFS. 113, 115–16 (2021).

Twenty-eight million people in the United States were uninsured as of 2020 (down from around fifty million before the passage of the ACA),[38] and uninsured individuals are much more likely to delay or avoid seeking medical care due to cost.[39] But even for those Americans who have insurance coverage, many still pay significant "out-of-pocket payments"—in the form of deductibles, copays, or coinsurance—when they utilize health care services.[40] Deductibles in particular have both become more prevalent and grown substantially over time.[41] Because of these costs, simply having health insurance does not guarantee having adequate access to care: Many Americans who have health insurance still report delaying or forgoing needed medical care due to cost.[42]

Not only is access to medical care in the United States inadequate, it is also deeply inequitable: Americans have markedly different abilities to access medical care, depending on their wealth and income, race, gender, geographic location, and other factors.[43] One important factor contributing to these disparities in access is the United States' fragmented health care financing system, which relies on a mix of private insurance (mostly employer-sponsored coverage, as well as some non-group coverage), and

38. KATHERINE KEISLER-STARKEY & LISA N. BUNCH, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2020, at 2 (2021).

39. Rachel Garfield, Kendal Orgera & Anthony Damico, *The Uninsured and the ACA: A Primer—Key Facts About Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act*, KAISER FAM. FOUND. (Jan. 25, 2019), https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/.

40. *See* CHRISTOPHER T. ROBERTSON, EXPOSED: WHY OUR HEALTH INSURANCE IS INCOMPLETE AND WHAT CAN BE DONE ABOUT IT 1 (2019).

41. *See* GARY CLAXTON ET AL., KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2019 ANNUAL 107–10 (2019), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019; Isaac D. Buck, *Affording Obamacare*, 71 HASTINGS L.J. 261, 280–81 (2020).

42. *See* LIZ HAMEL, CAILEY MUÑANA & MOLLYANN BRODIE, KAISER FAMILY FOUNDATION / LA TIMES SURVEY OF ADULTS WITH EMPLOYER-SPONSORED HEALTH INSURANCE 10 (2019), https://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance (reporting that "about half (51 percent) of adults with employer health coverage report that they or someone in their household has skipped or delayed some type of medical care or prescription drugs in the past 12 months because of the cost").

43. *See* Allison K. Hoffman & Mark A. Hall, *The American Pathology of Inequitable Access to Medical Care*, *in* THE OXFORD HANDBOOK OF COMPARATIVE HEALTH LAW 213, 213 (David Orentlicher & Tamara Hervey eds., 2020) ("What most defines access to healthcare in the United States may be its stark inequity."); JAMILA MICHENER, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS 54 (2018) ("Medicaid provides uneven and inconsistent access to policy benefits across geographic space."); Samuel L. Dickman, David U Himmelstein & Steffie Woolhandler, *Inequality and the Health-Care System in the USA*, 389 LANCET 1431 (2017); Doty et al., *supra* note 37, at 117 (surveying 11 high-income countries and finding that "income-related disparities in health status, affordability, and primary care access were most pronounced in the US").

public programs such as Medicare and Medicaid.[44] The drafters of the ACA intentionally preserved this fragmented structure under the theory that the law would be much more likely to be enacted if it did not radically alter the status quo.[45]

Discrepancies among different sources of insurance coverage mean that even those Americans who have health insurance coverage in practice have quite different abilities to access medical care.[46] Although the ACA created more uniformity in terms of what benefits insurers must cover and what kinds of cost-sharing they can impose,[47] different plans may still vary in terms of their cost-sharing, their provider networks, their reimbursement rates, and their covered benefits.[48] These differences contribute to disparities in access to care. For instance, in part because the Medicaid program pays physicians around two-thirds of Medicare reimbursement rates, fewer physicians are willing to treat Medicaid patients, meaning that Medicaid enrollees may have more difficulty accessing certain kinds of care—particularly specialty care.[49]

The inequalities created by this fragmented health care financing system are compounded by longstanding racial and economic disparities. People of color are more likely to be uninsured,[50] and are also more likely to suffer discriminatory treatment in medical settings,[51] both of which may cause them

44. *See generally* EINER R. ELHAUGE, THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (2010).

45. *See* Erin C. Fuse Brown et al., *Social Solidarity in Health Care, American-Style*, 48 J.L. MED. & ETHICS 411, 412 (2020) ("The ACA's core compromise on coverage preserved the existing fragmentary mix of public and private sources, rather than replacing it with a truly universal and unified system."); Allison K. Hoffman, *What Health Reform Reveals about Health Law*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 49, 56 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017) ("Politically no law would have passed without the support of—or at least without active opposition from—the insurance industry."); Jonathan Oberlander & Theodore R. Marmor, *The Health Bill Explained at Last*, N.Y. REV. BOOKS, Aug. 19, 2010, https://www.nybooks.com/articles/2010/08/19/health-bill-explained-last/ ("[T]he central assumption of both the Obama administration and the Democratic leadership in Congress was that only legislation that did not seek to radically change [the health care system] had a chance of success.").

46. *See* Hoffman & Hall, *supra* note 43.

47. *See* Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1585–92 (2011) (outlining the main changes that the ACA made to the individual and small-group markets).

48. *See* Hoffman & Hall, *supra* note 43; Dickman et al., *supra* note 43.

49. *See* Sara Rosenbaum, *Medicaid Payments and Access to Care*, 371 NEW ENG. J. MED. 2345, 2345–46 (2014).

50. EDWARD R. BERCHICK, JESSICA C. BARNETT & RACHEL D. UPTON, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018, at 16 (2019).

51. *See generally* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE (2015) (arguing that unconscious racism in the health care delivery system is a fundamental driver of health disparities in America).

to delay or avoid seeking treatment.[52] The hospitals and clinics that Black Americans use also tend to be lower quality, staffed by less qualified providers and stocked with fewer resources.[53] The COVID-19 pandemic has reflected these preexisting disparities: Inequalities in access to high-quality health care likely help to explain why Black, Latino, and Indigenous populations have been disproportionately likely to suffer serious illness or death as a result of contracting COVID-19.[54]

Likewise, lower-income Americans are less likely to be insured,[55] to be able to pay any associated deductibles or copayments, or to have the education or social connections that can be essential in navigating the Byzantine American health care system.[56] Lower-income workers are less likely to receive health insurance coverage through their employer, and those that do face much higher deductibles.[57] Again, the COVID-19 pandemic has brought these inequalities in access into sharp relief, as wealthy and powerful individuals have benefitted from better access to testing, cutting-edge treatments, and vaccines, while many less-privileged individuals have had a much more difficult time getting tested or obtaining medical treatment.[58]

---

52. *See, e.g.*, Marcella Alsan & Marianne Wanamaker, *Tuskegee and the Health of Black Men*, 133 Q.J. ECON. 407 (2018) (finding that the 1972 disclosure of the Tuskegee Study was linked to increases in mistrust of the medical profession, decreases in physician interactions, and reduced life expectancy for Black men); Garfield et al., *supra* note 39 ("Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.").

53. Angus Deaton, *What Does the Empirical Evidence Tell Us About the Injustice of Health Inequalities?*, *in* INEQUALITIES IN HEALTH: CONCEPTS, MEASURES, AND ETHICS 263, 268 (Nir Eyal et al. eds., 2013).

54. *See* Michele K. Evans, *Health Equity—Are We Finally on the Edge of a New Frontier?*, 383 NEW ENG. J. MED. 997, 997 (2020); Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J.L. & BIOSCIENCES 1, 10–15 (2020).

55. Robin A. Cohen, Emily P. Terlizzi & Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2018*, NAT'L CTR. FOR HEALTH STAT. 3 (2019), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf; Peter J. Cunningham, *Why Even Healthy Low-Income People Have Greater Health Risks Than Higher-Income People*, COMMONWEALTH FUND (Sept. 27, 2018), https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks.

56. *See* PAMELA HERD & DONALD P. MOYNIHAN, ADMINISTRATIVE BURDEN: POLICYMAKING BY OTHER MEANS 30–31 (2018); MICHENER, *supra* note 43, at 126–27; Hoffman & Hall, *supra* note 43.

57. Drew Altman, *Employer-Based Coverage is Unaffordable for Low-Wage Workers*, AXIOS (Sept. 26, 2019), https://www.axios.com/employer-based-coverage-is-unaffordable-for-low-wage-workers-f6855a5e-83ed-452e-825a-7ed966dd0f3b.html; Gary Claxton, Bradley Sawyer & Cynthia Cox, *How Affordability of Health Care Varies by Incomes Among People with Employer Coverage*, PETERSON-KFF HEALTH SYS. TRACKER (2019), https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/#item-start.

58. *See* Shamus Khan, *How Rich People Will Cut the Line for the Coronavirus Vaccine*, WASH. POST (Dec. 18, 2020), https://www.washingtonpost.com/outlook/coronavirus-vaccine-rich-people/2020/12/18/3a2f188e-40ae-11eb-8bc0-ae155bee4aff_story.html; Casey Ross & Priyanka Runwal, *'Covid is All About Privilege': Trump's Treatment Underscores Vast Inequalities in Access*

Although there are a variety of different factors that affect access to care,[59] the health care reform debate in the United States has long primarily focused on the goal of universal health insurance coverage.[60] Of note, the lack of insurance coverage results in *both* the lack of *adequate* access to health care services and *inequalities* in access to health care. By contrast, other factors contribute to inequalities in access to care, but do not necessarily result in inadequate access to care. For instance, although Medicaid's lower reimbursement rates have contributed to Medicaid beneficiaries having worse access to some forms of specialty care than those with private health coverage, this does not by itself imply that they have inadequate access.[61]

B. Proposed Reforms

Faced with these challenges, policymakers have put forward a dizzying array of health care reform plans.[62] These plans aim to improve the affordability of health care by reforming our health care financing system: they would all expand health insurance coverage to many more Americans, and in doing so, they would likely significantly improve access to health care, increase financial security, and reduce socioeconomic and health disparities.[63] However, there are important differences among these plans.

---

to Care, STAT (Oct. 6, 2020), https://www.statnews.com/2020/10/06/covid-is-all-about-privilege-trumps-treatment-underscores-vast-inequalities-in-access-to-care/; Sheryl Gay Stolberg, *Trump and Friends Got Coronavirus Care Many Others Couldn't*, N.Y. TIMES (Dec. 23, 2020), https://www.nytimes.com/2020/12/09/us/politics/trump-coronavirus-treatments.html.

59. *See generally* Roy Penchansky & J. William Thomas, *The Concept of Access: Definition and Relationship to Consumer Satisfaction*, 19 MED. CARE 127 (1981) (developing a taxonomic definition of access to health care that includes five dimensions: availability, accessibility, accommodation, affordability, and acceptability).

60. *See, e.g.*, PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 27 (2011) ("For American liberals in the twentieth century, health insurance for all was a persistent dream and a perennial disappointment, often on the horizon but always seemingly just beyond reach.").

61. *See* Julia Paradise, *Data Note: Three Findings About Access to Care and Health Outcomes in Medicaid*, KAISER FAM. FOUND. (Mar. 23, 2017), https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/ (noting that "[m]ost doctors accept new Medicaid patients" and that "[d]ata and research provide evidence that Medicaid provides effective access to care for those it covers").

62. *See Compare Medicare-for-All and Public Plan Proposals*, KAISER FAM. FOUND. (May 15, 2019), https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/; Dylan Scott, *The Real Differences Between the 2020 Democrats' Health Care Plans, Explained*, VOX (Dec. 19, 2019, 8:00 AM), https://www.vox.com/policy-and-politics/2019/12/19/21005124/2020-presidential-candidates-health-care-democratic-debate.

63. Scott, *supra* note 62 ("The Democrats running agree on a few key themes: Everybody should have health insurance; health insurance should cover most medical services; and people should pay less money for health care, both for premiums and out-of-pocket expenses, than they do now.").

At a general level, the plans fall into two broad camps. The first category of plans, referred to as "Medicare for All," would create a new universal federal health insurance program that would be far more generous and expansive than any program that currently exists.[64] The second category of plans, such as President Biden's plan, would expand coverage to most or all Americans, while preserving key features of the existing health care financing system.[65] There are multiple examples of each kind of proposal, which differ in certain respects. To simplify, I will focus primarily on Senator Sanders's Medicare for All proposal and President Biden's plan—as described during his 2020 Presidential campaign—each of which is described below.

1. Medicare for All

The first category of plans is referred to as "Medicare for All." At the outset, it is important to note that the name "Medicare for All" is somewhat misleading. Medicare for All would not, as its name suggests, simply extend eligibility for the Medicare program, as it currently exists, to all Americans.[66] Instead, it would create a new universal federal health insurance program that would be far more generous and expansive,[67] and far less reliant on the private sector.[68]

64. Medicare for All Act of 2019, S. 1129, 116th Cong. (2019); Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).

65. During the presidential election, President Biden's campaign estimated that his plan would cover "more than an estimated 97% of Americans." *Health Care*, *supra* note 5. The Urban Institute has estimated that a proposal similar to Biden's would cover all legal United States residents, leaving 2% of U.S. residents uninsured overall. Linda J. Blumberg, *Cutting Through the Jargon: Health Care Reform Design Issues and Trade-Offs Facing Us Today*, URB. INST. 12 (June 2020), https://www.urban.org/sites/default/files/publication/102326/cutting-through-the-jargon-health-care-reform-design-issues-and-trade-offs-facing-us-today.pdf. Some other estimates have been slightly lower, though the plan's effects are difficult to estimate accurately without more details. *See Biden's Healthcare Proposals*, UNIV. OF PA. WHARTON SCH. OF BUS. (Oct. 7, 2020), https://budgetmodel.wharton.upenn.edu/issues/2020/10/6/biden-healthcare-proposals (estimating that the Biden plan would reduce the uninsured rate to 6% by 2030, but stating that this estimate does not take into account the effects of Biden's public option as "this rather complicated proposal lacks enough detail to model").

66. Huberfeld, *Is Medicare for All the Answer?*, *supra* note 28, at 84 ("Current proposals do not reflect precise use of the word Medicare but rather something more atmospheric, meaning some kind of legislative reform that offers more in the way of national public insurance. 'Medicare' is used as a public relations tool, knowing it is a politically popular program that could draw in public support . . . ."); David A. Hyman & Charles Silver, *Medicare for All: Four Inconvenient Truths*, 20 HOUS. J. HEALTH L. & POL'Y 133, 137 (2020) (noting that "M4A [Medicare for All] differs in a variety of fundamental respects from the Medicare program that currently exists").

67. Micah Johnson, Sanjay Kishore & Donald M. Berwick, *Medicare For All: An Analysis of Key Policy Issues*, 39 HEALTH AFFS. 133, 133 (2020) (defining Medicare for All as "a single public insurance plan that provides comprehensive health coverage to all Americans").

68. Private companies play important roles in Medicare today, from helping administer the program and processing claims to delivering benefits through Medicare Part C (also known as

Medicare for All departs from the incremental health care reform proposals in at least three key respects: First, Medicare for All would cover a broader set of benefits than many of the incremental proposals, including dental, vision, medical transportation, and comprehensive reproductive services.[69] Importantly, it would also cover home and community-based long-term care services.[70] At present, long-term care is primarily covered by the Medicaid program, and is only available for those who have almost no income or assets.[71] Not only would the list of benefits covered under Medicare for All be significantly more expansive than those covered by Medicare currently, but also it would be more comprehensive than the benefit packages covered by many other countries' single-payer health care systems.[72]

Second, Medicare for All would eliminate cost-sharing (such as copayments, coinsurance, and deductibles), with the exception that Senator Sanders's Medicare for All bill would allow up to $200 per year of cost-sharing for prescription drugs for households with incomes over 200% of the federal poverty level.[73] This too would represent a substantial departure from the status quo, since currently Medicare has significant cost-sharing requirements.[74] In 2016, for example, Medicare beneficiaries spent $5,460 on average out of their own pockets on health care.[75]

Third, Medicare for All would transform a fragmented health care financing system into a nearly uniform one in which all Americans would be covered under a single government program. This program would largely

Medicare Advantage) and delivering prescription drug insurance through Medicare Part D. *See* Sherry A. Glied & Jeanne M. Lambrew, *How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Health Insurance Plans*, 37 HEALTH AFFS. 2084, 2085 (2018); Huberfeld, *Is Medicare for All the Answer?*, *supra* note 28, at 83.

69. Medicare for All Act of 2019, S. 1129, 116th Cong. § 201 (2019).

70. *Id.*

71. *See* Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y, L., & ETHICS 147, 162–65 (2016).

72. *See* Sherry Glied et al., *Considering 'Single Payer' Proposals in the U.S.: Lessons from Abroad*, COMMONWEALTH FUND 4–5 (2019); CONG. BUDGET OFF., KEY DESIGN COMPONENTS AND CONSIDERATIONS FOR ESTABLISHING A SINGLE-PAYER HEALTH CARE SYSTEM 9 (2019), https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf.

73. Medicare for All Act of 2019, S. 1129, 116th Cong. § 202 (2019).

74. Medicare Part A, which covers inpatient hospital stays, skilled nursing facility stays, home health visits, and hospice care, had a deductible of $1,364 in 2019. Medicare Part B, which covers physician visits, outpatient services, preventive services, and some home health visits had a deductible of $185 in 2019 and typically has coinsurance of 20%, meaning that beneficiaries must pay 20% of their total costs of care after meeting their deductible. *An Overview of Medicare*, KAISER FAM. FOUND. (Feb. 13, 2019), https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/.

75. Juliette Cubanski et al., *How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?*, KAISER FAM. FOUND. (Nov. 4, 2019), https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/.

subsume existing public health care programs, including the traditional Medicare program, Medicaid, and the Children's Health Insurance Program (CHIP).[76] It would also radically curtail the role of private health insurance.[77] It would prohibit private insurers from offering *duplicative* insurance coverage that covers services already offered by the new public program.[78] Although Medicare for All would technically allow *supplemental* insurance that covers services not covered in the public plan,[79] it would have an extremely limited role (likely in practice limited to nursing home care), given the expansive range of benefits covered by Medicare for All.[80] Likewise,

76. Katie Keith & Timothy Jost, *Unpacking the Sanders Medicare-For-All Bill*, HEALTH AFFS. BLOG (Sept. 14, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170914.061996/full/.

77. Some health scholars and politicians have used the term "Medicare for All" more expansively as encompassing proposals that entail a mix of public and private insurance programs. *See, e.g.*, William M. Sage, *Adding Principle to Pragmatism: The Transformative Potential of "Medicare-for-All" in Post-Pandemic Health Reform*, 20 YALE J. HEALTH POL'Y, L., & ETHICS 1, 9 (2021) (outlining "six possible ways to implement Medicare-for-All reform"). Perhaps most notably, Vice President Kamala Harris introduced a health care plan in July 2019 that she termed "Medicare for All," though it preserved a significant role for private insurers. Kamala Harris, *My Plan for Medicare for All*, MEDIUM (July 29, 2019), https://medium.com/@KamalaHarris/my-plan-for-medicare-for-all-7730370dd421. *See also* Paige Winfield Cunningham, *The Health 202: Is There a Middle Road on Medicare-For-All? Kamala Harris Thinks So*, WASH. POST (July 30, 2019), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/07/30/the-health-202-is-there-a-middle-road-on-medicare-for-all-kamala-harris-thinks-so/5d3f5340602ff17879a18729/ ("[W]hat Harris is proposing now isn't quite Medicare-for-all. It's more like Medicare Advantage-for-all."). More generally, Jonathan Oberlander distinguishes between the "hybrid" model of Medicare for All, which would allow private insurance plans, and the "pure" model of Medicare for All, which would prohibit private insurance. Jonathan Oberlander, *Navigating the Shifting Terrain of US Health Care Reform—Medicare for All, Single Payer, and the Public Option*, 97 MILBANK Q. 939, 943–44 (2019). This Article refers to Medicare for All in the "pure" sense, which is the basis for current legislation bearing the name "Medicare for All" and reflects the original meaning of the term. *See id.* at 944 (noting that "[t]he pure model . . . is how the health reform community has until now generally understood Medicare for All"). *See also* Buck, *The Meaning of "Medicare-for-All"*, *supra* note 32, at 166–67 (distinguishing between "Medicare for some" and the "classic version of 'Medicare-for-All'").

78. Medicare for All Act of 2019, S. 1129, 116th Cong. § 107(a) (2019).

79. *Id.* § 107(b).

80. Karen Pollitz et al., *What's The Role of Private Health Insurance Today and Under Medicare-for-All and Other Public Option Proposals?*, KAISER FAM. FOUND. (July 30, 2019), https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/. By contrast, the Medicare for All bill introduced in the House of Representatives by Rep. Jayapal would prohibit this type of private coverage as well since it covers institutional long-term care. *Id.* The Sanders Medicare for All bill would also allow for coverage of private contracting between patients and health care providers who do not participate in the new Medicare program, but the Jayapal bill would prohibit this practice. *Id.* Although Senator Sanders has often mentioned cosmetic surgery insurance as another type of private supplemental insurance that Medicare for All would allow, there is in fact currently no market for insurance that covers only the costs of cosmetic surgery. Margot Sanger-Katz, *Some Democrats Talk About Cosmetic Surgery Insurance. It Doesn't Exist.*, N.Y. TIMES (July 3, 2019), https://www.nytimes.com/2019/07/03/upshot/democrats-cosmetic-surgery-insurance-medicare.html.

since Medicare for All would virtually eliminate cost-sharing, it would render unnecessary *complementary* insurance, which covers cost-sharing under the public plan.[81] Again, this would be a substantial departure from the status quo. Currently, many Medicare beneficiaries purchase private insurance policies—such as Medigap policies—that shield them from large out-of-pocket expenses and provide access to services not covered by Medicare.[82]

2. Incremental Proposals

The second category of health care reform plans are sometimes referred to as "incremental" proposals.[83] This too is something of a misnomer since each of these proposals would, if enacted, represent a significant departure from the status quo by significantly expanding health insurance coverage, and in some cases, specifically increasing public coverage.[84] Indeed, some of these proposals include specific policies that were considered too radical to be included in the ACA only ten years earlier.[85] For instance, some incremental proposals would create an option for certain populations to buy into Medicare or Medicaid,[86] while still others would focus on expanding subsidies on the ACA exchanges.[87] The perception of these proposals as

81. Johnson et al., *supra* note 67, at 136.

82. Juliette Cubanski et al., *A Primer on Medicare: Key Facts About the Medicare Program and the People It Covers*, KAISER FAM. FOUND. (Mar. 20, 2015), https://www.kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/.

83. *See, e.g.*, Caitlin Owens, *Health Care's Two Political Realities*, AXIOS (Apr. 30, 2019), https://www.axios.com/medicare-for-all-incremental-reform-health-care-2020-democrats-d16e0c83-8e49-4bf6-8eb9-40ddc014936f.html.

84. *See* Matthew Yglesias, *Joe Biden's Health Care Plan, Explained*, VOX (July 16, 2019, 11:30 AM), https://www.vox.com/2019/7/16/20694598/joe-biden-health-care-plan-public-option (arguing that Joe Biden's health care plan would, "if implemented, arguably be the most dramatic piece of new social legislation since the Great Society").

85. *See* Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117, 1117, 1119 (2010).

86. *See, e.g.*, Medicare at 50 Act, S. 470, 116th Cong. (2019); Medicare Buy-In and Health Care Stabilization Act of 2019, H.R. 1346, 116th Cong. (2019); State Public Option Act, S. 489, H.R. 1277, 116th Cong. (2019).

87. *See, e.g.*, Protecting Pre-Existing Conditions and Making Health Care More Affordable Act of 2019, H.R. 1884, 116th Cong. (2019). Of note, in March 2021, President Biden signed into law the American Rescue Plan Act (ARPA), which builds on the ACA's coverage provisions in several ways, including by increasing the generosity of subsidies for private coverage on the ACA exchanges for two years. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021) §§ 9661–9663. In addition, at the time this Article was going to print, the House of Representatives had just narrowly passed the Build Back Better Act, which would further expand on the health coverage provisions in ARPA if enacted into law. *See generally* Edwin Park et al., *Build Back Better Act: Health Coverage Provisions Explained*, GEORGETOWN UNIV. HEALTH POL'Y INST.: CTR. FOR CHILDREN AND FAMILIES (Nov. 2021), https://ccf.georgetown.edu/wp-content/uploads/2021/11/Build-Back-Better-FINAL-Nov19.pdf (explaining the Act's Medicaid, CHIP, and private insurance provisions).

incremental reflects how far the debate over health care reform has shifted over the past ten years, at least on the Democratic side.[88] Nevertheless, these proposals are incremental compared to Medicare for All in the sense that they largely preserve the three key features of the current health care financing system that Medicare for All would transform or eliminate.

First, the incremental proposals would, for the most part, cover a similar set of health benefits to those that are covered by existing health programs.[89] The Biden plan would introduce a public option that would cover the ten categories of benefits deemed "essential health benefits" (EHBs) under the ACA.[90] These include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.[91] These EHB categories have significant gaps: for instance, they do not cover custodial long-term care (either at home or at an institution), routine non-pediatric dental care, or routine non-pediatric vision care.[92]

Second, these plans would still require a substantial level of cost-sharing, although some of them would reduce cost-sharing to some degree. The Biden plan would increase the size of the tax credits offered on the ACA exchanges by linking them to so-called "gold" insurance plans that cover 80% of medical costs.[93] This provision would result in lower deductibles, copayments, and out-of-pocket maximums.[94] Other prominent public option proposals would continue to apply the current cost-sharing limits in existing health care programs.[95]

88. Julie Rovner, *Biden's 'Incremental' Health Plan Still Would Be a Heavy Lift*, KAISER HEALTH NEWS (July 22, 2019), https://khn.org/news/bidens-incremental-health-plan-still-would-be-a-heavy-lift/.

89. *See Side-by-Side Comparison of Medicare-for-All and Public Plan Proposals Introduced in the 116th Congress*, KAISER FAM. FOUND. 4 (May 15, 2019), https://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress [hereinafter *Side-by-Side Comparison*].

90. Scott, *supra* note 62.

91. Affordable Care Act § 1302(b), 42 U.S.C. § 18022(b)(1) (2010).

92. *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb (last visited Oct. 30, 2021).

93. *Health Care*, *supra* note 5.

94. Scott, *supra* note 62; LINDA J. BLUMBERG ET AL., URB. INST., FROM INCREMENTAL TO COMPREHENSIVE HEALTH INSURANCE REFORM: HOW VARIOUS REFORM OPTIONS COMPARE ON COVERAGE AND COSTS 16–17 (2019), https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf.

95. *Side-by-Side Comparison*, *supra* note 89, at 5.

Third, the incremental proposals would maintain the current patchwork of health insurance programs, and in particular preserve a role for private insurance. President Biden's plan would lower the Medicare eligibility age to sixty, expand the subsidies on the ACA exchanges, and create a new Medicare-like "public option" that would compete with private insurers on the ACA exchanges.[96] The public option would offer premium-free coverage for people who currently fall into the Medicaid "coverage gap," who are ineligible for Medicaid because their state has declined to expand Medicaid under the ACA, and it would automatically enroll low-income beneficiaries when they interact with certain institutions like public schools, or programs geared toward low-income people.[97] Although this program would increase the number of Americans enrolled in public coverage, Americans would still be allowed to enroll in private coverage, and many—if not most—people with employer-based coverage would be expected to keep it.[98]

II. TWO CONCEPTIONS OF THE RIGHT TO HEALTH CARE

The two categories of health care reform proposals discussed above are supported by two distinct conceptions of the right to health care. By this, I do not necessarily mean that these conceptions have different notions of what it means for something to be a "right," but rather that they differ in terms of

96. There are other public option proposals as well. *See, e.g.*, Keeping Health Insurance Affordable Act of 2019, S. 3, 116th Cong. (2019); Choose Medicare Act, S. 1261, 116th Cong. (2019). A public option was originally included in the version of the ACA passed by the House of Representatives, but it was excised from the Senate version after objections from Senators Ben Nelson and Joe Lieberman. *See* JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 136–37 (2011).

97. *Health Care*, *supra* note 5; Joe Biden, *Joe Biden Outlines New Steps to Ease Economic Burden on Working People*, MEDIUM (Apr. 9, 2020), https://medium.com/@JoeBiden/joe-biden-outlines-new-steps-to-ease-economic-burden-on-working-people-e3e121037322. There are estimated to be more than two million uninsured adults who fall into the Medicaid coverage gap. *See* Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

98. *See* Dylan Scott, *Joe Biden's Health Care Plan, Explained in 800 Words*, VOX (Nov. 6, 2020, 10:50 AM), https://www.vox.com/21540041/election-2020-joe-biden-health-care (explaining that Biden's plan would likely not result in an exodus from employer coverage since it would not allow employees to use their employers' contributions to their health insurance premiums to pay for coverage through the public option, nor would it allow employers to place their employees on the public plan). The Urban Institute estimated that around 18.5 million people would drop employer-sponsored coverage under the proposal upon which an earlier version of the Biden plan appeared to be based, leaving nearly 130 million people enrolled in employer coverage. LINDA J. BLUMBERG ET AL., URB. INST. & ROBERT WOOD JOHNSON FOUND., *The Healthy America Program, An Update and Additional Options* 10 (Sept. 2019), https://www.urban.org/sites/default/files/publication/100910/the_healthy_america_program_an_update-1_2.pdf.

the scope of that right and what it entails.[99] In brief, the Right to a Decent Minimum entails a right to some basic level of health care.[100] This right is grounded in the notion of "sufficiency," the idea that what is morally important is that people have enough.[101] By contrast, the Right to Equal Access is egalitarian, meaning that there should be some level of equality in health care access.[102] The Right to Equal Access implies that differences in people's access to health care may be objectionable even if everyone has access to a decent minimum of health care services. Put more succinctly, the Right to Equal Access diagnoses the problem with the U.S. health care system as one of *unequal* access, whereas the Right to a Decent Minimum implies that the problem is one of *inadequate* access.

In order to fully understand the scope and implications of these two conceptions of the right to health care, we must examine their underlying distributional justifications.[103] In this Part, I consider two prominent accounts of the Right to Equal Access: one based on what is sometimes referred to as the "insulation ideal" and one based on the idea of fair equality of opportunity. Then I consider two prominent accounts of the Right to a Decent Minimum: one based on a prudent insurance package and one based on a modified market conception.

Each of these accounts has its own assumptions and premises, many of which are quite complex and rich, and I cannot do justice to all of the issues that they raise in this Article. Moreover, the list of accounts in this Part is by no means exhaustive; at the end of this Part, I briefly consider a few other accounts that support these different conceptions of the right to health care. Nevertheless, even offering a basic sketch of the four distributional accounts below provides a sense of the range of different justifications for providing a legal entitlement to health care, their different implications in terms of what the right to health care implies, and the challenges they entail.

99. This article does not address the specific ways in which these accounts may differ in terms of what it means for health care to be a "right," or the many associated conceptual and jurisprudential questions surrounding rights more generally. *See generally* Wenar, *supra* note 2.

100. *See, e.g.*, Erin C. Fuse Brown, *Developing A Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 445 (2013) (defining the right to health care as "the non-excludable right to access and receive some minimum level of health care services").

101. *See supra* note 20 and accompanying text.

102. *See supra* note 19 and accompanying text.

103. DANIELS, JUST HEALTH CARE, *supra* note 3, at 5 ("[T]he appeal to a right to health care is not an appropriate starting point for an inquiry into just health care. Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation. Rather, we are justified in claiming a right to health care only if it can be harvested from an acceptable, general theory of distributive justice, or, more particularly, from a theory of justice for health care.").

A. The Right to Equal Access

Accounts of the Right to Equal Access share two features: First, they are egalitarian, in the sense that they are concerned with limiting inequality in access to health care. This is either because there is something about unequal access to health care that is intrinsically objectionable (perhaps because it signals unequal respect for persons or conflicts with the notion that life is priceless) or because it has consequences that are undesirable (such as undermining equality of opportunity).[104] The second common feature of these accounts is presupposed by the first—namely, that health care is "special," such that there are special reasons why health care should be distributed equally, which may or may not apply to other goods and services.[105] In particular, these accounts imply that health care should not be treated as a commodity, like cars or televisions, and should not be distributed based on ability to pay.[106] Many people share this intuition (even those who do not find inequalities to be particularly objectionable in other contexts), though it is not necessarily obvious why health care should have any special moral significance.[107]

As a result of these two shared features, accounts of the Right to Equal Access also must contend with two challenges: The first is how to ensure that demands for equality in access to health care do not lead to a "leveling down" of health care services (i.e., making the rich worse off while not making anyone else better off),[108] while at the same time not turning into a "bottomless pit" that consumes all of society's resources.[109] Second, insofar

104. Harry Frankfurt draws this same distinction in the context of economic inequality, referring to the latter as "derivative[]" reasons why inequality is objectionable, and the latter as reasons that "attribute[] to economic equality . . . *intrinsic* value." FRANKFURT, *supra* note 20, at 17. Frankfurt himself argues that economic inequality is not in itself intrinsically objectionable, but suggests that it may lead to objectionable consequences. *Id.* at 16–17. T.M. Scanlon makes a related distinction: According to Scanlon, economic inequality may be considered objectionable for reasons that have nothing to do with inequality (for instance, because it leads to negative consequences such as worse health outcomes), or for reasons that "are grounded, ultimately, in some idea of why equality itself is to be sought, or why inequality itself is objectionable." SCANLON, *supra* note 19, at 2. Scanlon refers to the former types of reasons as ones that are egalitarian in a "broader" sense, and the latter that are egalitarian in a "narrower" sense. *Id.*

105. DANIELS, JUST HEALTH CARE, *supra* note 3, at 17.

106. Shlomi Segall, *Is Health Care (Still) Special?*, 15 J. POL. PHIL. 342, 343 (2007).

107. *See* DANIELS, JUST HEALTH, *supra* note 17, at 18.

108. SCANLON, *supra* note 19, at 3.

109. Norman Daniels, *Health-Care Needs and Distributive Justice*, 10 PHIL. & PUB. AFFS. 146, 148 (1981) (citing CHARLES FRIED, RIGHT AND WRONG 126ff (1978)). *See also* Charles Fried, *Equality and Rights in Medical Care*, 6 HASTINGS CTR. REP. 29, 31 (1976) ("[I]f we commit ourselves to the notion that there is a right to whatever health care might be available, we do indeed get ourselves into a difficult situation where overall national expenditure on health must reach absurd proportions—absurd in the sense that far more is devoted to health at the expense of other important social goals than the population in general wants. . . . And if we recognize that it would be absurd to commit our society to devote more than a certain proportion of our national income to

as the special moral importance of health care rests on the special moral importance of *health*, each of these accounts must grapple with the fact that there are other goods and services (e.g., public health interventions, education, housing) that may play a larger role in determining health outcomes than medical care.[110] Therefore, to the extent that the demand for equality in health care access is based on the contribution of medical care to health outcomes, it would seem to apply—with equal or greater force—to these other goods and services.

This Section below focuses on two prominent accounts of the Right to Equal Access: one that is sometimes referred to as the *insulation ideal* and one that is based on the idea of *fair equality of opportunity*. In several respects, the insulation ideal and the fair equality of opportunity account are strange bedfellows. The fair equality of opportunity account is a comprehensive philosophical account of justice in health care, whereas the insulation ideal reflects an intuitive aversion to rationing health care that is untenable in practice. In addition, the insulation ideal demands complete equality in access to all forms of health care that provide any health benefit, whereas the fair equality of opportunity account requires only equal access to certain kinds of health care services. Nevertheless, these approaches are helpful to consider together because together, they provide a sense of the broad range of different approaches to limiting inequality in health care and the different challenges facing such approaches.

1. The Insulation Ideal

The most extreme account of the Right to Equal Access is variously referred to as the *insulation ideal* or the *rescue principle*.[111] According to Ronald Dworkin (who describes this ideal but opposes it himself), this position has three features: (1) that health care (by which he appears to mean exclusively medical care) is the most important social good, because life and

health, while at the same time recognizing a 'right to health care,' we might then be caught on the other horn of the dilemma. For we might then be required to say that because a right to health care implies a right to equality of health care, then we must limit, we must lower the quality of the health care that might be purchased by some lest our commitment to equality require us to provide such care to all and thus carry us over a reasonable budget limit.").

110. *See, e.g.*, Elizabeth H. Bradley et al., *Variation in Health Outcomes: The Role of Spending on Social Services*, *Public Health, and Health Care, 2000–09*, 35 HEALTH AFFS. 760, 760 (2016) ("Taken together, social, behavioral, and environmental factors are estimated to contribute to more than 70 percent of some types of cancer cases, 80 percent of cases of heart disease, and 90 percent of cases of stroke.").

111. *See* DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 309; Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 885. Similarly, Einer Elhauge calls the "absolutist position" the idea "that health care should be provided whenever it has any positive health benefit, denouncing as immoral any attempt to weigh health against mere monetary costs." Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1457 (1994).

health are the most important things; (2) that health care should be distributed equally even in a society that is rife with inequality; and (3) that it is "intolerable" when needed health care is "withheld on grounds of economy."[112] A health care system that satisfied the insulation ideal would ensure equal access to health care by providing all the health care services that promoted health to everyone who needed it.

Although the insulation ideal is less often defended than invoked to present a point of contrast with another theory of justice in health care,[113] a few rough justifications have been offered for this position. For instance, some proponents deny the "act/omission" distinction, concluding that failing to save a life is the same as killing;[114] others draw on religious beliefs and the sanctity of life; still others simply feel "that any failure to provide beneficial care reflects a cold-hearted indifference toward human suffering or conflicts with the moral belief that life and health have priceless value."[115]

Although many people find the insulation ideal to be intuitively appealing,[116] it is not a tenable way to guide the distribution of health care.[117] Given the rise of expensive medical technology, the amount of money required to address this ideal would not leave enough resources to provide other valuable social goods.[118] Moreover, even if the United States were to spend its entire wealth on health care, it still could not afford to provide all the medical care to every person who would benefit from such care.[119] In

112. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 885.

113. Dworkin attributes this position to Rene Descartes and Michael Walzer. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 885–86. However, Walzer himself appears to reject Dworkin's characterization of his view. *See* Michael Walzer, *'Spheres of Justice': An Exchange*, N.Y. REV. BOOKS, July 21, 1983, https://www.nybooks.com/articles/1983/07/21/spheres-of-justice-an-exchange/; *see also* Segall, *supra* note 106, at 344 n.9, 345–46 n.14.

114. Elhauge, *supra* note 111 (citing JONATHAN GLOVER, CAUSING DEATH AND SAVING LIVES 92–112 (1977); JOHN HARRIS, THE VALUE OF LIFE 28–33 (1985)).

115. *Id.* (citing GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 32, 39, 49 (1978); DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS 213 (1990)); *see also* Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES MAG. (July 15, 2009), https://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html ("The way we regard rationing in health care seems to rest on [the] assumption . . . that it's immoral to apply monetary considerations to saving lives . . . .").

116. Elhauge, *supra* note 111, at 1459 ("Moral absolutism has powerful emotive appeal. Easy as it may be to reject in the abstract, moral absolutism remains difficult to reject in practice. Indeed, the persistent power of absolutist beliefs in the face of unending escalation of health care costs is the most striking moral phenomenon of health law policy in the past quarter-century.").

117. *Id.* ("[M]oral absolutism is wholly untenable as a societal system of resource allocation.").

118. Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFFS. 55, 58 (1984); Fried, *supra* note 109, at 31.

119. *See, e.g.*, Katherine Baicker & Amitabh Chandra, *Uncomfortable Arithmetic—Whom to Cover Versus What to Cover*, 362 NEW ENG. J. MED. 95, 97 (2010) ("There is only 100% of Gross Domestic Product to go around, whereas we could theoretically spend a virtually unlimited

addition, it is not clear why the insulation ideal should be exclusively concerned with medical care, rather than with the array of other public health measures and social determinants of health, given that each of the rough justifications offered above (e.g., alleviating suffering, preserving the sanctity of life) seem equally applicable to at least some of these other measures. Once resource constraints and the importance of other social goods are acknowledged, the insulation ideal provides no guidance as to how health care should be allocated.[120]

2. Fair Equality of Opportunity

The second variant of the Right to Equal Access has been developed by Norman Daniels, drawing on John Rawls's general theory of justice as fairness, and in particular, his principle of "fair equality of opportunity."[121] Rawls's principle of fair equality of opportunity holds that people's natural talents and skills should determine the opportunities (and in particular, the jobs and offices) available to them.[122] This implies not only that there must be a prohibition on laws that restrict some people's opportunities (such as racially discriminatory laws or religious quotas), but also that there must be affirmative measures (such as education programs) to help correct for past discriminatory practices and differences in people's family and social circumstances that have prevented the development of their talents and skills.[123]

Although Rawls himself does not address the implications of his theory of justice for health care, Daniels argues that health care institutions play an important role in ensuring fair equality of opportunity.[124] This is the case,

---

amount of money on health care."); Elhauge, *supra* note 111, at 1459 ("Most knowledgeable observers believe we could today easily spend 100% of our GNP on health care without running out of services that would provide some positive health benefit to some patient."); Alan Williams, *Priority Setting in Public and Private Health Care: A Guide Through the Ideological Jungle*, 7 J. HEALTH ECON. 173, 173 (1988) ("[N]o country (not even the richest) can afford to carry out all the potentially beneficial procedures that are now available, on all the people who might possibly benefit from them.") (emphasis omitted).

120. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 886 ("Once, however, this suggestion of the ancient ideal is rejected as incredible, the ideal has nothing more to say. It has, as it were, no second best or fall-back level of advice. It simply falls silent.").

121. *See* DANIELS, JUST HEALTH CARE, *supra* note 3, at 39–48. *See generally* JOHN RAWLS, A THEORY OF JUSTICE (1971).

122. RAWLS, *supra* note 121, at 39–40.

123. DANIELS, JUST HEALTH, *supra* note 17, at 52–53. Rawls distinguishes the former from fair equality of opportunity, referring to it as *formal* equality of opportunity. *Id.* at 52.

124. *Id.* at 42–48. To be more specific, for the purposes of developing his theory of justice as fairness, Rawls makes a simplifying assumption that people "are fully functional over a normal lifespan," an assumption which drew criticism that Rawls's theory was not useful in the real world. *Id.* at 47; *see* Kenneth J. Arrow, *Some Ordinalist-Utilitarian Notes on Rawls's Theory of Justice*, 70 J. PHIL. 245, 251 (1973). Daniels tries to address this criticism by relaxing this assumption and

Daniels argues, because meeting health needs has an important impact on equality of opportunity.[125] Health, which Daniels describes as "normal species-functioning," makes a "significant—if limited—contribution to protecting the range of opportunities individuals can reasonably exercise."[126] Thus, Daniels maintains that health care is special because it contributes to maintaining or restoring health, which in turn is necessary to protect fair equality of opportunity.[127] If, as Rawls argues, society has an obligation to protect the fair equality of opportunity, "then health-care institutions should be designed to meet that obligation."[128]

On this basis, Daniels argues that there must be "universal access, based on health needs," to the subset of health care services (which Daniels refers to as the "basic tier") that promotes "fair equality of opportunity under reasonable resource constraints."[129] He writes that "there should be no obstacles – financial, racial, geographical, and so on – to access the basic tier" of the system.[130] Without such a guarantee, some people's health outcomes would be worse than others by no fault of their own, and this would undermine equality of opportunity.

There are several important differences, however, between Daniels' account and the insulation ideal. First, Daniels' account implies that only certain health care services must be distributed equally on the basis of health care needs: namely, those health care services in the basic tier that are necessary for maintaining or restoring normal functioning.[131] Daniels' account thus provides a means of limiting the demands that health care makes

concluding that there is a societal obligation to protect normal functioning. *See* Norman Daniels, *Capabilities, Opportunity, and Health*, in MEASURING JUSTICE: PRIMARY GOODS AND CAPABILITIES 131, 131–33 (Harry Brighouse & Ingrid Robeyns eds., 2010) [hereinafter Daniels, *Capabilities, Opportunity, and Health*]. Rawls, in his later work, endorsed Daniels' account of the relationship between health and fair equality of opportunity. *Id.* at 136.

125. DANIELS, JUST HEALTH CARE, *supra* note 3, at 45; *see also* Leonard M. Fleck, *Just Health Care (II): Is Equality Too Much?*, 10 THEORETICAL MED. 301, 303 (1989) ("Losing one's health is not like losing one's job. Losing one's job may result in a temporarily constrained standard of living. But even in a weak economy one will still have the opportunity to find another job, or create work for oneself. By way of contrast, loss of health means that virtually all opportunities for life plans in a normal range are lost or very severely constrained.").

126. Norman Daniels, *Justice and Access to Health Care*, *in* STAN. ENCYC. OF PHIL., 1, 25 (Edward N. Zalta et al., 2017), https://leibniz.stanford.edu/friends/preview/justice-healthcareaccess/.

127. DANIELS, JUST HEALTH CARE, *supra* note 3, at 45.

128. *Id.* at 79.

129. DANIELS, JUST HEALTH, *supra* note 17, at 143.

130. DANIELS, JUST HEALTH CARE, *supra* note 3, at 79–80. Although Daniels' views have evolved over time, especially early in his career, he clearly committed to a principle of equal access to the basic tier. *Id.* at 80 (arguing for "[t]he importance of such equality of access to the basic tier").

131. *Id.* at 53.

upon societal resources and avoiding the "bottomless pit" objection.[132] Although it is not obvious at first glance which services are necessary to promote normal functioning, Daniels argues that "[h]ealth needs" or "things we need to maintain normal functioning" are "objectively ascribable,"[133] and that this gives us at least "a crude measure of the relative importance of meeting different health needs."[134]

Second, Daniels acknowledges that there are other important factors that affect health besides medical care, and that there are other factors besides health that affect opportunity. In Daniels' first book outlining his theory, he defined "health care" broadly to include not just medical care, but also public health interventions.[135] In more recent work, he has also emphasized the role of social determinants of health, such as early childhood education, nutritional programs, and economic inequality.[136] Likewise, Daniels acknowledges that there are other factors besides health—he singles out education in particular—that "are strategically important contributors to fair equality of opportunity."[137]

Third, Daniels acknowledges that given resource constraints and the importance of these other social goods, we cannot meet everyone's health care needs.[138] In fact, Daniels argues that "setting limits [on health spending] is a general requirement of justice, not something we must regrettably do only in countries with few resources and should resist doing in wealthier ones."[139] He argues that the various institutions that affect fair equality of opportunity (such as health care and education) "must be weighed against each other," as must the resources required to promote opportunity be weighed against other social goods.[140] He also argues that shifting some resources away from medical care toward the social determinants of health may be appropriate.[141]

---

132. *Id.*

133. DANIELS, JUST HEALTH, *supra* note 17, at 37.

134. *Id.* at 45.

135. DANIELS, JUST HEALTH CARE, *supra* note 3, at ix.

136. *See, e.g.*, DANIELS, JUST HEALTH, *supra* note 17, at 4; Norman Daniels, Bruce Kennedy & Ichiro Kawachi, *Justice Is Good for Our Health*, *in* IS INEQUALITY BAD FOR OUR HEALTH? 3, 25–31 (Joshua Cohen & Joel Rogers eds., 2000). *But see* Marcia Angell, *Pockets of Poverty*, *in* IS INEQUALITY BAD FOR OUR HEALTH?, *supra*, at 42, 45–46 ("[Daniels, Kennedy, and Kawachi] are on less solid ground in their contention that inequality somehow contributes to poor health directly, above and beyond the effects of poverty itself. . . . Inequality just *seems* to be a direct contributor to poor health, whereas the real cause is poverty.").

137. DANIELS, JUST HEALTH CARE, *supra* note 3, at 46.

138. DANIELS, JUST HEALTH, *supra* note 17, at 63.

139. *Id.* at 104.

140. DANIELS, JUST HEALTH CARE, *supra* note 3, at 54.

141. Daniels, Kennedy, & Kawachi, *supra* note 136, at 25 ("We do not suggest, then, that our society should immediately reallocate resources away from medicine to schools, for example, in the hope and expectation that a better-educated population will be healthier. But the arguments here suggest that some reallocations of resources to improve the social determinants are justifiable.").

To determine how these goods should be weighed, what services should be included in the basic tier, and what limits on health spending are appropriate, Daniels (in collaboration with James Sabin) proposes a procedural solution to this problem: a "fair deliberative process" to determine how to account for these resource constraints while still protecting fair equality of opportunity.[142]

In sum, Daniels' account suggests that health care is special because it is an important contributor to maintaining fair equality of opportunity. This provides a rationale for why inequality in access to health care must be limited, which may or may not apply to other goods. His account suggests that some health care services—those necessary to maintain normal functioning—must be provided equally and fully. The contents of this "basic tier" of services must be determined by a fair, deliberative process.

The fair equality of opportunity account has drawn a number of objections.[143] Some critics question the empirical basis for Daniels' argument that health care is special by arguing that the distribution of health care has a relatively trivial impact on the distribution of health outcomes.[144] Others argue that Daniels' fair equality of opportunity account cannot justify health care treatment for elderly patients who have already completed their life plans.[145] Still others argue that Daniels' account fails to meet the "leveling down" objection, since "[e]qual *unhealth* among all people would be consistent with equal opportunity as well."[146]

B. The Right to a Decent Minimum

The accounts of the Right to a Decent Minimum share two common features: First, they argue that there is a societal obligation to provide access to some absolute level of health care benefits. This right is grounded in the notion of "sufficiency," the idea that what is morally important is that people have enough, not that some people have more than others.[147] Unlike the Right to Equal Access, the Right to a Decent Minimum does not view it as

142. DANIELS, JUST HEALTH, *supra* note 17, at 25, 117–39.

143. *See* Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 CORNELL J.L. & PUB. POL'Y 403, 421–22 (2006) (outlining several different critiques).

144. *See* Gopal Sreenivasan, *Opportunity Is Not the Key*, 1 AM. J. BIOETHICS 1b (2001). *But see, e.g.,* Deaton, *supra* note 53, at 269 ("One reason for pinpointing the effects of health care is the clear importance of health-related innovations for the decline in mortality in the developed world over the past half century.").

145. Segall, *supra* note 106, at 342–43. Segall characterizes Daniels as claiming that "[h]ealth is strategically important because it contributes significantly to our ability to pursue and realize our life plans." *Id.* at 347.

146. F.M. KAMM, *Health and Equality of Opportunity*, *in* BIOETHICAL PRESCRIPTIONS: TO CREATE, END, CHOOSE, AND IMPROVE LIVES 393, 393–94 (2013).

147. *See* FRANKFURT, *supra* note 20.

problematic if some people have better access to health care than others, as long as everyone has some basic level of access to the services included in the decent minimum. In contrast to the insulation ideal, the Right to a Decent Minimum does not require that everyone have access to *all* health care services. In addition, in contrast to the fair equality of opportunity account, the Right to a Decent Minimum does not require *equal* access to a basic set of health care services, only *sufficient* access.

Second, the accounts of the Right to a Decent Minimum do not view health care as "special" in the sense that there are special reasons for why it needs to be distributed more equally than other goods. These accounts do not view health as being of special moral importance, and the rationales they offer for why the government should ensure access to a decent minimum of health care seem applicable to a range of other social benefits.

Because it is not concerned with ensuring equal access to health care, the Right to a Decent Minimum avoids both the leveling down objection and the bottomless pit objection. However, the Right to a Decent Minimum faces a different challenge—that of specifying which services are included in the decent minimum.[148] In addition, the Right to a Decent Minimum must still justify why society has an obligation to provide access to some level of health care goods. Although some of these accounts do not explicitly invoke the language of "rights" at all, they nevertheless each provide justifications for enacting a legal right to health care.

This Section below focuses on two prominent arguments in favor of the Right to a Decent Minimum: a prudent insurance ideal and a modified market account. The prudent insurance ideal stems from a more general theory of equality of resources developed by Ronald Dworkin, whereas the modified market account emphasizes maximizing overall welfare through market mechanisms.

1. The Prudent Insurance Ideal

The first variant is Ronald Dworkin's "prudent insurance" ideal, which asserts that we should provide access to the kinds of care for which it would be prudent for people to purchase insurance coverage, under certain idealized conditions.[149]

148. *See* DANIELS, JUST HEALTH CARE, *supra* note 3, at 74–75; *see also* FRANKFURT, *supra* note 20, at 15 ("Calculating the size of an *equal share* of something is generally much easier—a more straightforward and well-defined task—than determining how much a person needs of it in order to have enough. The very concept of having an *equal* share is itself considerably more transparent and intelligible than the concept of having *enough*. A theory of equality is much easier to articulate, accordingly, than a theory of sufficiency.").

149. DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 311–13. For another version of the prudent insurance approach, see Allan Gibbard, *The Prospective Pareto Principle and Equity of Access to Health Care*, 60 MILBANK MEM'L FUND Q. HEALTH & SOC'Y 399 (1982).

Dworkin's account rests on inquiring how much people would spend to insure themselves against negative health outcomes under certain idealized "fair-free market" conditions.[150] First, suppose that society provides for an equal distribution of resources, but that people are free to use those resources as they see fit to pursue their own life goals. This is part of Dworkin's more general egalitarian theory: that we have an obligation to treat each other as equals, and that the best way to do that is by ensuring equality of resources, a concept which he develops through imagining an initial auction and subsequent trading.[151] Second, suppose that all information about the value, side effects, and costs of particular medical procedures are known by the public. Third, suppose that no one has any information about the "antecedent probability" of anyone contracting any disease or other health condition.[152]

Dworkin suggests that under these fair-free market conditions, most people would choose to purchase health insurance coverage to protect against the possibility of experiencing certain kinds of conditions.[153] He hypothesizes that individuals might start off by making their own insurance arrangements, and that over time, these would evolve into "collective institutions and arrangements."[154] He speculates that insurance companies might offer a "basic scheme" of insurance coverage that would be "much the same for everyone."[155]

Dworkin argues that in our non-idealized society, we should design our health care financing system to approximate the system that would develop under his idealized fair-free market conditions. He justifies this conclusion by arguing that "a just distribution is one that well-informed people create for themselves by individual choices, provided that the economic system and the distribution of wealth in the community in which these choices are made are themselves just."[156] Therefore, according to Dworkin, the government should aim to provide everyone with a package of health insurance benefits that approximates those benefits that most people would choose for themselves if they were purchasing health insurance under fair-free market conditions.[157]

150. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 888–89 (spelling out these assumptions).

151. *See generally* Ronald Dworkin, *What Is Equality? Part 2: Equality of Resources*, 10 PHIL. & PUB. AFFS. 283 (1981).

152. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 889 (emphasis omitted).

153. *Id.* at 889–90.

154. *Id.* at 890.

155. *Id.*

156. DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 313.

157. *See id.* at 316–17.

Although Dworkin acknowledges that we cannot know what individuals would spend on health care under his idealized conditions "with any precision,"[158] he contends that there are at least a few kinds of procedures that would certainly cover most people in such a plan, including "standard prenatal care," primary care examinations, and inoculations.[159] Dworkin also contends that there are certain kinds of procedures that would definitely *not* be covered in the basic plan.[160] For example, Dworkin contends that "[i]t would be irrational for almost any twenty-five-year-old to insure himself as to provide for life-sustaining treatment if he falls into a persistent vegetative state."[161] Similarly, he claims that "it would not be prudent" for almost anyone to pay for insurance coverage for expensive medical intervention after someone entered the late stages of irreversible dementia.[162] He also ventures that the basic package would likely not include "ultra-expensive marginal diagnostics or extraordinarily costly treatments that have some but very little prospects for success."[163]

Although Dworkin's account is an egalitarian one in the sense that it is concerned with equality generally, it does not require a particular level of equality in access to health care. Under Dworkin's account, people may choose to purchase health insurance beyond the "basic" level of coverage.[164] Dworkin explicitly acknowledges that in a just society (as he understands it), "some people would have better medical care—some people would live longer and healthier lives—only because they had more money."[165] More generally, he acknowledges that his "conception of equality will not make people equal in the amount of money or goods each has at any particular time; still less will it mean that everyone will lead the same kind of life."[166] Dworkin defends this conception of equality as "dynamic and sensitive to people's differing convictions about how to live."[167]

Nor does Dworkin appear to think that health care is special, such that there are special reasons why the distribution of health care in particular should be equal. Rather, he concedes that his interest in health care is

158. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 889.

159. *Id.* at 894. *But see* Daniels, *Justice and Access to Health Care*, *supra* note 126, at 33 ("Since there is no feasible way to meet the assumptions about the distribution of medical knowledge or the exclusion of knowledge of individual risks, these assumptions make Dworkin's argument completely hypothetical and theoretical rather than practical.").

160. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 891.

161. DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 313.

162. *Id.* at 314.

163. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 896.

164. *Id.* at 890.

165. *Id.* at 896.

166. *Id.* at 888.

167. *Id.* at 898.

"largely practical," driven by the fact that there is more middle- and upper-class interest in health care and that Americans are more open to government involvement in health care than in other areas.[168] Dworkin suggests that he views health care reform as a means of promoting equality of resources more generally, rather than thinking there are special reasons to promote an equal distribution of health care.[169]

2. The Modified Market Account

A second prominent account of the Right to a Decent Minimum is what has been referred to as the "modified market account."[170] This view first came to the fore in the early 1970s,[171] and has been incredibly influential. In particular, it influenced the structure and development of the 2010 Patient Protection and Affordable Care Act.[172] This view has two main parts: First, it supports the provision of a decent minimum of health care on the grounds that doing so will improve overall welfare; and second, it implies that the most efficient (i.e., welfare-enhancing) way to provide a decent minimum is through market mechanisms.[173]

This account emphasizes market mechanisms because it explains the demand for health care in terms of "preferences," rather than needs, and so it treats health care like any other commodity.[174] Thus, market mechanisms are viewed as necessary to deliver health care benefits since they are the best means of enabling people to satisfy their own health care preferences.[175] Another implication of this view is that it does not object to inequalities in access to health care, but rather views such inequalities "merely as the expression of different preference curves, just as food budgets might vary among a welfare recipient, a factory worker, and a wealthy industrialist."[176] That being said, the modified market account does not leave health care completely to the free market; it acknowledges that some forms of government intervention or subsidies are necessary to correct for market

168. *Id.* at 897.

169. *Id.* at 897–98.

170. DANIELS, JUST HEALTH, *supra* note 17, at 249.

171. *See* Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX: J. L.-MED. 155, 156 (2004).

172. *See* Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. 1926, 1931 (2019). Norman Daniels characterizes the modified market account as "not really a position represented in the empirical literature on access . . . [but rather] a composite abstracted from views which are common in economics and health planning literature." DANIELS, JUST HEALTH CARE, *supra* note 3, at 71.

173. *See generally* ENTHOVEN, *supra* note 25.

174. DANIELS, JUST HEALTH CARE, *supra* note 3, at 71–72; Rosenblatt, *supra* note 171, at 176.

175. *See* Hoffman, *supra* note 172, at 1932–33.

176. *See* DANIELS, JUST HEALTH CARE, *supra* note 3, at 73.

failures, such as informational or financial barriers, that would otherwise prevent access to a decent minimum.[177]

How does the provision of a decent minimum maximize societal welfare? One possible answer is that health insurance—like wealth and income—has diminishing marginal utility, so that providing a basic level of benefits is an efficient means of maximizing health benefits.[178] Yet this still leaves a puzzle unanswered: If health care is just a commodity, then why not just provide cash vouchers and let people choose for themselves which commodities to purchase? Indeed, economic orthodoxy suggests that providing cash transfers would be a much more efficient means of improving welfare than providing in-kind benefits like health insurance coverage.[179]

Economists have offered a number of possible justifications for why governments nevertheless frequently choose to offer in-kind benefits, and why they often choose to provide health care benefits in particular.[180] One justification is that people simply have a preference for redistributive policies when it comes to health care, so that ensuring a basic level of access to health care makes everyone happier.[181] A second justification is that providing

177. *See, e.g.*, Fried, *supra* note 109, at 33 ("What if, instead, each person were assured a certain amount of money to purchase medical services as he chose?").

178. *See, e.g.*, Amy Gutmann, *For and Against Equal Access to Health Care*, 59 MILBANK MEM'L FUND Q. HEALTH & SOC'Y 542, 549 (1981) ("Several defenders of the market as a means of allocating goods and services also support a moderate degree of income redistribution on grounds of its diminishing marginal utility, or because they believe that every person has a right to a 'basic minimum.'"); *see also* Kenneth J. Arrow, *A Utilitarian Approach to the Concept of Equality in Public Expenditures*, 85 Q.J. ECON. 409, 409 (1971). *But see* FRANKFURT, *supra* note 20, at 17–40 (arguing that regarding income and wealth, the principle of diminishing marginal utility depends on false assumptions).

179. *See* Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?*, 26 J. HEALTH POL., POL'Y & L. 967, 978 (2001) ("While elementary justice seems to require greater equality in the distribution of medical care, the question is complicated by the fact that the poor suffer deprivation in many directions. Economic theory suggests it might be better to redistribute income and allow the poor to decide which additional goods and services they wish to buy.") (citation omitted); Mark V. Pauly, *Valuing Health Care in Money Terms*, *in* VALUING HEALTH CARE: COSTS BENEFITS, AND EFFECTIVENESS OF PHARMACEUTICALS AND OTHER MEDICAL TECHNOLOGIES 117 (Frank A. Sloan ed., 1995) ("If we want to provide benefit to low-income people, a more efficient approach would be to use the money that would have been spent on the program [as opposed to making] a direct money transfer to them, since the money will benefit low-income people more than the program would.").

180. *See generally* Janet Currie & Firouz Gahvari, *Transfers in Cash and In-Kind: Theory Meets the Data*, 46 J. ECON. LIT. 333 (2008) (reviewing various theoretical explanations for in-kind transfers and the empirical evidence supporting such theories).

181. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 954 (1963) ("[T]here is a more general interdependence, the concern of individuals for the health of others. The economic manifestations of this taste are to be found in individual donations to hospitals and to medical education, as well as in the widely accepted responsibilities of government in this area. The taste for improving the health of others appears to be stronger than for improving other aspects of their welfare."); Mark Shepard, Katherine Baicker & Jonathan S. Skinner, *Does One Medicare Fit All? The Economics of Uniform Health Insurance Benefits* 8 (Nat'l

health benefits has positive externalities: the benefits of providing health insurance extend beyond the insured. This may be because, for example, universal access to health care reduces the spread of communicable diseases,[182] or makes the labor force more productive.[183] A third justification is paternalism: Many people prefer in-kind benefits out of a concern that if the poor were given cash vouchers, then they would fail to spend the vouchers appropriately.[184]

One challenge to the modified market account is that because it is grounded in utilitarianism, it does not actually justify providing the decent minimum to everyone.[185] In particular, Allen Buchanan suggests that utilitarianism would not justify providing the decent minimum to people with physical or mental conditions that will render the costs of the minimum greater than their contribution to social utility.[186]

* * *

Although this Article focuses on the four accounts described above, these are by no means the only possible accounts of the Right to Equal Access and the Right to a Decent Minimum. For instance, Amy Gutmann suggests that the values of equal efforts to relieve pain and equal respect would also support a principle of equal access to health care.[187] Another prominent variant of the Right to Equal Access stems from Amartya Sen's and Martha Nussbaum's influential work on *capabilities*. Capabilities, as Sen and Nussbaum define them, are "what people are actually able to do and to be."[188]

Bureau of Econ. Rsch., Working Paper No. 26472, 2019) (suggesting that most countries use in-kind transfers because of an "*egalitarian social preference* for health").

182. Elhauge, *supra* note 111, at 1480–81.

183. Walter McClure, Alain C. Enthoven & Tim McDonald, *Universal Health Coverage? Why?*, HEALTH AFFS. (July 25, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170725.061210/full/.

184. *See generally* Zachary Liscow & Abigail Pershing, Why Is So Much Redistribution In-Kind and Not in Cash? Evidence from a Survey Experiment (Oct. 2020), (unpublished manuscript) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3672415 (conducting a survey experiment and finding that respondents' preferences for in-kind redistribution were primarily driven by paternalistic concerns).

185. Buchanan, *supra* note 118, at 60.

186. *Id.*

187. Gutmann, *supra* note 178, at 548.

188. Martha C. Nussbaum, *Capabilities as Fundamental Entitlements: Sen and Social Justice*, 9 FEMINIST ECON. 33, 33 (2003). According to Sen, "[a] person's 'capability' refers to the alternative combinations of functionings that are feasible for her to achieve." AMARTYA SEN, DEVELOPMENT AS FREEDOM 75 (2000). *Functionings*, in turn, represent "the various things a person may value doing or being," ranging from being free from disease to participating in the community. *Id.* In other words, capabilities represent a form of liberty: the liberty to achieve different lifestyles. *Id.* at 74; Amartya Sen, Tanner Lecture on Human Values, Delivered at Stanford University: Equality of What?, 217–19 (May 22, 1979).

Understood in this way, people are equal when they have the same capability sets.[189] Although the precise relation between capabilities and health is disputed,[190] the capabilities approach treats health care with special moral importance and justifies some degree of equality in access to health care services.[191]

In practice, it is not clear how much these other variants of the Right to Equal Access differ from the fair equality of opportunity account. It seems plausible that an account of the Right to Equal Access that is focused on efforts to relieve pain or support equal conditions of self-respect might require equal access to a broader range of health care services than necessary to ensure fair equality of opportunity.[192] Likewise, some proponents of the capabilities approach claim it requires a more robust level of equality than the fair equality of opportunity account,[193] though Daniels himself suggests

189. AMARTYA SEN, INEQUALITY REEXAMINED 39–55 (1992). Of note, equality of capabilities does not, however, require equality of *all* capabilities. As Elizabeth Anderson puts it, "[b]eing a poor card player does not make one oppressed." Elizabeth S. Anderson, *What Is the Point of Equality?*, 109 ETHICS 287, 317 (1999). Instead, Sen calls for equality of what he refers to as "basic capabilities," which are "prerequisites to other capabilities." Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 YALE J.L. & HUMANS. 273, 302, 302 n.119 (2006). Sen himself does not provide a full list of these capabilities, but he specifically mentions "[t]he ability to move about . . . the ability to meet one's nutritional requirements, the wherewithal to be clothed and sheltered, [and] the power to participate in the social life of the community." Sen, *supra* note 188, at 218. Nussbaum provides a more comprehensive list of ten "Central Human Capabilities," which she claims are "central requirements of a life with dignity." Nussbaum, *supra* note 188, at 40.

190. Nussbaum includes the capability of "[b]odily [h]ealth," which she defines as "[b]eing able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter," on her list of the ten Central Human Capabilities. *Id.* at 41. Others have distinguished between "central" and "non-central health capabilities," the former of which are "prerequisites for other capabilities." Ruger, *supra* note 189, at 302. Yet others have argued that health in itself is not a capability, but that some level of health is actually necessary for all ten of Nussbaum's capabilities. Per-Anders Tengland, *Health and Capabilities: A Conceptual Clarification*, 23 MED., HEALTH CARE & PHIL. 25, 25 (2020).

191. Jennifer Prah Ruger writes that the capabilities approach necessitates reducing disparities in access to health care because "unequal access can reduce individuals' capability to function." JENNIFER PRAH RUGER, *A Health Capability Account of Equal Access*, *in* HEALTH AND SOCIAL JUSTICE 144 (2009). Thus, the capabilities approach "requires society to ensure social conditions, goods, and services in proportion to individuals' and groups' health needs, as determined by the requirements each individual or group has to achieve their potential in health." *Id.* at 141.

192. Gutmann, *supra* note 178, at 547.

193. RUGER, *supra* note 191. More generally, Sen and Nussbaum argue that the capabilities approach is preferable to the Rawlsian emphasis on equality of resources both because the latter "fetishizes" resources over human beings, and because the capabilities approach accounts for the fact that people have different needs for resources depending on their individual circumstances. Thus, the same set of resources will not necessarily make people equally well off in terms of what they can do or be. Sen, *supra* note 188, at 215–16; Martha C. Nussbaum, *Human Functioning and Social Justice*: *In Defense of Aristotelian Essentialism*, 20 POL. THEORY 202, 233 (1992). For instance, a mobility-impaired person will need more resources to attain the same level of mobility as a person without such an impairment. Sen, *supra* note 188, at 215. That being said, the extent

that the two accounts largely converge, at least once Rawls's theory is extended to health and health care in the way he proposes.[194]

There are other justifications that can be offered for the Right to a Decent Minimum as well. For instance, Allen Buchanan concludes that no single theory of justice can provide an adequate foundation for a universal Right to a Decent Minimum.[195] Instead, he makes a pluralistic case for a legal entitlement to health care that stems from the combined weight of multiple moral considerations,[196] together with an argument for what he terms "[e]nforced [b]eneficence."[197] Henry Shue justifies the right to a decent minimum of health care services as part of a category of "basic rights" that are necessary to realize other rights, such as the right to free assembly.[198] These accounts may differ in terms of how they determine the contents of the decent minimum.

The various accounts of the Right to Equal Access and Right to a Decent Minimum differ both in the types of assumptions and arguments that they

to which Sen's and Nussbaum's capabilities approach differs from Rawls's theory of justice more generally is disputed. Rawls himself appeared to view his theory as capturing the importance of capabilities. *See* DANIELS, JUST HEALTH, *supra* note 17, at 50 n.29 ("[T]he account of primary goods does take into account, and does not abstract from, basic capabilities: namely, the capabilities of citizens as free and equal persons in virtue of their two moral powers.") (citation omitted).

194. Daniels, *Capabilities, Opportunity, and Health*, *supra* note 124, at 134.

195. Buchanan, *supra* note 118, at 59.

196. Buchanan outlines three different moral considerations in support of a Right to a Decent Minimum. *Id.* at 67–68. First, he argues that certain groups have "special" (as opposed to universal) rights to a decent minimum: groups who have experienced a history of prejudice and discriminatory treatment that has affected their health (such as Black Americans and Native Americans); groups whose health has been unjustly affected by unjust treatment by private parties (such as people sickened by a corporation dumping toxic pollutants); and groups who have made special sacrifices for the good of society, such as veterans. *Id.* at 67. Second, he argues that the principle of harm prevention, which has been invoked to support public health interventions generally, should provide the same protections across racial and geographic groups. *Id.* at 67–68. Third, he outlines a few "prudential arguments" in favor of providing health care, such as improving the productivity of the labor force and ensuring the fitness of the citizenry for national defense. *Id.* at 68. Buchanan argues that the combined weight of these considerations supports a legal entitlement to a decent minimum of health care for at least certain groups, perhaps the groups that we are most concerned about lacking health care. *Id.*

197. *Id.* Buchanan articulates two arguments for what he calls "enforced beneficence." Both arguments assume that there is a moral obligation of beneficence to provide help to people in need, and that this includes the provision of at least certain forms of health care. *Id.* at 69. However, Buchanan argues that even if one grants the assumption that people will act on these charitable obligations, there are certain forms of beneficence—such as health care—that can only be provided through the contributions of large numbers of people, and that legal enforcement is necessary to achieve such coordinated joint efforts. *Id.* at 70.

198. *See* HENRY SHUE, BASIC RIGHTS: SUBSISTENCE, AFFLUENCE, AND U.S. FOREIGN POLICY 22–25 (1980) (describing the right to "minimal preventive public health care" as part of broader "right to subsistence" which is a "basic right" necessary to realize other rights); *see also* James W. Nickel, *Linkage Arguments For and Against Rights*, OXFORD J. LEG. STUD. (forthcoming) (explaining how these types of "Justificatory Linkage Arguments" can be used to support—and attack—rights claims).

rely on as well as their implications in terms of what the right to health care implies. Broadly, the accounts of the Right to Equal Access all support some level of equality in access to health care services, yet they vary in terms of whether *all* health care services must be distributed equally, or only some subset. By contrast, the accounts of the Right to a Decent Minimum all support the right to some basic level of health care benefits and do not object to inequalities in health care access, yet they suggest different approaches to determining the basic minimum. As I will show in Part III, these different approaches lead to distinct practical implications for health care reform.

III. IMPLICATIONS AND COMPARISONS

This Part first examines the implications of the two conceptions of the right to health care with respect to the three key policy issues described above: what health care benefits should be covered, whether cost-sharing is appropriate, and whether private health insurance should be preserved. Then, it compares these theoretical implications to the actual approaches taken by Medicare for All and the incremental plans.

Making these comparisons helps to illuminate the normative underpinnings of the debate over health care reform, and to understand some of the most salient differences between Medicare for All and the incremental reforms. Yet it also reveals that there are surprising areas of convergence between the two theoretical conceptions of the right to health care, and accordingly, that there is room for greater convergence between the two types of reform proposals. In addition, it reveals that in at least one important respect, both types of reforms fall short of the perspective of either conception of the right to health care.

A. Theoretical Implications

I begin by examining the implications of the Right to Equal Access and the Right to a Decent Minimum with regard to the three aforementioned policy issues. Although these two conceptions largely converge when it comes to the issue of covered benefits, they diverge with regard to cost-sharing and private health insurance (see Table 1 below). These divergent implications stem from their different views about inequalities in health care access: The Right to Equal Access views at least some kinds of inequality in health care access as inherently objectionable, whereas the Right to a Decent Minimum does not. However, the different versions of these conceptions of the right to health care do not have uniform implications. For instance, although all the accounts of the Right to Equal Access would restrict the provision of private health insurance and cost-sharing to some degree, the individual accounts of this right differ in terms of just how strictly they would do so.

Table 1: Theoretical Implications for Key Policy Issues in Health Care Reform

	The Right to Equal Access		**The Right to a Decent Minimum**	
	Insulation Ideal	*Fair Equality of Opportunity*	*Prudent Insurance Ideal*	*Modified Market Account*
Reasonable limits on covered benefits?	None	Yes (accountability for reasonableness)	Yes (imprudent purchases)	Yes (e.g., cost-effectiveness)
Cost-Sharing?	None	Yes, outside of the basic tier	Yes	Yes
Private health insurance?	None	Yes, with restrictions	Yes	Yes

1. Covered Benefits

Perhaps surprisingly, it is not clear that the Right to Equal Access necessarily justifies covering a broader set of health care benefits than the Right to a Decent Minimum. Because the accounts of the Right to a Decent Minimum are not particularly specific regarding which benefits would be included in the "decent minimum,"[199] it is at least possible to imagine a decent minimum of health care benefits that is comparable to the benefits covered under the Right to Equal Access.[200]

Moreover, three out of the four accounts of the right to health care (all except for the insulation ideal) suggest that a just distribution of health care is not only compatible with imposing reasonable limitations on covered

199. Arti Kaur Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 IND. L.J. 1015, 1021 (1997) ("Close examination of even the most systematic approaches to specifying adequate care demonstrates that each of them is, at the most fundamental level, wholly indeterminate.").

200. Daniels, *Justice and Access to Health Care*, *supra* note 126, at 40–41 (noting that "Dworkin's prudential insurance approach might have the same scope as the opportunity-based view if the insurance policy that (most?) prudent buyers purchase includes protections against health risks that go beyond treatments for illness").

health care benefits, but it in fact requires imposing such limitations.[201] This follows from the fact that, in a society with limited resources, public financing of health care benefits has opportunity costs: Any decision about covering health care benefits will leave less money to pay for other important social goods, such as education, transportation, and housing.[202] This in turn implies that a just health care system must place *some* reasonable limits on the amount of health care spending.[203]

The Right to Equal Access

Of all the versions of the right to health care described in Part II, only the insulation ideal suggests that there is no need to set limits on covered benefits. The insulation ideal suggests that every kind of medical care that contributes at all to people's health should be covered, no matter the cost, and no matter how minimal the benefits.[204] While this ideal may be intuitively appealing to many people,[205] it is especially vulnerable to the bottomless pit objection, since attempting to satisfy it would leave no resources for other important social goods, such as education, transportation, housing, or national defense.[206] Therefore, as discussed above, the insulation ideal is not a realistic principle to guide a just distribution of health care.

By contrast, the fair equality of opportunity account provides that a just distribution of health care must include limits on covered services, and in particular that it must weigh health care benefits against other social goods.[207] This is true for a couple of reasons: First, insofar as the special importance of health care derives from its impact on health, non-medical services such as public health, education, and housing arguably contribute more to health than

201. *See* DANIELS, JUST HEALTH, *supra* note 17, at 104 ("[S]etting limits is a general requirement of justice, not something we must regrettably do only in countries with few resources and should resist doing in wealthier ones."); DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 315 ("If we substituted the prudent insurance approach for the rescue principle as our abstract ideal of justice in health care, we would therefore accept certain limits on universal coverage, and we would accept these not as compromises with justice but as required by it.").

202. *See, e.g.,* Katherine Baicker & Amitabh Chandra, *Do We Spend Too Much on Health Care?*, 383 N. ENG. J. MED. 605, 607 (2020).

203. Gopal Sreenivasan, *Why Justice Requires Rationing in Health Care*, *in* MEDICINE, CARE, AND SOCIAL JUSTICE: ESSAYS ON THE DISTRIBUTION OF HEALTH CARE 143, 144 (Rosamond Rhodes et al. eds., 2012) [hereinafter Sreenivasan, *Why Justice Requires Rationing in Health Care*].

204. *See supra* notes 111–120 and accompanying text.

205. *See* David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue*, 265 JAMA 2218, 2219 (1991) ("[T]here is a fact about the human psyche that will inevitably trump the utilitarian rationality that is implicit in cost-effectiveness analysis: people cannot stand idly by when an identified person's life is visibly threatened if effective rescue measures are available.")

206. *See supra* note 109.

207. *See supra* note 140 and accompanying text.

health care does.[208] Second, the claim that health care is morally distinctive does not imply that it is the only important social good—or even the most important one.[209]

The fair equality of opportunity account attempts to address the bottomless pit objection by articulating a limitation on covered health care benefits: It provides that there must be equal access to a "basic" tier of benefits, based on health needs, that are "needed to maintain, restore, or compensate for the loss of normal species-typical functioning."[210] In earlier work, Daniels argued that this at least provides a "principled" approach, albeit an "abstract" one, of carving out certain benefits to which there would not be guaranteed access.[211] In more recent work, Daniels (together with James Sabin) has developed a procedural method, called "accountability for reasonableness," for determining what types of benefits would be included in the basic tier.[212] This process emphasizes "that the rationales for important . . . plan decisions should not only be publicly available, but should also be those that 'fair-minded' people can agree are relevant to pursuing appropriate patient care under necessary resource constraints."[213]

The Right to a Decent Minimum

The different variants of the Right to a Decent Minimum suggest a few different ways that the incremental proposals might determine which benefits to cover. Dworkin's prudent insurance ideal suggests that the contents of the basic package would include those services for which most people would purchase insurance coverage, under the three "fair free market conditions" that he outlines.[214] As discussed above, he argues that this process would

208. *See, e.g.*, Elhauge, *supra* note 111, at 1460 ("The need for making tradeoffs is further underscored by studies showing that income, environment, sanitary housing, and good nutrition result in larger health improvements per expenditure than health care does.").

209. *See* DANIELS, JUST HEALTH, *supra* note 17, at 104 ("Opportunity is also not the only important social good. Basic liberties must also be protected, including institutions that assure people that they can effectively exercise them, especially their right of political participation.").

210. DANIELS, JUST HEALTH CARE, *supra* note 3, at 79.

211. *See id.*

212. *See* DANIELS, JUST HEALTH, *supra* note 17, at 143–44 ("Determining what is in that basic tier must be clarified in light of arguments about how to protect fair equality of opportunity under reasonable resource constraints; these arguments require a fair process (accountability for reasonableness) for appropriate democratic deliberation.") (citation omitted). *See generally* Norman Daniels & James Sabin, *The Ethics of Accountability in Managed Care Reform*, 17 HEALTH AFFS. 50, 51 (1998) (developing the concept of "accountability for reasonableness").

213. *Id*. at 51.

214. DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 315 ("If most prudent people would buy a certain level of medical coverage in a free market if they had average means—if nearly everyone would buy insurance covering ordinary medical care, hospitalization when necessary, prenatal and pediatric care, and regular checkups and other preventive medicine, for example—then the

likely exclude certain services, such as "extraordinarily costly treatments that have some but very little prospects for success."[215] Dworkin argues that this is the case because most young people would likely "think it wiser to spend what that insurance would cost on better health care earlier, or on education or training or investment that would provide greater benefit or more important security."[216]

By contrast, some proponents of the modified market approach have suggested determining the content of the decent minimum by either simply listing the types of services that would be covered or by appealing to an average level of services in the current health care system.[217] Both of these approaches are more administratively simple than resorting to a procedure, but they are arbitrary: they raise the question of why these services, and not others, should be included in the basic minimum.[218] Appealing to an average means that the contents of the decent minimum will reflect unnecessary or wasteful features of the current health care system, and exclude any features that are typically not covered, but which may still be quite valuable.[219] In addition, these approaches do not actually provide an effective means of limiting health care spending.[220] As Einer Elhauge observes, "any list that simply limits the categories of services funded does nothing to limit expenditures on care *within the funded categories*."[221] Faced with such a list, pharmaceutical companies, medical device manufacturers, and hospitals will simply focus on delivering expensive drugs, treatments, and technologies that fall into the specified categories.[222]

A less arbitrary and more effective method would be to employ either cost-effectiveness analysis (CEA), which weighs the costs and benefits of particular treatments, or comparative effectiveness research (CER), which weighs the relative efficacy of the treatment being considered compared to

unfairness of our society is almost certainly the reason some people do not have such coverage now. A universal health-care system should make sure, in all justice, that everyone does have it.").

215. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 896.

216. DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 314.

217. *See, e.g.*, ENTHOVEN, *supra* note 25; *see also* DANIELS, JUST HEALTH, *supra* note 17, at 250 ("[P]roponents of the market view shy away from developing a full justification of the focus on a decent minimum, perhaps because doing so may undercut the idea that health care is a commodity like any other.").

218. *See* Daniels, *Justice and Access to Health Care*, *supra* note 126, at 19–20 ("It is typical of such appeals to lists that there is no rationale offered for why items are on the list. If mental health services are included, we are often not told which ones; and there may be categorical omissions, such as dental care, without explanation.").

219. Daniels, *Justice and Access to Health Care*, at 20.

220. Elhauge, *supra* note 111, at 1470–71.

221. *Id*. at 1471 (emphasis added).

222. *Id.*

other treatments.[223] Although CEA and CER may call to mind top-down bureaucratic rationing, some proponents argue that these methods can be implemented in such a way as to improve the market for health care by addressing informational problems and misaligned incentives, thereby enabling patients and providers to make better decisions.[224] Adopting either approach would be in line with the modified market approach's objective of maximizing welfare, though it would raise a host of other moral, pragmatic, and political objections.[225]

2. Cost-Sharing

The Right to Equal Access and the Right to a Decent Minimum have divergent implications when it comes to cost-sharing: whereas the Right to Equal Access requires greatly restricting the use of cost-sharing, the Right to a Decent Minimum does not. In brief, this is because the Right to Equal Access is concerned with limiting inequality in access to health care services, whereas the Right to a Decent Minimum is only focused on providing some access to a decent minimum of health care services. The Right to Equal Access views at least some forms of inequality in access to health care as intrinsically objectionable, even if the public has access to a decent minimum.

The Right to Equal Access

Although both variants of the Right to Equal Access imply the need for strict limits on cost-sharing, they have slightly different implications. The insulation ideal implicitly prohibits *any* amount of cost-sharing that would impede access to health care because it forbids any restrictions on access to

223. Johnson et al., *supra* note 67, at 134.

224. *See, e.g.*, Amitabh Chandra, Anupam B. Jena & Jonathan S. Skinner, *The Pragmatist's Guide to Comparative Effectiveness Research*, J. ECON. PERSPS., Spring 2011, at 27, 42; Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523, 527–28 (2014).

225. *See, e.g.,* DANIELS, JUST HEALTH, *supra* note 17, at 114 ("Unfortunately, [cost-effectiveness analysis] carries with it some morally controversial — and, many insist, unacceptable — assumptions.") (citations omitted); Jerome Groopman, *Health Care: Who Knows 'Best'?*, N.Y. REV. BOOKS, Feb. 11, 2020, https://www.nybooks.com/articles/2010/02/11/health-care-who-knows-best/ ("Over the past decade, federal 'choice architects'—i.e., doctors and other experts acting for the government and making use of research on comparative effectiveness—have repeatedly identified 'best practices,' only to have them shown to be ineffective or even deleterious."); Hadorn, *supra* note 205, at 2225 ("[T]he use of cost-effectiveness analysis is unlikely to produce a socially or politically acceptable definition of necessary care."); Sharona Hoffman & Andy Podgurski, *Improving Health Care Outcomes Through Personalized Comparisons of Treatment Effectiveness Based on Electronic Health Records*, 39 J.L., MED. & ETHICS 425, 427–28 (2011) (expressing concerns that both CEA and CER may lead providers to pursue treatments that are not suitable for individual patients).

health care that promote health "on grounds of economy."[226] Thus, out-of-pocket costs could be charged for health care only on the condition that they did not deter anyone's access to care.[227] Since even very small amounts of cost-sharing—such as copayments of $1 or $5—have been shown to lead patients to delay seeking necessary medical services, the insulation ideal would require dramatically scaling back—if not completely eliminating—cost-sharing.[228]

By contrast, the fair equality of opportunity account would restrict cost-sharing only for the "basic tier" of health care services that are necessary for promoting fair equality of opportunity.[229] For services included in the basic tier, cost-sharing would be restricted since it would create inequalities in opportunity.[230] The intuition underlying this conclusion is simple: Cost-sharing creates financial barriers to accessing health care, which disproportionately affect the sick (who have greater need for health care) and the poor (who are least able to afford it).[231] Cost-sharing places these populations in a bind: They may choose to defer or forgo seeking medical care, which may detrimentally affect their health.[232] Alternatively, if they fail to cut back on medical care, then they will face disproportionate financial

226. *See supra* note 112 and accompanying text.

227. Gutmann, *supra* note 178, at 544.

228. *See* Samantha Artiga, Petry Ubri & Julia Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, KAISER FAM. FOUND. 4 (June 1, 2017), https://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

229. DANIELS, JUST HEALTH CARE, *supra* note 3, at 79–80; DANIELS, JUST HEALTH, *supra* note 17, at 143–44.

230. *See* DANIELS, JUST HEALTH CARE, *supra* note 3, at 80 ("[T]he basic tier is defined by reference to the impact of health-care services on opportunity, and inequalities of opportunity are not to be tolerated for the sorts of economic reasons that might make the preservation of these obstacles appealing.").

231. DANIELS, JUST HEALTH, *supra* note 17, at 259; Johnson et al., *supra* note 67, at 135–36.

232. Some empirical research suggests that low-income and sicker populations are more likely to cut back on medical care in response to cost-sharing than high-income populations, though there is not a clear consensus. *See* Artiga et al., *supra* note 228, at 4 ("Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals."); Katherine Baicker & Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, J. ECON. PERSPS., Spring 2011, at 47, 58 ("There is some evidence that the frequent users of health care (the sickest) are more likely to adjust utilization in response to changes in cost-sharing. . . . Overall, the evidence to support the contention that low-income groups are more price sensitive is suggestive, but seems less than fully reliable.") (citation omitted); Samuel L. Dickman et al., *Health Spending for Low-, Middle- and High-Income Americans, 1963-2012*, 35 HEALTH AFFS. 1189, 1195 (2016) (suggesting that the fact that wealthy Americans have higher medical expenditures than the poorest Americans, despite being in better health, likely reflects—at least in part—the disproportionate impact that cost-sharing has on poor people's access to health care); HAMEL ET AL., *supra* note 42, at 2 (finding that three-quarters of those in the highest-deductible plans who say that someone in their family has a chronic condition report that a family member has forgone or delayed medical care over the previous year due to concerns about cost).

burdens compared to healthy and high-income populations.[233] For services outside of the basic tier, some amount of cost-sharing would presumably be acceptable.

The Right to a Decent Minimum

By contrast, neither of the variants of the Right to a Decent Minimum would eliminate cost-sharing. Although Dworkin does not explicitly address the issue of cost-sharing, he acknowledges that under the prudent insurance ideal, "some people would have better medical care—some people would live longer and healthier lives—only because they had more money."[234] He notes that "some people would be able and willing to make provision for queue-jumping, or elective cosmetic surgery, or other benefits that the basic provision made available through general collective schemes would not provide."[235] This suggests that not only is the prudent insurance ideal consistent with some people having access to a broader set of health care benefits than those provided under the public scheme, but that it is also compatible with some people having *better* access to the same benefits provided by the public scheme—which would be the case if the public scheme had greater cost-sharing requirements.

Likewise, the modified market account supports some level of cost-sharing. Indeed, the very notion of cost-sharing derives from the market view of health care as a commodity like cars or televisions.[236] According to this view, health insurance artificially lowers the cost of health care, and in doing so, creates "moral hazard," causing people to consume health care services that they do not value sufficiently to justify the costs of providing that care.[237] In theory, cost-sharing presents a solution to this problem by requiring patients (who are often referred to in this context as "consumers") to pay a portion of their health care costs out-of-pocket so that they will have more of

233. *See* Amitabh Chandra, Jonathan Gruber & Robin McKnight, *The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts*, 33 J. HEALTH ECON. 57, 65 (2014) (finding that "those who are chronically ill, and especially those with diabetes, high cholesterol and asthma, have a lower price elasticity of demand").

234. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 896.

235. *Id.* at 890.

236. *See* DANIELS, JUST HEALTH, *supra* note 17, at 19 ("In general, the extensive use of cost-sharing suggests that many legislators, employers, and plan administrators believe that mechanisms for marketing other commodities are also appropriate for health care; that is, they believe that health care may not be as special as some think it should be.").

237. *See generally* Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AMER. ECON. REV. 531 (1968); Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251 (1973); *see also* Joseph P. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, J. ECON. PERSPS., Summer 1992, at 3, 15.

an incentive to not seek low-value health care.[238] In practice, however, cost-sharing has not had this intended effect: Instead of prompting patients to become smarter health care "consumers," recent empirical research finds that cost-sharing in fact causes people to cut back indiscriminately on both low- and high-value care.[239] To address this problem, some market-oriented health scholars have endorsed "Value-Based Insurance Design," which "aligns patients' out-of-pocket costs with the value of services."[240]

3. Private Insurance

The Right to Equal Access and the Right to a Decent Minimum also diverge when it comes to private health insurance: The former supports restrictions on private health insurance to limit inequalities in access to health care, whereas the latter only supports such restrictions as necessary to preserve access to the decent minimum. Again, in essence this is because the Right to Equal Access is concerned with limiting inequality in health care access, whereas the Right to a Decent Minimum is only focused on providing access to a decent minimum.

The Right to Equal Access

The Right to Equal Access restricts private health insurance because it contributes to inequalities in access to health care. Allowing private health insurance may contribute to inequalities in health care access in two ways: First, it does so *directly* because different health insurance plans may provide different levels—or "tiers"—of access to health care.[241] For instance, wealthier people may obtain supplemental coverage that provides access to benefits that are not offered by the public scheme, or they may purchase private insurance that provides faster access to health care services (i.e., shorter wait times) or a broader network of providers.[242]

Second, allowing private health insurance may *indirectly* contribute to inequalities in health care access by undermining the provision of benefits in

238. *See* Hoffman, *supra* note 172, at 1970; John A. Nyman, *American Health Policy: Cracks in the Foundation*, 32 J. HEALTH POL., POL'Y & L. 759, 760–61 (2007).

239. *See* Zarek C. Brot-Goldberg et al., *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, 132 Q.J. ECON. 1261, 1261 (2017).

240. *See, e.g.*, Haley Richardson et al., *V-BID X: Creating a Value-Based Insurance Design Plan for the Exchange Market*, HEALTH AFFS. BLOG (July 15, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190714.437267/full/.

241. *See* Benjamin J. Krohmal & Ezekiel J. Emanuel, *Access and Ability to Pay: The Ethics of a Tiered Health Care System*, 167 JAMA INTERNAL MED. 433, 433 (2007) (distinguishing between the number of payers in a health care system and the number of tiers).

242. *See supra* note 48 and accompanying text; CONG. BUDGET OFF., *supra* note 72, at 12.

the public plan.[243] This could happen because of the economic effects of private health insurance.[244] For instance, if private plans offer higher reimbursement rates (as is currently the case in the United States),[245] then providers may prioritize patients with access to private insurance over those enrolled in the public scheme.[246] Alternatively, the provision of private health insurance could undermine the political sense of solidarity essential for maintaining the resources necessary for the public plan.[247] Such consequences are not inevitable, however.[248] Indeed, it is possible that allowing private health insurance could actually improve the public plan. For instance, if private insurance plans selectively contract with higher-quality providers, this could encourage providers to improve their quality generally.[249]

Although both variants of the Right to Equal Access would restrict all private health insurance, they differ in terms of their rationales and just how strictly they would do so. The insulation ideal would—at least in theory—create a one-tier system of infinite generosity, where everyone would have access to any medical service that provided any health benefit. Under such a system, there would be no need for wealthier people to purchase private insurance coverage, since the public plan would guarantee full access to medical care for everyone based on their health needs.[250]

---

243. *See* Daniels, *Justice and Access to Health Care*, *supra* note 126, at 52.

244. *See* Norman Daniels, *Symposium on the Rationing of Health Care: 2 Rationing Medical Care — A Philosopher's Perspective on Outcomes and Process*, 14 ECON. & PHIL. 27, 33 (1998).

245. MATTHEW FIEDLER, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y, CAPPING PRICES OR CREATING A PUBLIC OPTION: HOW WOULD THEY CHANGE WHAT WE PAY FOR HEALTH CARE? 1 (Nov. 2020), https://www.brookings.edu/wp-content/uploads/2020/11/Price-Caps-and-Public-Options-Paper.pdf ("Commercial health insurers pay much higher prices for health care services than public insurance programs like Medicare or Medicaid.").

246. *See* CONG. BUDGET OFF., *supra* note 72, at 13 ("If providers were allowed to participate in both the single-payer system and the substitutive insurance market and if provider payment rates in the substitutive insurance plan were higher than in the single-payer system, providers might prioritize treating those enrollees. If many people enrolled in substitutive insurance, patients in the single-payer health plan might have longer wait times."); Gutmann, *supra* note 178, at 552 ("Without restricting the free market in extra health care goods, a society risks having its best medical practitioners drained into the private market sector, thereby decreasing the quality of medical care received by the majority of citizens confined to the publicly funded sector. The lower the level of public provision of health care and the less elastic the supply of physicians, the more problematic (from the perspective of the values underlying equal access) will be an additional market sector in health care."); Johnson et al., *supra* note 67, at 136 ("Duplicative insurance could . . . induce further inequities in care if providers exited the public system or gave priority to privately insured patients.").

247. Daniels, *Justice and Access to Health Care*, *supra* note 126, at 52; Krohmal & Emanuel, *supra* note 241, at 434.

248. Gutmann, *supra* note 178, at 553 (describing such effects as "empirically contingent").

249. *See* CONG. BUDGET OFF., *supra* note 72, at 13.

250. Gutmann, *supra* note 178, at 544.

The fair equality of opportunity principle, on the other hand, is compatible with some forms of private health insurance.[251] This is because the fair equality of opportunity account does not require complete equality in access to health care, since not all forms of health care contribute to opportunity.[252] Still, Norman Daniels specifies two constraints that the fair equality of opportunity principle imposes on private insurance: First, private plans must not undermine the public plan so that it still "protects normal functioning as much as possible under resource constraints."[253] The public plan must provide universal and equal access, based on health needs, to the subset of health care services that promote fair equality of opportunity under reasonable resource constraints (what Daniels refers to as the "basic tier").[254]

Second, Daniels writes that "the structure of inequality that results . . . [must not be] objectionable."[255] In particular, he suggests that it would be more morally objectionable if the public plan only served the poorest groups while most other people purchased private insurance than if most people used the public plan and only the richest people bought private insurance.[256] Daniels argues that this is because under the former system, but not the latter, the poor might justifiably complain that they are being denied the medical resources that are necessary to achieve the range of normal opportunities that are available to most people.[257]

The Right to a Decent Minimum

By contrast, the Right to a Decent Minimum is compatible with private health insurance as long as it does not undermine access to a decent minimum of health care.[258] Since the various accounts of the Right to a Decent

251. Daniels, *Justice and Access to Health Care*, *supra* note 126, at 51.

252. DANIELS, JUST HEALTH CARE, *supra* note 3, at 79 ("[T]he fair equality of opportunity account shares with the market approach the view that health-care services have a variety of functions, only *some* of which may give rise to social obligations to provide them.").

253. DANIELS, JUST HEALTH, *supra* note 17, at 251.

254. *See supra* note 129 and accompanying text.

255. Daniels, *Justice and Access to Health Care*, *supra* note 126, at 52.

256. DANIELS, JUST HEALTH, *supra* note 17, at 259.

257. Norman Daniels, *Is the Oregon Rationing Plan Fair?*, 265 JAMA 2232, 2234 (1991). It is not obvious that this second constraint is distinct from the first that Daniels articulates. It would seem that if the basic tier were so barebones that only the poorest groups availed themselves of it, then it would fail to protect normal functioning as much as possible under reasonable resource constraints.

258. *See, e.g.*, Buchanan, *supra* note 118, at 58 ("Granted that individuals are allowed to spend their after-tax incomes on more frivolous items, why shouldn't they be allowed to spend it on health? If the answer is that they should be so allowed, as long as this does not interfere with the provision of an adequate package of health-care services for everyone, then we have retreated . . . to something very like the principle of a decent minimum."); Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 890 (specifying that under the prudent insurance ideal, "people would

Minimum do not view health care as special, they regard it as arbitrary to prohibit wealthy individuals from purchasing better access to health care, while at the same time allowing them to purchase fancier cars and houses.[259]

While the Right to a Decent Minimum is generally compatible with a tiered health care system, the prudent insurance ideal and the modified market account support allowing people to enroll in private insurance for somewhat different reasons. The prudent insurance ideal does so since it supports a distribution of health care resources that reflects what people would choose for themselves under "fair free-market conditions."[260] Allowing some people to purchase more generous coverage if they wish is consistent with Dworkin's conception of equality, which is "sensitive to people's differing convictions about how to live."[261]

By comparison, the modified market account supports tiering on the basis that it leads to greater efficiency gains than establishing a single "one-size-fits-all" public plan.[262] Economists Mark Shepard, Katherine Baicker, and Jonathan Skinner show that these efficiency gains have actually grown over time for three main reasons: rising income inequality has led to greater divergence between the health care preferences of the rich and the poor; expensive medical technology is increasingly crowding out other important social goods; and the requisite tax financing has become prohibitively costly.[263] Moreover, although allowing tiering would lead to greater inequalities in access to health care, Shepard, Baicker, and Skinner point out that these inequalities can be offset by using the savings from a less generous health care program to provide progressive cash transfers.[264] Similar to Dworkin, they point out that low-income people may prefer having *less* generous health insurance coverage if it means they have more resources to spend on other goods and services such as housing, education, and transportation.[265]

B. Comparisons with Medicare for All and Incremental Reforms

In this Section, I compare the theoretical implications of the two conceptions of the right to health care described above with the approaches

be free to negotiate specialized insurance in addition to [the] basic insurance package") (emphasis omitted).

259. Gutmann, *supra* note 178, at 545, 553.

260. DWORKIN, SOVEREIGN VIRTUE, *supra* note 22, at 317.

261. Dworkin, *Justice in the Distribution of Health Care*, *supra* note 13, at 898.

262. Shepard et al., *supra* note 181, at 1; *see also* DANIELS, JUST HEALTH CARE, *supra* note 3, at 79 (suggesting that the modified market view is not only compatible with supplemental private insurance, but in fact requires it).

263. Shepard et al., *supra* note 181, at 1.

264. *Id.* at 15.

265. *Id.*

actually taken by Medicare for All and incremental proposals on these issues. Exploring these comparisons reveals that Medicare for All is supported by the Right to Equal Access in its approach to private insurance and cost-sharing, whereas the incremental plans are supported by the approach of the Right to a Decent Minimum. Yet it also reveals that Medicare for All's approach is even more restrictive than necessary to conform to the Right to Equal Access. Moreover, it shows that both sets of reforms fall short of both theoretical conceptions of the right to health care in one important respect: failing to place reasonable limits on health care spending.

1. Covered Benefits

As described above, both theoretical conceptions of the right to health care require placing reasonable limits on health care spending in order to avoid the bottomless pit objection. Yet even if one settles on a particular conception of the right to health care, determining which benefits should be guaranteed to all and which ones should not is challenging, to say the least.[266] Decisions to limit health care benefits must not only find a method of weighing these benefits against other social goods, but also of deciding how health care benefits should be aggregated across specific populations.[267] This raises difficult moral questions: For instance, should priority be given to treating the worst-off patients, maximizing overall welfare, or to some more intermediate position?[268]

Further compounding these challenges, the question of which benefits should be covered—and which ones should not—is one of the most politically controversial issues involved in health care reform. In the United States, the notion of government "rationing" of health care has long been a bugaboo, so much so that even the slightest hint of limits on health care benefits is viewed as politically toxic.[269] Perhaps the most famous example of this toxicity occurred when former Alaska Governor Sarah Palin mischaracterized an innocuous ACA provision that merely enabled Medicare

266. *See* Gutmann, *supra* note 178, at 556–57 ("We need to find some principle or procedure by which to draw a line at an appropriate level of access to health care short of what is socially and technologically possible, but greater than what an unconstrained market would afford to most people, particularly to the least advantaged. I suspect that no philosophical argument can provide us with a cogent principle by which we can draw a line within the enormous group of goods that can improve health or extend the life prospects of individuals.").

267. *See generally* F. M. KAMM, MORALITY, MORTALITY, VOL. 1: DEATH AND WHOM TO SAVE FROM IT (1993).

268. DANIELS, JUST HEALTH, *supra* note 17, at 105.

269. *See* Colleen M. Grogan & Adam Oliver, *Is It Rationing if the Public Decides?*, 38 J. HEALTH POL., POL'Y & L., 1067, 1067 (2013) ("The term *rationing* has been bandied about so frequently in polarized political settings in the United States that most of us on this side of the Atlantic cringe when we hear the word. We cringe because the term is used as an opposition device to any reform proposal no matter how big or small its intent or potential impact.").

to pay for doctors' appointments to discuss end-of-life issues with their patients as a requirement to institute so-called "death panels."[270]

In light of these philosophical and political challenges, it is small wonder that the United States health care system largely fails to place reasonable limits on covered spending.[271] Currently, Medicare covers any treatments that are deemed "reasonable and necessary,"[272] which in practice has been interpreted to exclude considerations of costs.[273] Private insurers, in turn, tend to follow Medicare's lead in their coverage determinations.[274] Although the ACA included several measures designed to incentivize high-value care and promote comparative effectiveness research,[275] it also placed restrictions on the use of comparative effectiveness research or cost-effectiveness analysis to inform coverage decisions.[276]

Neither Medicare for All nor the Biden plan would drastically alter this state of affairs. At least in their current forms, both reform proposals shy away from providing a specific procedure for placing limits on which benefits will be covered. As described above, Medicare for All would provide for coverage of a comprehensive set of benefits, including dental,

270. *See* Elizabeth Weeks Leonard, *Death Panels and the Rhetoric of Rationing*, 13 NEV. L.J. 872, 873 (2013).

271. This may be starting to change, however. *See* Carl H. Coleman, *Cost-Effectiveness Comes to America: The Promise and Perils of Cost-Effectiveness Analysis in Medication Coverage Decisions*, 38 GA. ST. U. L. REV. (forthcoming) (manuscript at 25–35), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3813407 (describing how payers are increasingly relying on cost-effectiveness criteria in making coverage determinations).

272. 42 U.S.C. § 1395y(a)(1)(A) (2006).

273. Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 549–53 (2013). *See also* Nathan Cortez, *Medicare for All: A Leap into the Known?*, LAW & POL. ECON. PROJECT (July 25, 2019), https://lpeproject.org/blog/medicare-for-all-a-leap-into-the-known/ ("Medicare . . . was designed to preserve physician autonomy and patient choice, not make cost-effectiveness decisions.").

274. NICHOLAS BAGLEY, AMITABH CHANDRA & AUSTIN FRAKT, HAMILTON PROJECT, CORRECTING SIGNALS FOR INNOVATION IN HEALTH CARE 12 (2015), https://www.hamiltonproject.org/assets/files/correcting_signals_for_innovation_in_health_care_bagley.pdf.

275. *See generally* Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing* Our Health Care Appetite*, 13 NEV. L.J. 822 (2013).

276. *See* Coleman, *supra* note 271, at 26–27; Richard S. Saver, *Health Care Reform's Wild Card: The Uncertain Effectiveness of Comparative Effectiveness Research*, 159 U. PA. L. REV. 2147, 2166–67 (2011); *see also* Govind Persad, *Priority Setting, Cost-Effectiveness, and the Affordable Care Act*, 41 AM. J.L. & MED. 119, 129 (2015) ("The ACA does place substantial limitations on the use of traditional cost-effectiveness analysis by certain actors in the healthcare system, and also fails to remove the limitations that other laws—most notably the Americans with Disabilities Act (ADA)—may place on cost-effectiveness analysis, particularly on methods that employ quality-adjusted life years (QALY) as a metric. But the ACA is not invariably hostile to the use of cost-effectiveness or comparative effectiveness information, so long as these approaches are employed without considering certain factors in a prohibited way.").

vision, hearing, and reproductive care.[277] Moreover, it does not specify a process for determining which services, drugs, and devices will be covered within these categories and which will not.[278] Instead, Medicare for All relies on reducing health care costs by improving administrative efficiencies and reducing provider payment rates.[279] Yet there is substantial disagreement concerning how much these provisions would reduce costs, in part because the existing Medicare for All proposals do not specify how much providers would be paid.[280]

Similarly, the Biden plan fails to place reasonable limits on covered services. As described above, the Biden plan would introduce a public option that would cover the ten categories of services listed in the ACA as "essential health benefits" (EHBs).[281] Yet these EHBs have not been defined in such a way as to provide a process for setting reasonable limits on which specific services will be covered.[282] Instead, the Biden proposal suggests that it will reduce health care costs in other ways, such as by using aggressive antitrust

277. *See supra* notes 69–70 and accompanying text.

278. *See* Johnson et al., *supra* note 67, at 134 ("Medicare for All would need a mechanism to specify which services, drugs, and devices are covered within each benefit category.").

279. Austin Frakt & Jonathan Oberlander, *Challenges to Medicare for All Remain Daunting*, 39 HEALTH AFFS. 142, 143 (2020). A different version of Medicare for All, introduced in the House of Representatives by Rep. Jayapal, would also adopt a system of global budgeting to limit health care costs—meaning that hospitals would be paid a fixed amount, prospectively, for all the services they deliver over a year, based on negotiations between providers and regional directors. Medicare for All Act of 2019, H.R. 1384, 116th Cong. § 611 (2019).

280. *See* Frakt & Oberlander, *supra* note 279, at 143 ("Precisely how and on what schedule Medicare for All would achieve cost savings through lower provider payments, as well as how large those savings would be, is not clear."); Katz et al., *supra* note 11.

281. Scott, *supra* note 62. Of note, although this Article focuses on the version of the Biden health care plan described during his 2020 presidential campaign, the Biden Administration has subsequently come out in favor of "improving access to dental, hearing, and vision coverage in Medicare." OFF. OF MGMT. & BUDGET, BUDGET OF THE U.S. GOVERNMENT: FISCAL YEAR 2022, at 24 (2021), https://www.whitehouse.gov/wp-content/uploads/2021/05/budget_fy22.pdf. The narrowing divide between the Biden approach and Medicare for All when it comes to covered benefits provides further support for the notion that the Right to Equal Access does not necessarily justify covering a broader set of health care benefits than the Right to a Decent Minimum. *See supra* notes 199–200 and accompanying text.

282. *See* Amy B. Monahan, *The Regulatory Failure to Define Essential Health Benefits*, 44 AM. J.L. & MED. 529, 561 (2018) ("The plans that serve as benchmarks in this process were all developed in a regulatory system that did not take cost into account, that were subject to piecemeal and ad hoc content regulation, and that were drafted by insurance companies who likely have very different goals than lawmakers and regulators. In other words, there is no reason to believe that these benchmark plans reflect societal priorities or values, or that they even result from a thoughtful, deliberative process."). The Department of Health and Human Services, which has authority for further defining EHBs, considered using a process-based approach to refine the contents of EHBs, but it ultimately opted to define EHBs by having the states designate an existing insurance plan in the state as "benchmark plan." *See* Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL., POL'Y & L. 441, 443–46 (2014).

enforcement to improve competition and by testing "innovative solutions that improve quality of care."[283]

As a result, at least in their current forms, both Medicare for All and the Biden plan fall short from the perspective of either theoretical conception of the right to health care.[284] Even if we assume that the reforms being considered would substantially reduce wasteful spending (which is, to say the least, an optimistic assumption),[285] that would not obviate the need to set reasonable limits on medical spending more generally.[286] The high level of health care spending in the United States has siphoned away government funding from other important social goods and services, such as education and infrastructure, and contributed to fewer jobs and lower wages for workers.[287] These costs are disproportionately borne by the poor.[288] Any just health care system must grapple with how to balance these kinds of costs against the benefits provided by medical spending.

Thus, if Medicare for All or the incremental reform proposals are to fully conform with either conception of the right to health care, they must provide some mechanism for placing reasonable limits on covered benefits. They could, for example, use a method in line with Daniels' and Sabin's

283. *Health Care*, *supra* note 5.

284. At least at first glance, the Biden plan would seemingly fall short of achieving either conception of the right to health care in another respect as well, in that it would leave a small percentage of Americans uninsured. *See supra* note 65. That being said, some estimates suggest that most or all of the remaining uninsured would be undocumented immigrants, and there are a range of normative views about what kinds of legal rights this population is owed. *See* Blumberg, *supra* note 65, at 12. *See generally* Joseph H. Carens, *The Rights of Irregular Migrants*, 22 ETHICS & INT'L AFFAIRS 163 (2008) (describing the different positions on this issue and arguing that undocumented immigrants deserve a range of legal rights). Although the accounts described in this Article do not, to my knowledge, directly address this issue, it is by no means obvious that the Right to a Decent Minimum would be less likely to support health care benefits for undocumented immigrants than the Right to Equal Access. Thus, to the extent that the Biden plan (or other incremental plans) would fail to cover this population, it does not appear to be because of some characteristic of the Right to a Decent Minimum.

285. *See* Baicker & Chandra, *supra* note 202, at 607 ("Promises of reforms that will both reduce spending and improve outcomes are popular to make, but evidence (and Congressional Budget Office scoring) suggests that they're difficult to keep."); Amy Finkelstein, *Why It's So Hard to Cut Waste in Health Care*, N.Y. TIMES (Jan. 22, 2021), https://www.nytimes.com/2021/01/22/business/why-its-so-hard-to-cut-waste-in-health-care.html (arguing that there is no "simple, miracle cure for excising most unnecessary medical care").

286. *See* DANIELS, JUST HEALTH, *supra* note 17, at 105 ("The fact of nonideal conditions in any system – inefficiency, profit taking at the expense of meeting needs, lack of universal coverage – does not exempt us from the task of learning how to set limits fairly."); *see also* Sreenivasan, *Why Justice Requires Rationing in Health Care*, *supra* note 203, at 150–51 (responding to the objection that the presence of waste in the health care system renders it unnecessary to ration medically necessary spending).

287. *See, e.g.*, ANNE CASE & ANGUS DEATON, DEATHS OF DESPAIR AND THE FUTURE OF CAPITALISM 191–211 (2020); Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LABOR ECON. 609 (2006).

288. CASE & DEATON, *supra* note 287.

"accountability for reasonableness" process, or some kind of cost-effectiveness or comparative effectiveness approach. Each of these approaches has its own advantages and disadvantages, which are beyond the scope of this Article to explore in more depth. My point is only that some reasonable limits are necessary, and that without any such limits, these plans both fall short from the perspective of either theoretical conception of the right to health care.

2. Cost-Sharing

The Right to Equal Access helps to justify what might otherwise seem like a puzzling feature of Medicare for All: namely, why it would nearly completely eliminate cost-sharing. This is not a necessary or inevitable feature of a single-payer health care system. Although some countries' single-payer systems do place substantial limits on cost-sharing, others, such as Sweden and Taiwan, impose cost-sharing on most health care services.[289] So why does Medicare for All prohibit virtually all cost-sharing?

If one understands Medicare for All through the perspective of the Right to Equal Access, then restricting cost-sharing is indeed necessary. Cost-sharing represents a financial barrier to accessing health care, which disproportionately burdens the poor and the sick.[290] By nearly eliminating cost-sharing, Medicare for All helps to ensure that access to care is based primarily on people's relative need for health care, rather than on their ability to pay.[291] Thus, Medicare for All's stringent approach to cost-sharing would eliminate one important source of inequality in access to health care.

By the same token, the Right to a Decent Minimum helps to justify the incremental reform proposals' failure to eliminate cost-sharing. The Right to a Decent Minimum does not require equality in access to health care services, but rather only support ensuring some level of access to a decent minimum of health care services. Thus, it is compatible with requiring people to pay some amount of out-of-pocket costs when they see a health care provider, even if doing so contributes to inequities in health care access. That being said, presumably even the Right to a Decent Minimum would place some outer limits on cost-sharing: If the cost-sharing requirements are sufficiently onerous, then there becomes a point at which insurance coverage fails to provide access to the decent minimum. To address this problem, some market-oriented health scholars have endorsed "Value-Based Insurance

289. CONG. BUDGET OFF., *supra* note 72, at 12.

290. *See supra* notes 226–233 and accompanying text.

291. Johnson et al., *supra* note 67, at 136.

Design," which "aligns patients' out-of-pocket costs with the value of services."[292]

Yet, while Medicare for All's approach to cost-sharing aligns more closely with that of the Right to Equal Access, it takes a more stringent approach than necessary to satisfy this ideal. Although both variants of the Right to Equal Access would greatly restrict cost-sharing, only the insulation ideal would necessarily eliminate cost-sharing for *all* types of services. As discussed above, the fair equality of opportunity account in particular appears to be compatible with imposing cost-sharing requirements on those services that fall outside of the "basic tier."[293] Thus, Medicare for All could satisfy this latter account of the Right to Equal Access while preserving a more limited role for cost-sharing.

3. Private Insurance

Perhaps the most controversial aspect of Medicare for All is that it would significantly restrict—if not completely eliminate—private health insurance. Medicare for All would prohibit duplicative insurance and effectively eliminate nearly all forms of supplemental insurance and complementary insurance. This would represent a radical transformation of the existing health care system, which relies heavily on private insurance companies not only to offer insurance coverage but also to administer benefits under public programs, including Medicare and Medicaid.[294]

Again, this feature of Medicare for All is difficult to understand if one thinks of Medicare for All simply as a single-payer health care system. Indeed, many countries that have single-payer health care systems, including Canada and the United Kingdom, allow supplemental private insurance and other forms of private insurance.[295] So why does Medicare for All take such a restrictive approach with private insurance? Again, the Right to Equal Access offers a clear answer to this question: Private health insurance is restricted because it contributes to inequalities in access to health care. Private health insurance contributes to inequalities in access by creating different tiers of access to care, and potentially also by undermining access to the benefits provided in the public plan.[296]

---

292. *See* Richardson et al., *supra* note 240.

293. *See supra* note 229 and accompanying text.

294. *See* Fuse Brown et al., *supra* note 45, at 421; Reed Abelson & Margot Sanger-Katz, *Medicare for All Would Abolish Private Insurance. 'There's No Precedent in American History.'*, N.Y. TIMES (Mar. 23, 2019), https://www.nytimes.com/2019/03/23/health/private-health-insurance-medicare-for-all-bernie-sanders.html.

295. CONG. BUDGET OFF., *supra* note 72, at 13.

296. *See supra* notes 241–247 and accompanying text. Notably, even a strict one-tier system would not ensure complete equality in access to care. For instance, people of color would still face racial discrimination when seeking care and low-income people would still find it harder to take off

That being said, in its strict approach to private insurance, Medicare for All seems to align more closely with the insulation ideal than with the fair equality of opportunity account. Like the insulation ideal, Medicare for All would create a strict one-tier system—but one so generous that it is designed to ensure that wealthy people would have little reason to purchase private insurance coverage, even if they were allowed to do so.

Having a one-tier system improves equality in access but creates an uncomfortable dilemma. As discussed above, the current version of Medicare for All is vulnerable to the bottomless pit objection since it fails to place reasonable limits on covered spending.[297] However, if Medicare for All were to address this objection by adopting reasonable limits—while maintaining a strict one-tier system—then it would be vulnerable to the leveling down objection. Wealthier people would largely be prevented from purchasing better access to health care, even though doing so would only serve to make them worse off and not to make anyone else better off.[298] There would also likely be practical difficulties associated with such "leveling down": For instance, wealthier people might resort to shadow markets or medical tourism to obtain access to health care not covered under the public plan.[299]

The fair equality of opportunity principle shows that the Right to Equal Access is compatible with a more permissive approach to private health insurance. As long as the public plan still provides universal and equal access, based on health needs, to the subset of health care services that promote fair equality of opportunity under reasonable resource constraints

---

work to attend doctors' appointments or find transportation to these appointments. *See supra* notes 50–59 and accompanying text. *See also* Segall, *supra* note 106, at 344 ("It is often acknowledged, for example, that even a free and universal health care service is still more accessible to the rich than it is to the poor.").

297. *See supra* notes 277–280 and accompanying text.

298. Buchanan, *supra* note 118, at 58 ("[T]he strong equal access principle . . . forces us to choose between two unpalatable alternatives. We can either set the publicly guaranteed level of health care lower than the level that is technically possible or we can set it as high as is technically possible. In the former case, we shall be committed to the uncomfortable conclusion that no matter how many resources have been expended to guarantee equal access to that level, individuals are forbidden to spend any of their resources for services not available to all. . . . If, on the other hand, we set the level of services guaranteed for all so high as to eliminate the problem of persons seeking extra care beyond this level, this would produce a huge drain on total resources, foreclosing opportunities for producing important goods other than health care.").

299. Jonathan Foley, *Taking Medicare for All Seriously*, HEALTH AFFS. BLOG (June 11, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190606.959973/full/; Krohmal & Emanuel, *supra* note 241, at 436. The phenomenon of medical tourism raises other important ethical concerns, including that it will impede access to health care in so-called "destination" countries: countries to which patients travel for medical treatment. *See generally* I. Glenn Cohen, *Medical Tourism, Access to Health Care, and Global Justice*, 52 VA. J. INT'L L. 1 (2011) (specifying certain conditions under which medical tourism may reduce access to care in destination countries, and examining the accompanying moral obligations of "home" countries and international bodies).

(and as long as the structure of inequality that results is not objectionable), then the fair equality of opportunity account is compatible with some amount of tiering.[300] Therefore, instead of completely prohibiting duplicative insurance, Medicare for All could impose requirements designed to bolster the public plan—for instance, by imposing requirements that make private duplicative insurance more expensive or less attractive to providers.[301] Such a middle-ground approach would make access to health care less equal than under a strict one-tier system, but would still limit inequality in access to those services that promote fair equality of opportunity and would be less vulnerable to the leveling down and bottomless pit objections.

Whereas Medicare for All would prohibit most forms of private health insurance coverage, the incremental health care reform proposals would preserve private health insurance. The Biden plan, for example, would increase both private and public coverage by expanding the subsidies on the ACA exchanges, creating a new public option, and lowering the eligibility age for Medicare.[302] This more permissive approach to private insurance avoids both the leveling down objection and the bottomless pit objection, since the government can place reasonable limits on the public scheme without preventing those who would prefer greater access to health care from seeking it. At the same time, however, this approach will lead to relatively greater inequalities in access to health care, as wealthier people will tend to opt for more generous private coverage. Furthermore, even the Right to a Decent Minimum requires imposing some basic restrictions on private health insurance to ensure that it does not undermine public access to the contents of the basic minimum. However, as long as adequate access to the contents of the basic minimum is preserved, this conception of the right to health care would not object to private coverage.

C. Divisions and Areas of Convergence

Examining the two conceptions of the right to health care shows that the debate over the future of health care reform is at once deeper and narrower than it is often understood to be.

This exercise clarifies what is at stake in the debate over health care reform: not just concerns about political feasibility or economic impacts, but also different moral or political values. Whether the access problem in American health care is viewed as one of *inadequate* access or one of *unequal* access leads to different conclusions about what kind of health care reform is normatively desirable.

300. *See supra* notes 251–257 and accompanying text.

301. CONG. BUDGET OFF., *supra* note 72, at 13.

302. *See supra* note 96 and accompanying text.

The Right to a Decent Minimum implies that the goal of health care reform should be to fill in the gaps in our current system so as to provide access to a decent minimum of care for those who currently lack such access. Under this conception of the right to health care, if everyone has access to the decent minimum, it is not morally objectionable that some people have greater access than others. Securing the right to health care does not, therefore, require radically restricting cost-sharing or private health insurance, as long as the structures of cost-sharing and private health insurance do not impede access to the decent minimum.

By contrast, the Right to Equal Access implies that ensuring access to a decent minimum may be a good start, but that it is insufficient to secure the right to health care. Rather, it entails that at least some forms of inequalities in access to health care are morally objectionable (such as those that impede fair equality of opportunity), and that it is necessary to reduce these inequalities. This requires restricting private health insurance and cost-sharing so that Americans do not experience significantly different levels of access to the same basic sets of services depending on the particular source of their insurance coverage.

To some extent, of course, the goals of ensuring adequate access and more equal access may converge.[303] Many of the same factors that impede adequate access to care (such as the lack of insurance coverage and excessive cost-sharing requirements) also contribute to inequalities in access to care.[304] Therefore, incremental reforms that are aimed at ensuring that everyone has access to adequate care—such as those embodied in the Affordable Care Act—will also tend to reduce inequality in access to health care.[305] The overlap is not perfect; some reforms, such as restricting private supplemental insurance coverage or ensuring that everyone has access to exactly the same set of benefits, would improve equality in access but are not necessary to

303. *See* MOYN, *supra* note 21, at 60 (describing how in the mid-twentieth century, "the thinking of the period" was that "the demand for a floor of sufficiency harmonized with a desire for a ceiling on inequality—or the floor was placed so high that any contrast between the one and the other made little sense").

304. *See supra* Tbl. 1 and accompanying text.

305. *See* Sara Rosenbaum, *Toward Equality and the Right to Health Care*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 32, at 311, 313 ("Despite its failings, the ACA has achieved dramatic, measurable gains in health equality, opening greater access for previously uninsured Americans who, after all, were disproportionately low income and underserved."). *See also* James W. Nickel, *Moral Grounds for Economic and Social Rights*, *in* THE OXFORD HANDBOOK ON ECONOMIC AND SOCIAL RIGHTS (forthcoming) (manuscript at 19), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3831503 ("[C]reating a floor of income and services significantly reduces economic inequality. It does this, first, by pulling up everyone below that income floor so that the lowest are not so low. And, second, when taxation is used to cover the costs of providing the floor, this usually transfers significant amounts of income and wealth from the top and middle to the bottom.").

ensure that all Americans have adequate access to care.[306] Taken to an extreme, reforms aimed at ensuring the Right to Equal Access could even jeopardize the Right to a Decent Minimum if they resulted in significantly leveling down access to health care. At the very least, though, these two goals are not mutually exclusive. Why not then just pursue whatever health care reforms would both reduce inequality in access and ensure adequate access to care?

The problem is that there are practical tradeoffs in pursuing either one of these conceptions of the right to health care. Any political capital and resources that policymakers and advocates devote to implementing reforms that reduce inequality in access to health care (such as placing restrictions on private insurance coverage) constitute forgone political capital and resources that could have been used to implement reforms to ensure that more Americans have access to adequate care (for example, by expanding ACA subsidies for individuals purchasing their own health insurance).[307] They also take capital and resources away from advocating for other policy priorities that have nothing to do with health care (such as reforms aimed at protecting voting rights or confronting climate change). These tradeoffs may be worthwhile from the perspective of the Right to Equal Access, which places special moral importance on distributing access to health care more equally, but they are difficult to justify from the perspective of the Right to a Decent Minimum, which does not view health care as morally distinctive.[308]

Likewise, even though incremental reforms that are aimed at addressing the Right to a Decent Minimum (such as those in the Biden plan) would also improve equality in access, they inevitably take capital and resources away from more fundamental reforms that would do more to improve equality in access to health care (such as Medicare for All). In fact, reforms that build on the existing fragmented health care financing system might actually make

306. *See supra* note 61 and accompanying text.

307. For an analogous point about whether the goal of tax law should be to reduce poverty or inequality, see David Kamin, *Reducing Poverty, Not Inequality: What Changes in the Tax System Can Achieve*, 66 TAX L. REV. 593, 639 (2013) ("My argument here is premised on there being trade-offs; devoting political capital to one of these goals could limit the ability to achieve the other—especially in tax negotiations (such as over fundamental reform) where both issues could very well be on the table.").

308. Shepard et al., *supra* note 181, at 15 ("This is the paradox of the egalitarian motive to provide equitable access to health care; while leveling the health care playing field, it comes at the opportunity cost of forgoing other public assistance that the poor and middle class might prefer."); *see also* Zachary Liscow, *Redistribution for Realists*, 107 IOWA L. REV. (forthcoming) (manuscript at 45), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3792122 (noting that "lower-income individuals . . . may not value [access to the best-available health care] at nearly the amount that it costs to provide and would prefer to receive those resources in other forms where redistribution is not as high").

a single-payer system more difficult to achieve in the long-run by undercutting its political momentum.[309]

At the same time, however, this exercise reveals that there are surprising areas of convergence between these two theoretical conceptions of the right to health care, and accordingly, that there is room for greater convergence between Medicare for All and the incremental proposals. This stems from the conclusion that, like the Right to a Decent Minimum, the Right to Equal Access does not require equal access to *all* forms of health care services.

In particular, with regard to the two policy issues on which the two conceptions of the right to health care diverge the most—restricting private health insurance and cost-sharing—the two conceptions are not as far apart as it might seem. The Right to Equal Access does not necessarily require prohibiting private health insurance and cost-sharing altogether. As described above, fair equality of opportunity supports restricting some forms of inequality in access to health care, yet it does not go so far as to necessitate a one-tier system or the complete elimination of cost-sharing.[310] Thus, with respect to these two issues, Medicare for All takes a more stringent approach than necessary to satisfy the Right to Equal Access. This implies that there is room for amending Medicare for All to cover a narrower set of services and to allow cost-sharing and private health insurance outside of those sets of services.

As described above, there are other possible accounts besides the four described in Part II that support the Right to Equal Access and the Right to a Decent Minimum.[311] It is possible that these other accounts might in turn have somewhat different implications. For instance, perhaps accounts that place greater emphasis on equal capabilities, equal efforts to relieve pain, or equal respect would justify Medicare for All's more stringent approach to cost-sharing and private health insurance. Yet it is not obvious that is the case, or if so, how such accounts would navigate between the bottomless pit objection and the leveling down objection.

Furthermore, any tenable version of the Right to Equal Access or the Right to a Decent Minimum must place reasonable limits on what kinds of services are covered. The fair equality of opportunity account implies one way to set such limits: covering those services that are necessary for maintaining or restoring normal functioning.[312] The modified market

309. *See* Jacob S. Hacker, *From the ACA to Medicare for All?*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 32, at 333, 344 ("[A] big problem with most partway proposals is that they seem poorly suited to create strong momentum to go all the way to universal coverage and systemwide price regulation. Indeed, they may actively work against going all the way by leaving out the least sympathetic groups . . . .").

310. *See supra* notes 251–257 and accompanying text.

311. *See supra* notes 187–198 and accompanying text.

312. *See supra* notes 121–129 and accompanying text.

account and prudent insurance ideal suggest different approaches to determining such limits.[313] In their current forms, both Medicare for All and the Biden plan fall short from the perspective of both conceptions of the right to health care by failing to place any reasonable limits on health care spending. Thus, both categories of reform plans have more work to do if their aim is to provide a just distribution of health care.

CONCLUSION

This Article helps bring to light the moral dimensions of the debate over health care reform. Simply declaring that health care is a right does not predetermine what kind of legal entitlement to health care there should be. The two predominant approaches to health care reform in the United States—the incremental approach of building on the current fragmented health care financing system, and the more radical approach of wiping the slate clean and enacting Medicare for All—are supported by two different conceptions of what the right to health care entails. The former is supported by the notion that the right to health care requires only access to a decent minimum of health care services, while the latter is supported by the idea that the right to health care requires some degree of equality in access.

The public debate over health care reform frequently fails to distinguish between these two conceptions of the right to health care. To be sure, some supporters of Medicare for All argue that it is morally distinctive because of its emphasis on reducing inequality.[314] Yet it is often not clear from their arguments why inequality in access to health care (as opposed to inadequate access) is objectionable, and whether these objections extend to all forms of inequality in access. Incrementalists, on the other hand, have tended to not even respond to the moral case for Medicare for All. Instead, they have tended to argue that it is politically infeasible or excessively costly, or deny that there are any salient moral differences between Medicare for All and incremental reforms.[315]

Greater understanding of the moral values at stake in health care reform is important since it may affect policymakers' and voters' judgments about what kind of reform is desirable. These effects could play out in various ways. On the one hand, greater awareness of Medicare for All's emphasis on reducing inequality in health care could, over time, help to build public support for a single-payer health care system (as some Medicare for All

313. *See supra* notes 214–225 and accompanying text.

314. *See supra* note 15 and accompanying text.

315. *See supra* notes 12–14 and accompanying text.

advocates appear to assume will be the case).[316] Indeed, many Americans support the notion that everyone should be treated equally in the health care system.[317] Thus, perhaps even those who are skeptical of Medicare for All's feasibility or economic impacts may find its emphasis on equal access appealing, if they are made aware of that emphasis. On the other hand, the opposite could happen: By more explicitly engaging with the moral case for Medicare for All, incrementalists could convince more Americans that the real problem is a lack of *adequate* access, not inequality in access per se, and thus that an incremental approach to health care reform is preferable.[318]

Alternatively, greater understanding of these divergent moral values could lead to increased support for some middle-ground approach, one that incorporates elements of both the Right to Equal Access and the Right to a Decent Minimum. For instance, greater understanding of these divergent moral values could result in greater support for a health care reform that does not immediately abolish the current fragmented health care financing system, but which instead incorporates more targeted reforms that are designed to make this system more equal, not just to ensure that everyone has access to the decent minimum.[319] Or instead, it could lead to greater support for a similarly ambitious egalitarian health care reform agenda as Medicare for All, but one which better reconciles the demand for equal access to health care with the necessity of reasonable limits.

Of course, Americans can—and should—take non-moral considerations, such as political feasibility, into account when deciding how to reform the health care system. Yet they must also consider a more basic question, one that underlies the purpose of reforming the health care system

316. *See, e.g.*, Adam Gaffney, *Single-Payer Won't Pass Now. But Its Popularity Proves Our Morals Are Changing*, WASH. POST. (Sept. 13, 2017), https://www.washingtonpost.com/news/posteverything/wp/2017/09/13/single-payer-wont-pass-now-but-its-popularity-proves-our-morals-are-changing/. *See also* James A. Morone, *How to Think about "Medicare for All"*, 377 NEW ENG. J. MED. 2209, 2209 (2017) (describing Medicare for All as "an exercise in moral persuasion," and writing that Medicare for All "responds with a strong claim for a right to roughly equal health coverage for everyone").

317. THE COMMONWEALTH FUND, N.Y. TIMES & HARV. T.H. CHAN SCHOOL OF PUB. HEALTH, AMERICANS' VALUES AND BELIEFS ABOUT NATIONAL HEALTH INSURANCE REFORM 10 (2019), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2019/10/CMWF-NYT-Harvard_Final-Report_Oct2019.pdf (finding that 77% of polled American adults believe that equal treatment in health care is very important).

318. Harry Frankfurt makes an analogous argument in the context of the debate over economic inequality, arguing that while economic inequality strikes many people as wrong, what really underlies their intuition is a distaste for poverty, not economic inequality per se. *See* FRANKFURT, *supra* note 20, at 40–41.

319. For one proposal along these lines, see Lindsay F. Wiley et al., *Health Reform Reconstruction*, 55 UC DAVIS L. REV. (forthcoming 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3760086 (advocating a strategy of "confrontational incrementalism").

in the first place: What kind of health care do we owe to one another? Acknowledging the two conceptions of the right to health care described in this Article is a necessary step in answering that question.