CHAPTER

4

THE ROLE OF COURTS IN HEALTH POLICY AND POLICYMAKING

Learning Objectives

After reading this chapter, you should be able to

- understand how the role of the judicial branch in policymaking differs from the roles of the legislative and executive branches;
- understand the three core roles played by courts in policymaking: constitutional referee, meaning giver, and rights protector;
- understand critical structural features of the judicial branch;
- understand the structure of federal and state court systems;
- understand the concepts of separation of powers, judicial review, and institutional competence;
- appreciate the importance of the states' police power in health policymaking;
- define the Constitution's supremacy clause;
- identify the three most common areas of disputes requiring courts to act as referees; and
- appreciate the importance of *NFIB v. Sebelius*.

As noted in Chapter 1, health policies established in the public sector take the form of laws, rules or regulations, other implementation decisions, and judicial decisions. All are authoritative decisions and, thus, policies. The nation's constitutionally determined structure (see Exhibit 2.1 for the resulting organization chart of the federal government) requires that the legislative branch enact laws, that the executive branch make additional policy to implement the laws, and that the judicial branch, especially through the courts, play a different and less direct part in policymaking (Anderson 1992; Teitelbaum and Wilensky 2013). This chapter explores the vital part the courts play in health policymaking.

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As we begin to examine how decisions rendered by courts—judicial decisions—are themselves health policy and, more important, how these decisions may significantly affect other health policies and policymaking, it should be acknowledged that some people take a restrictive view of the part courts should play in policymaking. Often using the pejorative phrase "judicial activism," some people assert that courts should not make new law (a job properly handled by the legislative or, to a more limited degree, executive branches), but instead should only apply existing law and interpret any unclear provisions of existing law, all as needed to resolve legal disputes between parties.

This limited view of the judicial role in policymaking reasons that, because judges are not politically accountable (at least in the federal court system where judges are appointed and have life tenure), they should not actually make policy. As this chapter will demonstrate, however, concerns about judicial activism or about judges "making law" are not relevant as applied to the impact that judicial decisions have on health policy and policymaking in the United States (Jacobson, Selvin, and Pomfret 2001). As we will see, even political conservatives, historically identified as critics of activist judges, sanction an important role for courts and invoke courts' authority in ways that affect health policy and policymaking.

This chapter focuses on the traditional core roles or functions of courts in the United States' constitutional scheme of government (see Appendix 11 for additional information on the constitutional scheme of government), how courts performing those roles in individual cases make policy in the form of authoritative judicial decisions, and how those decisions affect other health policies and the policymaking process. We begin our exploration of the unique part courts play in health policymaking by considering the three core roles of courts.

The Core Roles of Courts

This section provides a brief overview of three core roles of the courts. Later sections will more fully describe these roles and provide specific case examples in which courts have played these roles in ways that affect health policy and policymaking.

A long-standing core role of courts in the United States' constitutional scheme of checks and balances among the branches of government is deciding disputes regarding the extent of authority enjoyed by each of the three branches. In performing this role, courts act as *constitutional referees*, making decisions about whether a branch of government has acted within the scope of its constitutional authority or has somehow overreached.

A second core role for courts is interpreting laws whose meaning or application to a particular dispute is somehow unclear. In performing this role, courts act as *meaning givers* in that they clarify the meaning of a law.

A third core role for courts is vindicating (or rejecting) the legal or constitutional rights of parties who come to court alleging a violation of their rights. In performing this role, courts act as *rights protectors* (or rights limiters).

Although these initial descriptions of core judicial roles are brief, much of this chapter is devoted to fleshing out some of their nuances and complicating aspects, as well as examining how each of these core roles of courts affects health policy and policymaking. The judicial branch of government, through the courts, plays a significant part in policymaking by serving as referee, meaning giver, and rights protector.

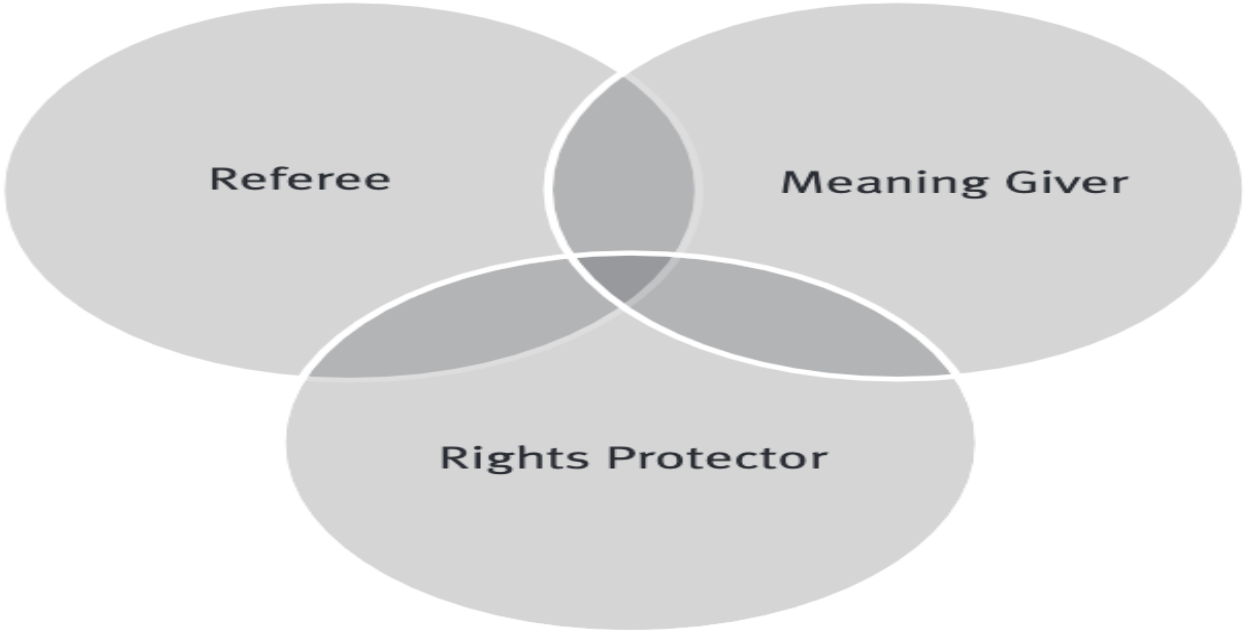
Premised on the fact that courts have no formal institutional role in either formulating policy (as the legislative branch does) or in implementing policy (as the executive branch does), the central question we examine in this chapter is: How do courts—acting as constitutional referees, meaning givers, and rights protectors—affect health policy and policymaking? What we will see is that, as they decide the cases brought to them by litigants, courts may sometimes play an important role in constraining and shaping policies relating to health, and—more rarely—even in creating them. We will also see how the judicial branch may supplement the work of the other branches, be in tension with what they do, or even have to fill gaps left by the other branches' failure to act.

Before examining these core roles more closely, two general points must be made about them. First, the three roles of courts are not mutually exclusive. In other words, a single lawsuit may call on a court to play more than one role simultaneously. For example, if an individual claims a government action violates one of her constitutional rights, the court hearing the case may have to decide on the existence and scope of the asserted constitutional right (its meaning-giver role) and then determine whether the government's action impermissibly infringes on that right (its rights-protector role).

In thinking about the three core roles that courts play in policymaking, it may be helpful to visualize a simple Venn diagram consisting of three overlapping circles, one for each of the judicial roles outlined previously and as shown in Exhibit 4.1. The diagram reflects that some cases potentially represent a point where the court must play two of its core roles to resolve the parties' dispute; some cases (those represented by the space where all three circles intersect) would require a court to perform all three roles simultaneously.

A second important general point about the three core roles of courts and their impact on health policy and policymaking is the fact that judicial

EXHIBIT 4.1 The Roles of Courts in Policymaking



decisions have effects in the public and private sectors. Recall from our discussion in Chapter 1 that policy is made in both of these sectors. The judicial decisions made by courts affect decisions made by actors in both sectors. This point is important because of the United States' heavy reliance on the private sector for healthcare financing and delivery.

Many decisions that affect the cost and quality of and access to healthcare are decentralized and privatized. For example, until the national health reform accomplished by the Affordable Care Act (ACA), employers had complete discretion to decide whether to provide insurance coverage for their employees, and insurers (whether traditional insurance companies or managed care plans) had great latitude in deciding what benefits to provide as part of their plans. In effect, the aggregated decisions by private-sector actors have provided the answers to many questions that might have been addressed through public policy, but were not.

These private-sector decisions may direct or influence the actions, behaviors, or decisions of others in important matters relating to health. A good example of how judicial decisions constrain or influence

private-sector policymaking related to health can be seen in how the courts have interpreted the Employee Retirement Income Security Act (ERISA), a law that Congress passed in 1974 to establish rules for employer pension and benefit plans.

By interpreting how ERISA applies in numerous cases, judicial decisions have played a critical role in establishing the balance of power among employers, health insurers, and employees in health benefits disputes. Later discussion in this chapter will show how specific cases invoking ERISA have required courts to play each of their traditional roles—referee, meaning giver, and rights enforcer.

Before providing a more in-depth discussion of the three core roles the courts play in health policy and policymaking, we will consider as background some key features of the structure and functioning of the judicial system in the United States. This background description includes the division of authority among the three branches of government and between the federal and state governments. It also explains several concepts specific to the judicial system: judicial review, the sources of law that courts rely on, and precedent. After this background discussion on the structure and function of the judicial branch, we will return to a closer examination of how judicial decisions affect health policy and policymaking.

Structure of the Judicial Branch

Two structural features of the judiciary are critical to appreciating how court decisions can affect health policy: (1) the judiciary's existence in a tripartite system of government, where government power is shared among three branches: executive, legislative, and judicial; and (2) the judiciary's existence in a federal system of government, where the authority to make policy is shared between the federal and state governments.

The extensive sharing of power in government, across branches and between levels, gives rise to disputes about whether a particular exercise of power is legitimate or overreaching, or is correctly exercised at the federal or state level. Deciding those disputes is the essence of the core refereeing role of the courts. For example, in this chapter we will discuss court cases that decided whether regulations promulgated by an implementing organization or agency in the executive branch (referred to in this chapter simply as *administrative agencies*) improperly usurped the legislative authority to make laws, as well as cases that considered whether state legislative attempts to enact health reform were invalid because an act of Congress had "preempted" state authority in a particular area.

The Courts in a Tripartite System of Government

As we have noted, under the US Constitution the judiciary is one of three coequal branches of government, each with its own responsibilities and authority. Article III of the Constitution vests the nation's judicial power in the Supreme Court and authorizes Congress to create lower federal courts. Congress has done so, establishing a system of federal district (trial) courts and intermediate courts of appeal, which are divided geographically into 13 federal circuits.

The federal courts have jurisdiction (the legal authority to make decisions or, technically, to enter judgments) over certain types of cases and controversies, including cases involving the federal Constitution or a federal law (also called a statute), as well as certain high-value cases where the parties reside in different states. Although more than 300,000 cases are filed in federal district courts each year, most lawsuits cannot be filed in a federal court because of the courts' limited jurisdiction.

Each state also has its own system of courts to adjudicate legal disputes. Each state judicial system is established by its state constitution and, like the federal courts, the state courts operate within a tripartite system of state government. Unlike federal courts, however, state court systems have "general jurisdiction" over a wide range of cases—basically all cases except a narrow range that can be brought only in federal court (e.g., cases against the United States or cases brought under certain federal laws or statutes). As a result, the large majority of lawsuits are filed in state courts.

Several concepts vital to understanding how the courts operate in a tripartite system of government are discussed in the following sections. These concepts are separation of powers, judicial review, and institutional competence.

Separation of Powers

As noted earlier, at both the federal and state levels the court system shares governmental authority with the legislative and executive branches of government. Under the Constitution's framework, these branches are separate from one another and equally powerful in different ways. Through this *separation of powers*, each branch exercises distinctive but limited powers, a feature the Constitution's framers at the federal level meant to prevent the tyranny that can flow from the concentration of power.

No branch is truly independent of the others, however, because each one's power is limited or "checked" by powers that the Constitution assigns to the other branches. For example, the Constitution gives the legislative branch the power to enact laws, but the president can veto a law that Congress passes and the judicial branch can determine that an act of Congress violates the Constitution. Similarly, while the president has the authority to

appoint federal judges, the federal courts can judicially review the constitutionality of executive branch actions. These are only examples of a broader set of constitutional "checks" that seek to strike a "balance" of governmental power among the three branches.

Judicial Review

The judicial branch has the exclusive power of *judicial review*—the power to interpret the Constitution to determine whether an act by a legislative body or an executive official exceeds constitutional limits. This power of judicial review is not expressly granted in the Constitution's text; instead, it is itself the product of judicial decision making in a landmark case (*Marbury v. Madison*) decided in 1803. While lower federal courts interpret the Constitution to assess a law's constitutionality, as a practical matter decisions invalidating laws typically are appealed to the Supreme Court, leaving it the final say on the question.

A court's power to interpret the Constitution to strike down laws enacted by Congress or an executive branch action is potentially enormous. Over the decades, however, the Supreme Court has prudently fashioned limits on when it will engage in judicial review, and the other branches have acquiesced in the Court's exercise of this power. Nonetheless, Supreme Court decisions holding a law unconstitutional are often cited in the political realm as prime examples of judicial activism (or policymaking by the courts). Engaging in judicial review is an important way that courts shape or constrain health policy by limiting (or validating) another branch's formulation or implementation of health policy.

Institutional Competence

Although the division of authority was constitutionally established as a means of protecting against a concentration of governmental power, it also is in accord with the concept that each branch of government has its own particular *institutional competence*. As Gostin (1995) suggests, each branch of government possesses particular strengths and weaknesses relevant to making policy generally and to health policymaking in particular. For example, through the legislative process involving agenda setting and legislation development, the legislative branch can investigate broadly the real-world conditions that require a policy response, including tapping into relevant expertise when needed.

In theory, the legislature can examine the "big picture" to determine whether new policy is needed and what form it should take. Because its members must regularly stand for election, they are publicly accountable, which helps ensure that policies do not deviate substantially from the popular will.

Once the legislature has formulated a new policy, the executive branch is responsible for implementing and enforcing it. In the case of many health

policies dealing with complicated financing or delivery systems or scientifically complex health risks, for example, the administrative agencies in the executive branch house the expertise necessary to flesh out policy details through the rulemaking process and perhaps to ensure policy compliance through enforcement actions.

By contrast, courts are not institutionally well suited to formulate or implement policy. Rather than looking at the larger picture of health policy problems and possible solutions, courts must focus on the lawsuit immediately in front of them. A judge's or jury's understanding of the facts is shaped by the parties' presenting evidence in an adversarial process—facts that may be highly germane to the parties' dispute, but may not shed light on social, economic, or health conditions more broadly. Moreover, while judges hearing cases have considerable expertise in interpreting and applying the law, they typically do not have training that would permit a sophisticated evaluation of the scientific, economic, or ethical questions inherent in policymaking in general.

Thus, the division of labor among the three branches of government, each with particular competence, is not only constitutionally mandated, it arguably is also efficient in allocating to each branch the policy-related tasks it is best equipped to handle effectively. Of course, these theories about how things should work don't always play out in the messy arena of real-life governing. The judgment of legislators, which in theory should be focused on the public interest, may be compromised by ideological commitments or by the influence of politically powerful interest groups. Administrative agencies similarly may be subject to powerful interest group pressure or ideological direction. Even the courts themselves are not immune from political pressures. Although recognizing that no system of government is perfect or always lives up to ideal standards, the United States' system of government, featuring its checks and balances, has stood the test of time.

Courts in a Federal System of Government

Because governmental power in the United States is shared between the national and state governments, the power-sharing relationships existing in the levels of government should be addressed. These relationships affect the functioning of courts, and judicial decisions affect the boundaries of these relationships. As was discussed briefly in Chapter 2, in our federal system of government, the term *federalism* refers to the Constitution's division between the national (federal) government and the governments of the states of the authority to govern, including the ability to formulate and implement policy.

The Constitution lists a number of powers that the federal government can exercise (e.g., the powers to tax and spend funds to provide for the

nation's defense and general welfare, to regulate interstate and foreign commerce, and to regulate immigration), and that list establishes the boundaries of federal authority. In short, the federal government is often said to be one of "limited powers."

In contrast, the Tenth Amendment of the Constitution makes clear that all governmental powers not accorded to the federal government are "reserved to the States." In other words, the states keep all the powers to govern and regulate that the Constitution does not give to the federal government. This broad scope of governmental power includes the states' "police power," which is their ability to regulate a wide range of areas to protect the common good of their citizens.

This division of governmental authority is evident in health policy. For example, many public health measures enacted by state governments, such as laws requiring vaccination or newborn screening, represent exercises of the police power. The states also retain the power to regulate the practice of medicine, the provision of healthcare services, and insurance, including health insurance. The federal government, by contrast, has used its spending authority to establish federal health insurance programs such as Medicaid and Medicare, its taxing power to fund those programs, and its power to regulate interstate commerce to regulate the marketing of tobacco and prescription drugs.

Questions about whether a particular matter can properly be addressed by Congress or is properly reserved to the states, however, can be contentious politically and legally and typically require judicial resolution. A prominent recent example, discussed in more detail later, is the politically charged question about Congress's constitutional authority to require individuals to purchase health insurance as part of the ACA, a question that the Supreme Court ultimately decided in 2012.

Another important aspect of federalism is the Constitution's supremacy clause, which states that the Constitution and federal laws authorized by the Constitution are the "supreme law of the land." The supremacy clause's effect is that federal laws may be found to preempt any state laws regulating the same subject. As we will see in later discussion, when some states sought to enact health reform measures in the 1990s and 2000s, they found their ability to do so to be constrained and limited by judicial applications of federal preemption under the supremacy clause. Federal preemption also has limited state courts' ability to apply state tort law as a mechanism for compensating consumers harmed by unsafe products, such as pharmaceuticals, regulated by federal law.

In summary, the Constitution creates a system in which the power to govern is shared—shared among the legislative, executive, and judicial branches of government and shared between the federal and state

governments. But in any system premised on sharing, situations arise when one participant claims that another is taking more than its allotted share. When these questions arise in our constitutional democracy (e.g., when a state asserts that the federal government is encroaching on rights reserved to the states or when Congress asserts that the president is overreaching his or her authority), the courts are responsible for settling them. In a later section of this chapter, which discusses courts as referees, we will explore several examples of how courts' resolutions of disputes regarding the reach of governmental authority have shaped health policy.

Functioning of the Courts

Beyond the discussion of the structure of the judicial branch and the description of how the courts operate in the federal system of government under the US Constitution, several aspects of how courts function will help us understand how courts make decisions that are by definition health policy and how their decisions in turn may affect other health policy and policymaking. In effect, we want to consider what courts actually do and how they do it.

What Courts Do: Resolving Cases and Controversies

Unlike legislatures, which can identify a problem and affirmatively initiate the policy formulation process in response, courts function in a reactive mode. They act only in response to lawsuits properly filed and subject to their jurisdiction. Only parties who have some stake in the outcome of a dispute or controversy are permitted to pursue litigation. As a result, except in the rare situations when a court is authorized to declare its opinion on a legal question in the absence of a live controversy (by issuing a "declaratory judgment" or "advisory opinion"), courts address legal questions in concrete disputes, not in the abstract or in anticipation of possible future disputes.

Courts resolve those legal questions in an adversarial system where attorneys advocate for their parties' positions, arguing legal authority and factual evidence particular to the case. The trial court (which in some, but not all, cases relies on a jury to determine what version of disputed facts is true) renders a decision resolving the dispute between the parties. If one or both parties disagree with the trial court's resolution and can point to an error in how it reached that resolution, they may choose to appeal the decision to an appellate court.

The federal judicial system has two levels of appellate courts. District (trial) court decisions can be appealed to a federal circuit court of appeals. A party disappointed by the decision of the circuit court of appeals can petition the US Supreme Court to hear its case, but the Court hears argument in

and decides only a small percentage of cases in which petitions are filed. As a result, the circuit court of appeals will have the final word in most federal cases where a party appeals. Similarly, most state court systems have two layers of appellate courts, and the states vary in how they address parties' ability to appeal beyond the first appellate level.

Understanding how courts decide cases is important to appreciating courts' role in shaping health policy. While far from a complete description of how courts function, the following discussion highlights several pertinent points about how they work.

How Courts Decide Cases: Identifying, Interpreting, and Applying "the Law"

The central function of the judicial system in the United States is to apply "the law" to the facts of a particular case to resolve a dispute between the parties involved. That dispute may be as mundane as whether a landlord violated the terms of a residential lease, or it may be as momentous as whether an act of Congress violated an individual's constitutional rights. In any case, the court must identify which law applies, what that law means, and how it applies to the particular case's facts.

The law to which the courts look in deciding a dispute derives from multiple sources of potentially binding legal authority. These sources of law include constitutions (federal and state), laws or statutes passed by legislative bodies, rules and regulations issued by implementing organizations and agencies, and the common law (a term referring to the body of judge-made law). In addition, in contract disputes between private litigants, a court is called on to enforce terms that parties have themselves agreed to; in these cases, the court is effectively applying the parties' "private law."

A common misconception is that the "law on the books" provides a clear answer to decide legal disputes. As a practical matter, however, in cases where a statute, regulation, common-law ruling, or contract provides a clear answer, it is rarely in the parties' interest to devote resources to litigating a dispute; these cases typically settle out of court. Consequently, many of the cases that courts are called on to decide raise legal questions for which the law's answer is uncertain.

In many cases this uncertainty reflects the difficulty of determining what general language used in a constitution or statute (or other source of law) means when applied to a specific case. The federal Constitution is itself fairly short and written mostly in general terms, a circumstance that has produced endless controversy over how courts should interpret its terms, with judges and scholars divided on which interpretive method is appropriate.

Statutes, or laws enacted by legislatures, tend to be longer and more specific, with rules and regulations written by administrative agencies being

even more detailed and definite. Even so, it is probably beyond the ability of any policymaker to anticipate and provide for every situation that may possibly arise. As a result, courts regularly must give meaning to a source of law that is ambiguous or vague, so that it can then apply the law to resolve the dispute at hand. In the later discussion on courts as meaning givers, we will explore several examples of how courts' interpretations of the law have shaped health policy.

How Courts Decide Cases: The Conservative Influence of Precedent

Given the inherent imprecision of language, the need frequently arises for courts to give meaning to a source of law. As a result, courts exercise significant power in interpreting the law. That power, however, is subject to a restraint found in judicial adherence to the principle of *stare decisis* (meaning "to stand by a decision"). This principle dictates that a court should decide legal questions (like a law's meaning) consistently with how the question has been decided previously by the same court or any court superior to it in the judicial hierarchy. For example, a federal district court follows the precedent of its own prior decisions, decisions of the circuit court of appeals for its federal judicial circuit, and decisions of the US Supreme Court. Reliance on precedent means that a court deciding a new case will be guided by how courts have decided previous, similar cases, thus ensuring some level of stability, predictability, and consistency in the law and satisfying the basic precept of justice that "like cases should be treated alike."

The power of precedent is not absolute, however, and the Supreme Court may overrule a prior decision if a majority of the Court becomes convinced that the prior case was wrongly decided and has produced a rule that is unworkable, particularly in light of changes in society. A notable example of such overruling was the Court's 2003 decision in *Lawrence v. Texas*, which declared unconstitutional Texas's criminal antisodomy statute and overruled the Court's prior decision in another case, *Bowers v. Hardwick*.

With this discussion of the structure and functioning of courts as background, we can return to a fuller consideration of the three roles courts play in health policy and policymaking: refereeing, meaning giving, and rights protecting. Specific cases are noted that illustrate each role.

Courts Acting as Referees

When the complexity of the policymaking process depicted in Exhibit 3.1 and discussed in Chapter 3 is considered, the frequent need for refereeing disputes among various parties is apparent. These disputes arise primarily in

three areas: (1) questions of the extent of congressional authority, (2) questions of the power of implementing agencies, and (3) questions of federalism pertaining to federal and state levels of government. Each of these areas is considered in the following sections, with actual case examples.

Courts Refereeing Questions of Congressional Authority

Our discussion of how courts act as constitutional referees to affect health policy begins with one of the most celebrated or reviled, depending on one's opinion about the ACA, Supreme Court decisions in recent times: *National Federation of Independent Businesses (NFIB) v. Sebelius*. This lawsuit challenged the constitutional authority of Congress to enact, as part of the ACA, a requirement that individuals have health insurance or pay a fine to the federal government. This so-called individual mandate is a crucial piece in the ACA's attempt to ensure near-universal health coverage for Americans.

As we have discussed previously, the ACA builds on the nation's existing structure of private health insurance, but restricts insurers' ability to limit or deny coverage or charge higher premiums for persons with preexisting health conditions. With those changes, the cost of health insurance could be expected to rise sharply unless people who are relatively healthy and young also enroll in health plans. The individual mandate, coupled with tax subsidies for low-income persons, supplied the mechanism to get those young and healthy "good risks" to purchase health insurance. Conceptually, this mechanism would satisfy the concerns of health insurance companies to create larger risk pools and increase access to care for millions of formerly uninsured Americans.

The law's opponents, however, objected that Congress did not have the constitutional authority to enact the individual mandate as part of the ACA. As discussed, the Constitution limits Congress's powers to legislate, and in *NFIB v. Sebelius* the Supreme Court considered the constitutionality of the individual mandate. Proponents of the ACA argued that the power to regulate interstate commerce (articulated in the commerce clause of the Constitution) extended to Congress's ability to mandate the purchase of health insurance as part of a comprehensive regulatory scheme affecting the financing and delivery of healthcare.

The Supreme Court historically has interpreted the commerce clause expansively, permitting Congress to regulate any economic activity that substantially affects interstate commerce. Because of the scope and economic importance of the healthcare and health insurance industries, this expansive reading of the commerce clause has supported a broad exercise of congressional power in health-related fields.

As for the individual mandate, proponents asserted that the failure of millions of Americans to have health insurance undoubtedly affected

interstate commerce. The Supreme Court, however, disagreed and held that the individual mandate did not regulate existing commercial activity; instead, it compelled individuals to engage in the activity of purchasing insurance. The Court was unwilling to extend Congress's commerce clause authority to permit regulation of individuals not already acting in the market, fearing that to do so, in the Court's words, "would open a new and potentially vast domain to congressional authority."

Many Court-watchers had assumed that if the Supreme Court held that the individual mandate was not authorized under the commerce clause, it would strike down this linchpin of the ACA, thus crippling the health reform law. To their surprise, the Court proceeded to consider other sources of constitutional authority for the individual mandate and ultimately upheld it as an exercise of Congress's constitutionally based taxing power. Although the law itself refers to the payment that persons who do not have health insurance must make to the government as a "penalty," the Court reasoned that Congress did not mean for the payment to punish persons for failing to purchase insurance, but instead to induce people to purchase coverage and to raise revenue—both of which are characteristic of taxes. Thus, the Court framed the individual mandate as a tax on persons who do not purchase health insurance and therefore within the scope of Congress's taxing powers. As a result, the Court judged the individual mandate to be constitutional.

NFIB v. Sebelius vividly illustrates how courts can affect health policy through their refereeing role. Although the Supreme Court's decision neither formulated nor implemented policy, through the process of judicial review the Court validated a crucial piece of the most sweeping health reform legislation in a generation. A Court decision striking down the individual mandate as beyond Congress's constitutional authority would have severely weakened the ACA.

As referees, courts have the power to rein in legislative policymaking by deciding a policy exceeds constitutional bounds. And although the Supreme Court upheld the individual mandate under the taxing power, many commentators suggest that its commerce clause holding augurs future limitations on congressional power. Finally, as discussed later in the section on courts as federalism referees, judicial decisions regarding the scope of congressional authority also may have implications for the federal government and states' sharing of power to make health policy.

Courts Refereeing Questions of the Power of Administrative Agencies

As we saw in Chapter 3, when Congress (or a state legislature) enacts a policy, it expects certain agencies in the executive branch to implement them. In formal terms, Congress delegates implementation authority to administrative

agencies in the executive branch. This authority includes the ability, indeed the responsibility, to write and issue rules and regulations that flesh out the details of a legislatively enacted policy and establish specific standards for regulated parties' compliance with the legislation.

Agencies also enforce those standards and, when a dispute arises about an agency's implementation and enforcement activities (e.g., when an individual disputes the Social Security Administration's determination that the individual is not disabled enough to receive Social Security disability benefits), the agency may adjudicate those disputes. However, when a dispute arises about an agency's authority to act in a particular way, the courts resolve those disputes.

Judicial decisions concerning the validity of an agency's exercise of authority can have an important impact on health policy. Although they all address whether an agency has somehow exceeded its proper authority, three types of challenges can arise. First, a party may challenge an agency's rule or regulation as an unreasonable interpretation of what Congress charged it to do and therefore invalid. A second type of challenge is similar, but goes further in asserting that the agency's promulgation of rules and regulations exceeds the scope of the authority Congress delegated to it. Third, a rule or regulation may be challenged as essentially legislative in nature. In these situations the claim is that the agency has usurped the legislative role by going beyond its role in implementing or enforcing the legislature's policy. Specific case examples illustrate each type of challenge in the following sections.

A Challenge Asserting an Unreasonable Interpretation of Authority: The IRS and Tax Subsidies Under the ACA

Even when Congress clearly delegates to an agency responsibility for issuing rules or regulations on a particular matter, questions may arise about whether the resulting rules or regulations legitimately interpret the authorizing statute. A core precept of administrative law, established by the Supreme Court, is that courts ordinarily should uphold an agency's reading of a law it is responsible for implementing, as long as that reading is permissible (Jost 2004; Richards 2007). This so-called *rule of deference* to agency judgment applies when a law being implemented is silent or ambiguous on some implementation issue. If the law speaks specifically to the issue, the rule does not apply. The rule of deference gives agencies a good deal of leeway in interpreting ambiguous language and filling gaps in laws and prevents courts from simply substituting their own judgment about how best to fulfill the legislature's policy objectives for the agency's judgment.

A contemporary example of this type of dispute can be found in *King v. Burwell*. At issue is the validity of Internal Revenue Service (IRS) rules and regulations making tax subsidies available to persons purchasing health

insurance on the federally run health insurance exchanges created under the ACA (Gluck 2014).

The lawsuit asserts that the rules and regulations are inconsistent with the ACA provision providing for tax subsidies, which refers only to exchanges "established by a State." In defending its rules and regulations, the IRS, as the agency with implementation responsibility, takes the position that, viewed in context, the ACA language is unclear and that providing subsidies to purchasers regardless of whether they buy health plans from federally run or state-run exchanges is consistent with the ACA's overall scheme and legislative history. The challengers, by contrast, argue that the particular statutory section's omission of any mention of federal exchanges is clear and unambiguous, so that the IRS interpretation should receive no deference and be struck down. Several lawsuits presenting this challenge have been litigated in the lower federal courts, producing conflicting conclusions, and the Supreme Court has agreed to decide *King v. Burwell* in 2015.

Both sides of the lawsuit agree that if the challenge succeeds, it could potentially hobble the ACA's implementation. In probing the courts' willingness to defer to agency interpretation of a statute, *King v. Burwell* addresses a core question of administrative law and illustrates how critical court decisions can be to the implementation of health policies.

A Challenge Asserting Agency Action Exceeding the Scope of Delegated Authority: The FDA and Tobacco Regulation

Sometimes the judicial challenge to an agency's implementation of a health policy considers whether the organization or agency has overstepped its delegated authority. In the 1938 Food, Drug, and Cosmetic Act (FDCA), Congress delegated to the Food and Drug Administration (FDA) the authority to regulate drugs and medical devices to make sure they are "safe and effective."

In 1996, after decades of mounting evidence regarding the health risks of tobacco and new revelations of tobacco industry deception and efforts to manipulate cigarettes' nicotine levels to enhance addictiveness, the FDA issued regulations designed to restrict the marketing and accessibility of tobacco products to children and adolescents (Gostin 2009). The FDA's rationale was that new evidence confirmed that nicotine was a "drug" and that cigarettes and other tobacco products were "devices" delivering it to users. Thus, the FDA viewed the development and issuance of these rules and regulations as properly within the scope of its authority as granted by the FDCA.

Tobacco companies challenged the rules in court, arguing that they exceeded the FDA's delegated authority under the FDCA. The case ultimately reached the Supreme Court, which in 2000 held in *FDA v. Brown & Williamson Tobacco Corporation* that the FDA lacked any authority to regulate tobacco products.

To reach this conclusion, the Court relied on the interplay of the FDCA's regulatory goal of ensuring that marketed drugs and devices are safe and Congress's passage of other laws specifically regulating tobacco. In short, the Court reasoned that Congress had made clear in other legislation that tobacco products could continue to be sold in the United States, but that regulating tobacco to ensure safety would actually require its removal from the market. Based on this reasoning, the Court found that Congress, in enacting the FDCA, did not intend to give the FDA the authority to regulate tobacco. In this case, the conclusion was not simply that *how* the FDA had regulated tobacco was inconsistent with Congress's policy directives; instead, the Court concluded that any FDA regulation of tobacco was out of bounds.

A Challenge Asserting an Agency's Exercise of Legislative Authority: New York City's Portion Cap Rule for Sugary Drinks

A third type of challenge to administrative agency authority arises from questions as to whether an agency has gone beyond developing and issuing rules and regulations intended to implement the legislature's policy and is instead itself exercising authority that is legislative in nature. Challenges asserting this type of misuse of authority more often arise at the state level. Although the legislative branch at either level of government can delegate to an executive branch agency the authority to interpret and implement a health policy the legislature has enacted, it cannot constitutionally delegate responsibility for making the broad policy judgments inherent in legislating. Any attempt by an agency to make policy judgments that are legislative in nature will be invalid.

When a lower state court, in *NY Statewide Coalition v. NYC Department of Health*, struck down in 2012 the New York City Board of Health's partial ban on the sale of sugary drinks larger than 16 ounces, a judicial determination that the board had made a policy decision reserved for the legislative branch lay at the center of the decision (Mariner and Annas 2013). The Board of Health, which is part of the city's Department of Health and Mental Hygiene, adopted the rule—officially known as the Portion Cap Rule, but popularly referred to as the "Big Gulp Ban"—as part of a broad effort to combat obesity. But the court decided that the City Charter's grant of authority to the Board of Health did not permit the board to ban the sale of a legal item as a means of combatting a chronic disease.

According to the court, any decision to take such a step (and to create a complex set of exceptions to the rule, as the board had done) belongs properly to the legislature, in this case the New York City Council. By this reasoning, when the board adopted the rule, it overreached and acted like a legislature, violating the constitutional separation of powers. According to the judge, such a ban could be made only by an elected city council, not by a

board appointed by the mayor. In June 2014, the highest court in New York State affirmed that decision.

The foregoing cases illustrate several ways that courts can affect health policy by functioning as a constitutional referee that establishes the boundaries for how the legislative and executive branches carry out their respective policymaking roles. As the next section describes, the courts, in their referee roles, also may settle disputes about how the power to make health policy is shared between the federal government and the states.

Courts Refereeing Federalism Questions

As noted earlier and discussed extensively in Chapter 2, both the federal and state governments have constitutional authority to make health policy, although the scope of their authority differs. Congress's authority is limited to its exercise of its enumerated constitutional powers, while all other powers are reserved to the states. This section explores how court decisions settling conflicts between federal and state exercises of authority can affect health policy. As we will see, in some cases the existence and exercise of federal power limits states' ability to make health policy relating to a particular concern, but in other instances state interests may constrain the exercise of federal power. In yet other situations, both the federal and state governments can make policy in a certain area, as long as their policies (often in the form of rules or regulations) do not conflict.

"Cooperative Federalism" and Federal Coercion

In the constitutional scheme of government in the United States, the federal government cannot constitutionally compel a state to enact a particular policy, nor can it "commandeer" state employees to implement policies adopted by Congress. Pursuant to its constitutional spending power, however, Congress can provide the states with financial incentives to pursue certain policy objectives. An example of the use of this motivational power was Congress's conditioning the disbursement of federal highway funds on each state's raising its legal drinking age to 21 years.

Another health-related example of Congress's power to incentivize states' behaviors was the enactment of the Medicaid program. As we have discussed, the federal government provides substantial matching funds for state-administered health insurance programs for poor people, as long as the state program meets certain federal standards.

The label "cooperative federalism" is sometimes applied to the federal government's use of financial incentives to encourage state-level implementation of federal policies. In such an approach, the federal and state governments act autonomously, but their policy interventions are cooperative. While largely positive, cooperative federalism does raise the possibility

that the federal government's financial inducement to a state—if extremely strong—could effectively override the state's autonomy in formulating policy.

Implementation of the ACA, for example, relies heavily on cooperative federalism, but one aspect of the law was judged to violate federalism principles. We noted in earlier discussion that the Supreme Court played a crucial role by determining the constitutionality of the individual mandate provision of the ACA. In the same case, *NFIB v. Sebelius*, a second important question arose, a federalism question dealing with a challenge to the constitutionality of the ACA's Medicaid expansion provision (Kaiser Family Foundation 2012).

The ACA originally conditioned continued federal Medicaid matching funds on each state's expanding its Medicaid eligibility criteria. The change in criteria would have expanded Medicaid from a program providing health coverage only to certain categories of poor people (e.g., children, pregnant women, people with disabilities, elderly individuals) to a program covering all persons with income below a certain threshold. According to the ACA, a state that chose not to expand coverage would lose all federal matching funds from its Medicaid program.

Opponents of the ACA argued that when Congress induced the states to expand Medicaid eligibility by threatening the loss of all their federal Medicaid funding, it acted coercively, not cooperatively, and thus exceeded its spending power authority. A majority of the Supreme Court in *NFIB v. Sebelius* agreed. According to Chief Justice Roberts, the amount of federal funding that states stood to lose if they did not expand their Medicaid eligibility criteria was so large that the law left states with no real choice—instead, the threatened loss of funding was like a "gun to the head" of the states. From this perspective, Congress was unconstitutionally compelling states to expand Medicaid under the guise of making a constitutionally valid conditional grant of federal funds.

Once the Court found that the ACA's expansion of Medicaid represented an unconstitutional compulsion of state action, though, the question became what effect that finding of unconstitutionality would have on the health reform law. One possibility (which four dissenting justices endorsed) was that the unconstitutionality justified striking down the entire law. Another, less drastic result could have been to sever from the rest of the ACA all provisions of the law relating to the Medicaid expansion and to strike down only the expansion provisions as unconstitutional. That result would have left in force the health insurance market reforms, the individual mandate, and numerous other provisions of the ACA, but no state would expand Medicaid, meaning that the approximately 17 million uninsured low-income persons expected to benefit from the expansion would not receive coverage.

Instead, a majority of the Court concluded that it could remedy the unconstitutionally coercive nature of the Medicaid expansion simply by

removing the coercion; their remedy was to deny the federal government's ability to withhold *all* Medicaid matching funds from states choosing not to expand. This remedy left states able to choose *either* to expand their Medicaid population as called for by the ACA and receive federal funding for the expanded population *or* to maintain their Medicaid program at pre-ACA coverage levels, without losing their existing funding.

The Medicaid expansion part of the *NFIB v. Sebelius* decision dramatically demonstrates the Court's power to affect health policy. As with the question of the individual mandate's constitutionality, it was within the scope of the Court's judicial review powers to strike down the health reform law entirely as unconstitutional, which would have rendered moot all the legislative and executive branch efforts to enact and implement the law. But even though it found that Congress exceeded its constitutional authority by attempting to coerce states to expand their Medicaid programs, the Court adopted its more modest remedy so that it could avoid unnecessary judicial intrusion on the legislative authority to formulate policy. In effect, the Court's decision permitted Congress to adopt the Medicaid expansion as a way to increase insurance coverage in states that cooperated, but denied its ability to compel states to go along with that policy.

The Supremacy Clause and Federal Preemption

The Supreme Court's decision in *NFIB v. Sebelius* regarding the Medicaid expansion used the spending clause of the Constitution to constrain Congress's ability to induce states' compliance with federal health policy objectives, but the more typical power-sharing disputes between the federal government and states involve the supremacy clause of the Constitution.

As noted earlier, the supremacy clause declares the Constitution and federal laws authorized by the Constitution to be the "supreme law of the land." Its effect is to permit Congress, by enacting a law on a particular topic, to preempt state laws in that area. The preemption may extend to state common-law actions (e.g., negligence or product liability lawsuits), as well as to statutory law. As a result, questions have arisen about the validity of state health policy initiatives in areas as diverse as a state-mandated hospital budget review for cost-containment purposes (not preempted), a state law prohibiting a particular form of hazardous waste disposal (not preempted), and a state law imposing burdensome requirements on "navigators" charged by the ACA to help consumers use insurance exchanges to enroll in health plans (preempted).

As these examples suggest, federal laws do not always preempt state laws or rules and regulations, and part of the courts' role as constitutional referees is to determine when the supremacy clause and federal preemption apply. The central issue in determining preemption is whether the federal

policymakers intended that the federal law displace state laws on the same subject. If a federal law explicitly includes a stated purpose of preempting state laws on the same subject, then a court simply interprets the statute's preemption language to determine whether the particular state law being challenged falls within the scope of preemption. The courts had to make such a decision, for example, when the Massachusetts attorney general issued regulations prohibiting retailers from using self-service displays of cigarettes and banning outdoor advertising of cigarettes in any location within 1,000 feet of a school. Cigarette manufacturers and retailers challenged the regulations as preempted by the Federal Cigarette Labeling and Advertising Act (FCLAA).

The FCLAA prescribes mandatory health warnings for cigarette packaging and advertising and contains an express preemption of state prohibitions "based on smoking and health" relating to cigarette advertising. Massachusetts argued that this preemption did not extend to state regulation of the location of cigarette advertising, as opposed to the content of cigarette advertising, an argument that some lower federal courts accepted. The Supreme Court, however, held in *Lorillard Tobacco Company v. Reilly* that Congress intended to preempt all health-motivated state regulation targeting cigarette advertising, including location restrictions. According to the Court, Congress's decision in the FCLAA to require health warnings on cigarette packaging and advertising and to include a broad preemption clause meant that Massachusetts could not implement its own policy to decrease youth exposure to cigarette advertising by regulating its location.

Even when Congress does not expressly state its intent to preempt state law, a court may find that preemptive intent is implicit in a federal policy. Perhaps the easiest case for finding preemption is when a state law directly conflicts with a federal law. If it would be physically impossible to comply with both the federal and state requirements, a court will invoke the supremacy clause to invalidate the state law. In sum, judicial decisions determining the existence and scope of federal preemption of state law in health-related areas establish a balance of authority between the states and the federal government.

Courts Acting as Meaning Givers

As we noted earlier, a second core role for courts is interpreting laws whose meaning or application to a particular dispute is somehow unclear. In this role, courts function as meaning givers, by clarifying the meaning of laws. In this section, we examine more extensively how courts performing their role as interpreters of the law—meaning givers—can shape the direction or evolution of health policies. There are of course situations in which the law

is entirely clear and needs no interpretation, but the facts are in dispute. For example, in a personal injury lawsuit it may be perfectly clear that the defendant will be liable to the plaintiff for injuries sustained in a car accident if he ran a red light before hitting her, but a factual dispute may exist about whether or not the light was red when the defendant went through the intersection. In that case, the court's primary role is that of fact-finder. Often, however, interpretation or meaning giving is needed.

It bears noting that courts actually play the meaning-giver role in most lawsuits. In each of the cases discussed in the previous section, for example, a court had to interpret the Constitution or a law to make a decision about whether a branch of government had acted within the bounds of its constitutional authority or how power should be shared between the federal and state governments.

The cases examined in this section, however, highlight how courts' interpretation of the language of laws can determine the language's policy impact. We will see that court decisions sometimes play an important role in establishing the effects of legislative action. The cases in this section also will preview the final section's discussion of cases in which courts' predominant role is to enforce rights claimed pursuant to contracts, statutes, or the Constitution. In those cases, courts may first have to interpret the relevant source of law to determine the existence and scope of the right claimed.

In particular, this suggests different scenarios where court decisions giving meaning to laws effectively delineate the policy implications of Congress's handiwork. First, in looking again at how broadly to interpret preemptive language in a federal law, we will see how courts' parsing of the preemption clause in a law having little to do with health has substantially affected states' ability to pursue state-level healthcare reforms. The discussion will then turn to judicial interpretations of statutes that regulate the conduct of actors in the healthcare marketplace and create rights on the part of healthcare consumers.

ERISA Preemption and State Health Reform

When Congress enacted ERISA in 1974, its main goal was to create a federal regulatory scheme for employer-sponsored pension plans to make sure they met certain standards for protecting employees. Congress, however, drafted the law to apply to employee benefit plans more broadly, including healthcare benefit plans. The law does not require employers to offer any particular benefit, but instead sets up uniform standards for administering whatever benefits are offered. Congress wanted to encourage employers to establish plans by displacing all state regulation of employee benefit plans; this preemption of state law would permit large multistate employers to avoid having to comply with varying and potentially conflicting plan regulations in different states.

To that end, ERISA includes a broadly worded preemption clause stating that it preempts all state laws that "relate to" employee benefit plans covered by ERISA. Although it wanted to establish the regulation of employee benefit plans—and particularly pensions—as an area of exclusive federal concern, Congress was concerned about unduly intruding on areas of traditional state regulation. So it qualified ERISA's preemption clause with a "savings" clause, which effectively saves from preemption any state law that "regulates insurance." Thus, in essence, state laws that relate to employment benefit plans are preempted, *but* a state can regulate insurance companies.

This gets even more complicated in a situation in which an employer provides health coverage for its employees by self-insuring (i.e., by acting as the insurer itself), rather than by purchasing contracts of insurance from an insurance company. ERISA anticipated this possibility. The statute includes an exception to the savings clause that provides an employee benefit plan shall not be deemed to be in the business of insurance for purposes of applying the savings clause. The simple effect of this "deemer clause" is to qualify the description provided earlier, as follows: State laws that relate to employment benefit plans are preempted, *but* a state can regulate insurance companies, *except for* an employee benefit plan that self-insures to provide health benefits. Language like this and complex legal provisions including exceptions to exceptions ensure a continuing vital role as meaning givers or interpreters for the courts!

For several decades following its enactment, the combination of ERISA's preemption clause, its savings clause, and its deemer clause produced a steady stream of lawsuits probing the precise scope of ERISA's preemption of state health policies. Typically, employers or insurance companies filed these lawsuits to argue that a state law could not be enforced against them because it was preempted by ERISA. The lawsuits required courts to interpret ERISA's statutory language to make decisions with important implications for states' ability to enforce their health policies.

Complicating matters, some of the language in this law that courts had to give meaning to is vague. (What does it mean for a state law to "relate to" an employee benefit plan? What kinds of state laws "regulate insurance"?) This vagueness left courts with a good deal of interpretive latitude. Indeed, numerous decisions by courts, including the Supreme Court, about how to interpret ERISA's preemption provisions over time have swung from an expansive understanding of ERISA's preemptive effect to a more limited one. According to Furrow and colleagues (2013, 370), ERISA preemption lawsuits have included "over twenty Supreme Court decisions and hundreds of state and federal lower court decisions." As a result, states' ability to pursue health policies having any connection to employer-provided health insurance over time has waned and, more recently, waxed.

A few examples help illustrate the role courts have played in disabling or enabling state health policies arguably related to ERISA. For several decades, many state legislatures passed laws requiring health insurers to include in their policies certain types of coverage (e.g., mental health coverage or maternity coverage). Because these "mandated benefit" laws applied to policies purchased as part of an employee benefit plan, insurers argued that the laws were preempted by ERISA. By interpreting the interaction of the preemption clause and the savings clause, the Supreme Court held in a 1985 case, *Metropolitan Life Insurance Company v. Massachusetts*, that a state law mandating coverage of certain mental health benefits did "relate to" employee benefit plans, but was saved from preemption as a law that "regulates insurance." In that case the Court went on to apply the deemer clause to conclude that the mandated benefit law could not be enforced against a self-insured plan providing health coverage to employees. As a result, workers whose employers bought group coverage from an insurance company would receive the benefit, but employees of self-insured employers might not. This result both frustrated the state's policy goal of ensuring coverage of the mental health services and provided additional incentive for employers to self-insure to avoid mandated benefits and other state regulation.

As Jacobson (2009, 88) describes, expansive judicial interpretations of ERISA's preemption provisions at least through the mid-1990s meant that, even as federal policy makers unable to enact comprehensive national health reform encouraged states to pursue their own reforms, a federal law "imperil[ed] aggressive state health coverage experiments." Since the mid-1990s, several Supreme Court decisions have suggested that lower courts should interpret ERISA's "relate to" language in the preemption clause more narrowly (which would shrink the law's preemptive scope) and should interpret the "regulates insurance" language in the savings clause more broadly (which would enlarge states' ability to adopt policies implicating health coverage). For example, in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company* in 1995, the Supreme Court found that a New York law imposing hospital bill surcharges on most commercial insurers survived preemption. Although the surcharge law had some economic effect on employee benefit plans, the Court read ERISA's "relates to" language as not extending to such an indirect effect.

In 2003, in *Kentucky Association of Health Plans, Inc. v. Miller*, the Supreme Court interpreted the savings clause to uphold a Kentucky "any willing provider" law (requiring health plans to permit any willing provider to join their networks) as a law that "regulates insurance." In that case, the Court adopted a new approach, more permissive of state regulation, to determining whether a state law "regulates insurance" for ERISA savings clause purposes. Thus, evolving judicial interpretations of ERISA's preemption

provisions have alternatively constrained and permitted many state health policy initiatives.

Judicial Interpretations of Laws That Regulate the Health Markets and Create Consumer Rights

Besides determining the breadth of federal preemption in the health policy domain, judicial interpretations of the substantive provisions of laws affect health policy and policymaking in other ways. Almost any law can require some judicial explication to clarify its meaning in a particular circumstance. Courts, however, are most likely to be called on to interpret or give meaning when (1) legislative language is vague or ambiguous, with multiple plausible meanings, and (2) a party trying to claim a right or avoid regulation under the statute has enough at stake to litigate its meaning.

When a public entity (e.g., an administrative agency with enforcement authority such as the Centers for Medicare & Medicaid Services or a state attorney general) brings a lawsuit to enforce a law's regulatory provisions, the court's interpretive judgment most obviously determines whether enforcement will succeed in the particular case. It may also signal to the enforcer and other regulated parties the types of conduct that might (or might not) trigger enforcement actions in the future. For example, in a 1982 case, *Arizona v. Maricopa County Medical Society*, the Supreme Court interpreted federal antitrust law (specifically, the Sherman Act's rule against price fixing) to find agreements among physicians setting the maximum fees to be charged to policyholders to be illegal per se. This decision signaled to doctors and other actors in health markets that neither physicians' status as professionals nor the courts' relative inexperience with applying antitrust law to the healthcare industry would immunize them from antitrust liability (Hammer and Sage 2002). From a policy perspective, the court decision also gave a green light to regulators to proceed with enforcement actions in the health field as a way to try to spur competition, efficiency, and cost savings.

Many laws create rights on the part of individuals to enforce the law through private lawsuits (or administrative adjudications). In cases involving such laws, Medicare for example, a court decision interpreting unclear statutory language determines the current plaintiff's ability to prevail, as well as the exposure of regulated parties to future similar suits.

One law in which individual enforcement has been particularly important and where the courts have struggled to give meaning to spare statutory language is the Emergency Medical Treatment and Active Labor Act (EMTALA). Congress enacted EMTALA in 1986 to address the problem of emergency rooms' "dumping" patients (refusing to see them or sending them immediately to a public hospital) because the patient was uninsured and unable to pay potentially large hospital bills (Perez 2007).

In formulating EMTALA as a response to this problem, Congress knew precisely what problem it wanted to address. The language it used in the law, however, failed in several respects to make clear exactly what the law obligated hospitals to do and, by extension, when patients harmed by violations have a right to recover. The most glaring of the law's ambiguities is the requirement that a hospital covered by EMTALA provide an "appropriate medical screening examination" to any person who comes to an emergency room seeking treatment.

EMTALA does not define the phrase "appropriate medical screening examination," and the text of the law provides only a few clues as to what Congress intended the phrase to mean. The law provides only that the screening examination is to be "within the capability of the hospital's emergency department" and that its purpose is "to determine whether or not an emergency medical condition . . . exists." As a result, when patients who suffered some kind of harm after visiting a hospital emergency room sued the hospital for violating EMTALA, it was left to the courts to distinguish an "appropriate medical screening examination" from one that somehow fell short of EMTALA's requirements.

As the court put it in a 1990 case, *Cleland v. Bronson Health Care Group, Inc.*, *appropriate* is "one of the most wonderful weasel words in the dictionary, and a great aid to the resolution of disputed issues in the drafting of legislation." In other words, *appropriate* is a handy term for promoting agreement among legislators, precisely because it sounds good while having no specific meaning.

As plaintiffs filed lawsuits alleging violations of EMTALA, courts had to give some meaning to an "appropriate medical screening examination." In doing so they relied on the clues in the rest of the law, as well as evidence of Congress's intent in enacting the law. It was clear that Congress did not intend to create a new federal cause of action for medical malpractice, or negligent medical care, and accordingly the courts consistently have rejected any argument that an "appropriate screening" requires a nonnegligent screening.

The courts have been less consistent in developing tests for what makes a screening inappropriate. Although most of the federal circuit courts of appeals have adopted the standard that a hospital's screening of a particular patient should be considered "appropriate" as long as it was similar to the screening the hospital typically gives to patients presenting with similar symptoms, some federal circuit courts of appeals have used a slightly different approach. Because the Supreme Court has not addressed this question, no definitive answer exists. The result of Congress's use of vague language in EMTALA is therefore that the standard a hospital is held to in screening an emergency room patient may vary depending on which federal circuit a hospital is located in. Thus, one downside of relying on courts to give

meaning to a policy is that—unless the Supreme Court provides a definitive interpretation—judicial interpretations of the legislature's policy objectives may not be consistent.

Courts Acting as Rights Enforcers

The discussion in the previous section of the policy implications of courts' interpretations of EMTALA illustrates how courts can play multiple roles in a single lawsuit. For example, in a patient's lawsuit alleging that a hospital failed to provide an "appropriate medical screening examination," the court must first give meaning to the statutory requirement; then it applies that requirement to the plaintiff's factual scenario. In doing the latter, the court decides whether the hospital violated the plaintiff's statutory right to the required screening, so that the plaintiff is entitled to a monetary judgment against the hospital. Thus, in these cases the court acts as both meaning giver and rights enforcer. Other laws on both the federal and state levels also create health-related rights for patients and providers, and persons who believe their rights have been violated may seek remedies through the courts.

This section, however, will focus primarily on how the courts' enforcement of (or, by contrast, limitation or denial of) common-law rights and constitutional rights can affect health policy. We will first consider how judicial resolution of claims brought by health plan subscribers against their plans can affect health policy. This discussion entails revisiting the subject of ERISA preemption, which has severely limited plan members' ability to sue for a denial of benefits. This section and the chapter will then conclude by considering how court decisions involving constitutional rights of both individuals and corporations have had an important impact on health policy.

Enforcement of Contract and Tort Rights: ERISA Preemption Revisited

Traditionally, a subscriber to a health insurance plan who believed her plan improperly had refused to pay for covered benefits could sue the plan in state court for breach of contract. The lawsuit would require the court to interpret and apply language in the health insurance policy (e.g., whether a particular treatment prescribed for the subscriber fell under the policy's exclusion of "experimental" treatments). And in a managed care setting, if a plan also employed physicians and other providers, a subscriber might file a tort action against the plan if he believed he had suffered injury because his doctor had skimped on his care to save the plan money. That tort action would require the court to decide whether the doctor had acted negligently in making medical decisions or treating the plaintiff.

Over the past several decades, however, courts regularly have found that ERISA preempts contract and tort lawsuits brought by plaintiffs who receive their health coverage through employer-sponsored health plans. As discussed, ERISA preempts state laws—including common-law contract and tort claims—that "relate to" employee benefit plans. Courts have interpreted ERISA's "relate to" preemption language broadly and also have invoked another provision of ERISA that limits remedies for the denial of benefits to a remedy provided by ERISA itself. As a result, courts have kept dissatisfied subscribers from pursuing state law claims, leaving them only the option to go after the remedy provided for in the law itself. The remedy provided by ERISA, however, is limited, permitting a plan member to recover only the value of the benefit that was improperly denied. By contrast, a broader range of remedies (and more generous damages awards) is available to a subscriber who prevails in a contract or tort action. Thus, the preemption of state law claims disadvantaged health plan subscribers who claimed they had been harmed by health plan decisions to limit their care.

Moreover, as Jacobson (2009) points out, these judicial decisions also had important policy implications. Because the preemption decisions limited the remedies available to plan members, they also limited the liability exposure of managed care plans. If the plan got sued and lost, it would have to pay the injured subscriber only the value of the benefit it should have provided to begin with. This judicial application of ERISA to provide plans protection from potential liability for a full range of economic, pain and suffering, and punitive damages effectively gave managed care organizations a green light to employ a variety of techniques to control costs aggressively.

At the same time, however, as news media began covering the plight of injured plan beneficiaries left without a meaningful remedy, the court decisions also prompted state legislatures and Congress to consider possible legislative fixes in the form of a "Patients' Bill of Rights" that would provide some kind of protections to health plan enrollees. Although congressional efforts in the 1990s and early 2000s to enact a federal patients' bill of rights ultimately failed, several states enacted such reforms (Law 2002). Thus, the story of ERISA preemption of health plan subscriber claims illustrates how courts' denial of subscribers' common-law rights catalyzed efforts to enact statutory protections.

Enforcement of Constitutional Rights

In contrast to the common law, which typically creates rights between private parties, the Constitution creates private rights against the exercise of governmental authority. Although state constitutions are also sources of important individual rights, this discussion focuses on the federal Constitution. While the Constitution's separation of powers and federalism provisions prevent

the concentration of power in any one branch of government and limit the government's authority to act in the first instance, the Bill of Rights and the Constitution's Fourteenth Amendment guard certain rights of individuals (and in some cases corporations) against governmental intrusion. For health policy purposes, the most important of these constitutional rights are found in the First Amendment (with its protection of free speech and religious freedom) and the Fourteenth Amendment (with its guarantees of equal protection and due process). Persons seeking the vindication of their constitutional rights call on the courts to claim those rights.

As Gostin (1995) points out, the courts have played their most robust—and controversial—role in making policy decisions with respect to constitutional rights in health-related matters. By recognizing constitutional protections of individual rights relating to reproduction (both contraception and abortion rights) and end-of-life decision making, the Supreme Court has addressed issues that are socially divisive and that legislatures had often failed to address. As a result, the "judiciary . . . has sometimes acted as a pathfinder when there was a paucity of established policy" (Gostin 1995, 345).

The effect of the Court's decisions on legislatures' ability to formulate policies in the areas of reproductive and end-of-life rights varies, though. The Court's decisions in the 1960s and 1970s establishing individual rights relating to contraception and abortion limited states' ability to enact policies regulating these areas, but subsequent Court decisions have eroded those limitations, emboldening state legislatures in recent years to enact a plethora of laws regulating abortion. By contrast, while assuming the Constitution provides some protection to individual autonomy in end-of-life decision making, as it did in the 1990 *Cruzan v. Director, Missouri Department of Health* case, the Court has been unwilling to declare that individuals have an absolute right either to terminate medical treatment or to receive physician assistance in dying. This reluctance largely leaves policy decisions about end-of-life care to state legislatures, many of which have enacted laws in the area.

The ability to assert constitutional rights is not limited to individuals; the Supreme Court has recognized that corporations may also claim some constitutional protections. Corporations' success in convincing courts to recognize their First Amendment free speech rights provides a vivid illustration of how court decisions can affect health policy, and in particular the government's ability to protect public health through tobacco policy.

In 2009 (nine years after the Supreme Court held that the FDA did not have delegated authority under the FDCA to regulate tobacco), Congress passed the Family Smoking Prevention and Tobacco Control Act (P.L. 111-31) granting the FDA that authority. One provision of that act mandates that the FDA develop new written health warnings to go on cigarette packages, as well as to select images to accompany those textual warnings (Orentlicher 2013).