

MAKING HEALTHCARE HUMAN: THE IMPACT OF DECOUPLING LABOR AND HEALTHCARE ON THE AMERICAN INSURANCE SCHEME

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INTRODUCTION

The United States is one of the wealthiest nations in the world,¹ but that wealth does not correlate with the extent to which all U.S. residents are able to meet their basic needs.² Many Americans find that they need to take on a “side hustle” to earn enough to pay for their basic living expenses.³ On the other end, the wealth of the top one percent of income earners continues trending upward.⁴ The healthcare delivery system is just one example which highlights the disparities worsened by the widening wealth gap. A significant portion of American residents receive their healthcare through employer sponsors.⁵ Thus, it follows that access to care is largely dependent on whether that individual or a family member has an employer that can and will sponsor that care. Even under the shadow of one of the most significant overhauls of healthcare in recent memory, the Patient Protection and Affordable Care Act (“Affordable Care Act,” “ACA,” or “the Act”), many remain uncovered.⁶ The United States, a member of the United Nations, is a signatory to several different covenants providing guidelines for the provision of adequate conditions for the flourishing of human rights and wellness.⁷ However,

1. *China Overtakes US as Richest Country in the World*, BUS. STANDARD (Nov. 17, 2021), <https://www.tbsnews.net/world/global-economy/china-overtakes-us-worlds-richest-nation-330970> [https://perma.cc/YJC6-YYCS].

2. Alexa Lardieri, *Study: 40 Percent of Americans Struggle to Afford Basic Needs*, U.S. NEWS (Aug. 28, 2018), <https://www.usnews.com/news/politics/articles/2018-08-28/study-40-percent-of-americans-struggle-to-afford-basic-needs> [https://perma.cc/S9V2-QFXW]; Jeffrey C. Fuhrer, *How Many Are in Need in the US? The Poverty Rate is the Tip of the Iceberg*, BROOKINGS INSTITUTION (June 20, 2024), <https://www.brookings.edu/articles/how-many-are-in-need-in-the-us-the-poverty-rate-is-the-tip-of-the-iceberg/> [https://perma.cc/JH3B-ZV2M] (“Forty-three percent of all families in the U.S. fall short of meeting basic needs.”).

3. Brandon Gomez, *Nearly 1 in 3 American Workers With a Side Hustle Still Struggle to Make Ends Meet*, CNBC (June 6, 2019), <https://www.cnbc.com/2019/06/06/nearly-1-in-3-us-workers-with-a-side-hustle-need-it-to-make-ends-meet.html> [https://perma.cc/35L3-P536].

4. Alexandra Killewald, Fabian T. Pfeffer, & Jared N. Schachner, *Wealth Inequality and Accumulation*, 43 ANN. REV. SOCIO. 379, 384 (2017), <https://pmc.ncbi.nlm.nih.gov/articles/PMC5546759/pdf/nihms887694.pdf> [https://perma.cc/BM46-FJX2]; Robert Frank, *The Wealth of the Top 1% Reaches a Record \$52 Trillion*, CNBC (Oct. 3, 2025), <https://www.cnbc.com/2025/10/03/the-wealth-of-the-top-1percent-reaches-a-record-52-trillion.html> [https://perma.cc/JLL9-UDWN].

5. David Blumenthal & David Squires, *The Employer Mandate: Essential or Dispensable?*, COMMONWEALTH FUND (June 4, 2015), <https://www.commonwealthfund.org/blog/2014/employer-mandate-essential-or-dispensable> [https://perma.cc/W8E2-YJBK].

6. Laxmaiah Manchikanti, Standiford Helm, Ramsin M Benyamin, & Joshua A. Hirsch, *A Critical Analysis of Obamacare: Affordable Care or Insurance for Many and Coverage for Few?*, 3 PAIN PHYSICIAN 111, 118 (2017).

7. WORLD HEALTH ORG. CONST.; G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948); G.A. Res. 2200A (XXI), International Covenant on Economic, Social and Cultural Rights (Dec. 16, 1966). Notably, the United States has not yet ratified the ICESCR, rendering its obligations under these covenants legally non-binding at this time, but indicating the aspirational nature of the United States’ relationship with its terms.

whether the United States' obligations under these covenants can be satisfied while relying on a system so deeply commodified and dependent upon one's access to employment is ripe for debate.

This article explores the history and rationales for the current structure of the U.S. healthcare system and analyzes the various weaknesses existing in the current scheme. Part I will outline the historical realities underlying the progression of the U.S. healthcare system's development. Part II will explain the key provisions of one of the most consequential changes to the U.S. system: the Affordable Care Act.⁸ Part III will examine the shortcomings of those key provisions and the consequences of those weaknesses in the context of the United States' international law obligations. Part IV proposes the single-payer solution to the issue of access to care, guided by international legal interpretations of human rights and the example set by Canada as a signatory to several of the same international covenants the United States has either ratified or acknowledged. This section also addresses reasonable counterarguments to the single-payer proposal. Lastly, this article concludes by proposing an overhaul and reframing of the key considerations for U.S. lawmakers as they work toward strengthening health-related law and policy.

I.

THE HEALTHCARE LANDSCAPE AND ORIGINS OF EMPLOYER-BASED BENEFITS

The development of medicine and the availability of new types of treatments and care towards the end of the 1920s led to a newfound interest in healthcare among Americans, as well as an interest in the potential for profit by healthcare providers.⁹ During the Progressive Era, various organized groups led the charge for more widely accessible health insurance.¹⁰ The American Association for Labor Legislation (AALL), for example, sought to reform the entirety of the capitalist and industrialist systems through the lens of worker health and safety, with social welfare as a top priority.¹¹ To that end, the AALL drafted a model bill in 1915 providing coverage to just those earning less than \$1,200 a year (except for

8. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 26 and 42 U.S.C.).

9. See Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 76 (2003) (explaining in the 20th century as "medical care became both more effective and more expensive . . . soon, medical costs and access to care" became a primary concern of health reformers); Aaron E. Carroll, *The Real Reason the U.S. Has Employer-Sponsored Health Insurance*, N.Y. TIMES (Sept. 5, 2017), <https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html> [<https://perma.cc/3WS9-KMEA>].

10. Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (last visited Oct. 8, 2025), <https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/> [<https://perma.cc/5XUU-N5YD>].

11. *Id.*; see also AM. ASS'N FOR LAB. LEGIS., ANNOUNCEMENT THIRTY-FIRST ANNUAL MEETING (1937), https://www.asanet.org/wp-content/uploads/1937_annual_meeting_program.pdf [<https://perma.cc/5RHH-ENDW>].

domestic and agricultural workers and the self- or unemployed) and including coverage for physicians', hospitals', and nurses' services, maternity benefits, death benefits, sick pay, and funeral expenses, the costs of which would be paid by the state, workers, and employers.¹² Many physicians who were members of the American Medical Association (AMA) joined the AALL in support of this proposal and helped to advocate for the bill's adoption by the legislature, but when several state medical societies opposed the proposed bill's method of physician compensation, the AMA abandoned its original position, completely rolling back its support for the model bill.¹³ A powerful source of opposition to a more socialized system was the concern of Americans rooted in the same fear which fueled the "Red Scare," of the 1920s;¹⁴ in particular, Americans' concern for potential domestic alignment with communism¹⁵ and any principles identified as adjacent, such as socialized healthcare.¹⁶ The federal government's attempts to eliminate any such threats, including those purportedly posed by compulsory enrollment (enrollment required by law), led to the cessation of the government's consideration of any similar system.¹⁷ The charge did not end there, however, and the Committee on the Cost of Medical Care (CCMC)—a group of dozens of economists, medical professionals, public health specialists, and interest groups first convening in 1926¹⁸—conducted a study concluding that more national resources should be put towards supporting healthcare infrastructure for the entirety of the U.S. population, including by providing for voluntary rather than compulsory health insurance, which was thought at the time to be an adequate means of covering the associated costs.¹⁹

Blue Cross took the lead to expand American healthcare access in 1929, joining together several Texas hospitals as a conglomerate to provide hospital services by way of a coverage plan, and Blue Shield followed ten years later, similarly consisting of a conglomerate of physicians from whom people would purchase these services.²⁰ Eventually, these entities would join to create the Blue Cross and

12. See Palmer, *supra* note 10; see also Alan Derickson, *Health for Three-Thirds of the Nation*, 92 AM. J. PUB. H. 180, 180 (2002).

13. Palmer, *supra* note 10.

14. *Id.*

15. See generally David R. Colburn, *Governor Alfred E. Smith and the Red Scare, 1919-20*, 88 POL. SCI. Q. 423 (1973).

16. Jeffrey St. Onge, *Operation Coffeecup: Ronald Reagan, Rugged Individualism, and the Debate over 'Socialized Medicine'*, 20 RHETORIC & PUB. AFFS. 223, 226-29 (2017), <https://www.jstor.org/stable/10.14321/rhetpublaffa.20.2.0223>.

17. *Id.*

18. Palmer, *supra* note 10.

19. Lippincott-Raven Publishers, *Committee on the Costs of Medical Care Reports*, 32 AM. J. OF NURSING 1286, 1289 (1932).

20. Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, 117 MONTHLY LAB. REV. 3, 5 (1994).

Blue Shield.²¹ At this point in time, most health insurance was purchased privately, but labor shortages resulting from the sharp uptick in World War II military service meant that employers needed to create attractive incentives in order to maintain a sufficient workforce.²² President Franklin D. Roosevelt made several attempts to expand health coverage, the most ambitious being the National Health Act of 1939, or the “Wagner Bill.”²³ The bill’s stated purpose was

To provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel.²⁴

The bill allowed the States discretion to decide whether to have a system at all and did not provide for compulsory health insurance or a federally administered program, but did provide for the federal issuance of grants to the States for “Public Health work and Investigation,” and other more targeted grants to provide funding for medical centers.²⁵ This bill lost its momentum in Congress given the national shift in priority to the Second World War.²⁶

In an effort to stabilize the United States’s increasingly fragile economy, President Roosevelt signed Executive Order 9250 in 1942, which prevented employers from raising wages²⁷—arguably the most effective device for attracting workers—out of concern that doing so at that time would create unmanageable inflation amidst the Depression.²⁸ Unable to raise wages, employers began competing instead for who could offer the most favorable health insurance plans.²⁹ When the Internal Revenue Service decided in 1942 that employer-based health insurance would be considered exempt income for workers,³⁰ purchasing insurance from one’s employer became more affordable than doing so otherwise given that benefit.³¹ Years passed, and while many Americans maintained employer-sponsored

21. Carroll, *supra* note 9.

22. *Id.*

23. *Id.*

24. John A. Kenney, *The National Health Act of 1939*, 31 J. NAT’L MED. ASS’N. 154, 154 (1939), <https://pmc.ncbi.nlm.nih.gov/articles/instance/2624243/pdf/jnma00746-0024.pdf> [<https://perma.cc/8SG8-QPGG>].

25. *Id.*

26. *Medicare Signed Into Law*, SENATE.GOV, https://www.senate.gov/artandhistory/history/minute/Medicare_Signed_Into_Law.htm [<https://perma.cc/Z44G-2D4J>] (last visited Oct. 8, 2025).

27. Exec. Order No. 9250, 7 Fed. Reg. 7871, 7871–74 (Oct. 3, 1942).

28. Carroll, *supra* note 9.

29. *Id.*

30. Leif O’Leary, *Are Employer-Sponsored Health Plans on Their Way Out?*, HARV. BUS. REV. (May 19, 2021), <https://hbr.org/2021/05/are-employer-sponsored-health-plans-on-their-way-out> [<https://perma.cc/8NQA-HHBV>].

31. Carroll, *supra* note 9.

health insurance, the price of care continued to increase for several reasons including but not limited to inflation, growing hospital expenses, and technological advancements in medicine.³² In response to these concerns, President Lyndon B. Johnson signed into law the Medicare and Medicaid programs³³—Medicare intending to provide coverage to those 65-plus or with certain disabilities, and Medicaid to provide coverage to those meeting state-determined thresholds of low-income and need.³⁴

Eventually, as a result of significant grassroots support from senior Americans, the shift toward something closer to a national health insurance program, a proposal that had received varying levels of support over the past several decades, was revisited again.³⁵ Concern for a program dependent on the contributions of *all* Americans by way of taxes remained, motivated both by an unwillingness to pay higher taxes as well as the belief that such a program was part of a larger “Communist” scheme giving excessive power to the government, further agitating the ongoing Red Scare.³⁶ As something of a middle ground, in the early 1970s, President Richard Nixon proposed a plan he believed would help “assure every American financial access to high quality health care.”³⁷ Nixon’s plan required that all employers offer insurance to full-time employees and provided temporary subsidies which would support small and low-wage employers’ ability to offer affordable coverage to their employees.³⁸ This proposal, however, fell apart in the wake of the Watergate Scandal.³⁹

In the 1980s, in response to the federal budget deficit, President Ronald Reagan signed into law the Consolidated Omnibus Budget Reconciliation Act (COBRA) which permitted former employees of healthcare-providing employers to retain enrollment in their former employer’s group plan in the event of any job

32. *Timeline of Developments in U.S. Health Care*, PBS, <http://www.pbs.org/healthcare-crisis/history.htm> [<https://perma.cc/39LD-D5W2>] (last visited Oct. 8, 2025).

33. 42 U.S.C. §§ 1395-1396.

34. *Medicare and Medicaid Act (1965)*, NAT’L ARCHIVES & RECS. ADMIN., <https://www.archives.gov/milestone-documents/medicare-and-medicaid-act> [<https://perma.cc/5BS3-68A6>] (last visited Oct. 8, 2025).

35. Carroll, *supra* note 9.

36. *The Challenge of National Healthcare*, NAT’L ARCHIVES & RECS. ADMIN., <https://www.trumanlibrary.gov/education/presidential-inquiries/challenge-national-healthcare> [<https://perma.cc/NDP6-43WM>] (last visited Oct. 8, 2025).

37. Shanoor Seervai & David Blumenthal, *Lessons on Universal Coverage from an Unexpected Advocate: Richard Nixon*, COMMONWEALTH FUND (Nov. 2, 2017), <https://www.commonwealthfund.org/blog/2017/lessons-universal-coverage-unexpected-advocate-richard-nixon> [<https://perma.cc/V4BA-LYEU>].

38. *Id.*

39. *Id.*

loss or reduction, so long as they paid the full cost of the premium.⁴⁰ This created valuable infrastructure through which individuals could avoid losing their coverage during periods of unanticipated employment outcomes.⁴¹ President Bill Clinton then contributed to the healthcare infrastructure by establishing the Children's Health Insurance Program (CHIP), which expanded Medicaid to serve uninsured children under the age of 19 whose families earned income below 200% of the federal poverty line.⁴² Still, about 15% of the population in the U.S. had no health insurance; many low-income individuals fell above Medicaid income limits, self-employed individuals could not afford private insurance, and not every business that employed workers offered coverage.⁴³ Many uninsured still received some level of care, however, because of the Emergency Medical Treatment and Labor Act ("EMTALA"), which ensured guaranteed emergency care regardless of whether one had insurance coverage or could afford services out-of-pocket.⁴⁴ This imposed an obligation on hospitals to provide potentially uncompensated emergency and non-emergency care to the many uninsured individuals who used emergency department visits for both their urgent and less-urgent needs.⁴⁵ While EMTALA fortunately ensured care for many who may not have obtained it otherwise, the cycle of individuals in need of care and resorting to emergency department visits due to their lack of affordable access to primary or specialty care was costly.⁴⁶ President Barack Obama's election then became the precursor to a renewed healthcare reform effort, leading to the passage of the ACA in 2010.

II.

KEY PROVISIONS OF THE ACA

With President Obama attempting to work alongside the Republican minority in Congress, the ACA's goals mirrored those of President Nixon with respect to

40. Consolidated Omnibus Budget Reconciliation Act, Pub. L. No. 99-272, § 1001, 100 Stat. 82; *An Employee's Right to Continue Workplace Health Insurance*, COBRAINSURANCE.COM, <https://www.cobrainsurance.com/what-is-cobra-insurance/> [<https://perma.cc/3LKD-6DBV>] (last visited Nov. 29, 2025).

41. COBRAINSURANCE.COM, *supra* note 40.

42. Erin Dooley & Meridith McGraw, *Program That Provides Low-Cost Health Care to 9M Children Set to Expire*, ABC NEWS (Sept. 29, 2017), <https://abcnews.go.com/US/program-low-cost-health-care-9m-children-set/story?id=50188069> [<https://perma.cc/2EMF-QJ59>].

43. NAT'L ACADS. OF SCI., ENG'G, & MED., HEALTH-CARE UTILIZATION AS A PROXY IN DISABILITY DETERMINATION 43 (2018), <https://www.ncbi.nlm.nih.gov/books/NBK500098/> [<https://perma.cc/8JLX-K6YB>].

44. *Id.*

45. *Id.*

46. *Id.*

addressing the persisting population of uninsured Americans.⁴⁷ The goals of the Act were to increase overall insurance coverage and to target the groups that had repeatedly been excluded from the insurance market.⁴⁸ The Act's expansion in coverage was aimed at creating a larger "risk pool,"⁴⁹ which refers to the collection of individuals and entities with varying medical costs, the combination of which would be *pooled* and then considered by insurers as they determine insurance premiums—the cost of insurance. Prior to the ACA, when those with preexisting conditions were most likely to obtain insurance, insurers increased healthcare premiums to account for the costs of care for individuals with higher expected utilization rates—in other words, those who typically needed more frequent or expensive treatment.⁵⁰ It was not uncommon for those less likely to need care to either abandon or never purchase coverage at all.⁵¹ The ACA, by mandating enrollment, expanding coverage, and altering certain other practices of the American health insurance system, sought to expand access to care by increasing eligibility for coverage and creating a larger risk pool.⁵² The risk pool would include both those predicted to need more as well as less care, with the hope that more participants paying premiums would generate a sufficient pool of funds from which to provide more affordable care for consumers across the board, and that the financial burden of care will be spread among all.⁵³

A. Dependent Coverage Provision

Young adults have historically been insured at low rates.⁵⁴ The Centers for Disease Control and Prevention (CDC) reported in 2011 that about 25% of all 18–24 year-olds had no health insurance.⁵⁵ Not only were young adults dropping off

47. Steffie Woolhandler & David U. Himmelstein, *The Affordable Care Act: How Nixon's Health Reform Proposal Became Democrats' Albatross*, 47 INT'L J. OF HEALTH SERVS. 612, 613 (2017), <https://www.jstor.org/stable/48513012?seq=2> [<https://perma.cc/75SP-3CS2>]; see also *supra* text accompanying notes 37–39.

48. Michael French, Jenny Homer, Gulcin Gumus, & Lucas Hickling, *Key Provisions of the Patient Protection and Affordable Care Act (ACA): A Systematic Review and Presentation of Early Research Findings*, 51 HEALTH SERVS. RSCH. 1735, 1736 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5034214/> [<https://perma.cc/6GUR-NRF7>].

49. NAT'L ACADS. OF SCI., ENG'G, & MED., *supra* note 43.

50. See *id.*; Stephen P. Gulley, Elizabeth K. Rasch & Leighton Chan, *Ongoing Coverage for Ongoing Care: Access, Utilization, and Out-of-Pocket Spending Among Uninsured Working-Aged Adults with Chronic Health Care Needs*, 101 AM. J. OF PUB. HEALTH 368, 368 (2011).

51. NAT'L ACADS. OF SCI., ENG'G, & MED., *supra* note 43, at 44.

52. See Matthew Fiedler, *The ACA's Individual Mandate in Retrospect: What Did It Do, and Where Do We Go From Here?*, 39 HEALTH AFFS. 429, 429–430 (2020), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01433> [<https://perma.cc/EC5B-SD29>].

53. *Id.*

54. Maureen Monaghan, *The Affordable Care Act and Implications for Young Adult Health*, 4 TRANSL. BEHAV. MED. 170, 170 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4041926/> [<https://perma.cc/8T5A-JTBE>].

55. *Id.*

of their parents' plans after graduating from high school or college, but they were above the age for CHIP eligibility as well.⁵⁶ The average annual household income in 2011 for this pervasively uninsured group was typically \$12,000.⁵⁷ Young adults seldom received valuable preventative care, instead utilizing acute care in emergency departments at high rates and/or delaying necessary care due to high out-of-pocket costs.⁵⁸ Section 2714 of the ACA provides that "a group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child . . . until the child turns 26 years of age."⁵⁹ For young adults, this would mean that issuers could not legally remove them from their parents' coverage due to their age or lack of full-time student status until age 26.⁶⁰ Insurers were obligated to offer these dependents the same benefits packages and for the same prices, all without requiring the dependent to purchase an individual policy.⁶¹ The adoption of this provision increased coverage availability for this segment of the population which had historically represented a critical coverage gap in the health insurance market.

B. Employer "Shared Responsibility" Provision

In 2020, over half the U.S. population utilized employer-sponsored health insurance,⁶² but of course, *all* families and individuals cannot access employer-sponsored coverage, as this would require everyone to have an employer who offers it (or to be a dependent of someone with such an employer) and to be able to afford the costs of the coverage which that employer offers.⁶³ To encourage employers to offer coverage, Section 1513 of the Act contains the "shared responsibility" provision, a major element of the ACA which applies to all common law employers and imposes penalties on large employers if one or more of their employees receives a premium tax credit through one of the ACA-created insurance exchanges.⁶⁴ A premium tax credit is "a refundable credit that helps eligible

56. *Id.*

57. *Id.*

58. *Id.*

59. 42 U.S.C. 300gg-14(a).

60. *Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families FAQs*, EMP. BENEFITS SEC. ADMIN., <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/young-adult-and-aca> [<https://perma.cc/6LLF-42NE>] (last visited Oct. 10, 2025).

61. *Id.*

62. Aditi P. Sen, *Research and Policy to Strengthen the Employer-Sponsored Health Insurance Market*, 57 HEALTH SERVS. RSCH. 439, 439 (2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9108054/pdf/HESR-57-439.pdf> [<https://perma.cc/F2D5-WSRY>].

63. *Id.*

64. 42 U.S.C. § 1513(a); CONG. RSCH. SERV., *THE AFFORDABLE CARE ACT'S (ACA) EMPLOYER SHARED RESPONSIBILITY DETERMINATION AND THE POTENTIAL EMPLOYER PENALTY 1* (2016).

individuals and families cover the premiums for their health insurance purchased through the Health Insurance Marketplace,”⁶⁵ with eligibility dependent on whether an employer does not offer any coverage at all, or offers coverage that is unaffordable or below minimum value as defined by the Act.⁶⁶ Millions of enrollees in marketplace coverage plans receive premium tax credits, which help them to afford the cost of coverage offered in their state’s ACA marketplace.⁶⁷ This assistance provides for (i) lower ceilings on premium contributions for those at all income levels, (ii) the elimination of premiums for those with an income between 100-150% of the poverty level with “benchmark” silver plans—the second-lowest cost plan available through one’s marketplace that covers themselves, their spouse, and their dependents who are enrolled in marketplace coverage—and (iii) extended eligibility for premium tax credits for those with income above 400% of the poverty level if their benchmark premium would exceed 8.5% of their household income.⁶⁸ Large employers who refuse to offer coverage or who offer unaffordable coverage are assessed a penalty, with affordability defined by the size of the contribution by the individual relative to their household income, and adequacy defined by whether the required percentage of healthcare expenses are covered.⁶⁹ Section 1513 also aims to expand the risk pool by requiring employers to participate, furthering the goal of collective contribution to ensure the system’s viability and affordability.⁷⁰

C. The Individual Mandate: Maintenance of Minimum Essential Coverage

As required by Section 1501, “[a]n applicable individual shall, for each month beginning after 2013, ensure that the individual, and any dependent of the individual who is applicable, is covered under minimum essential coverage for such month.”⁷¹ The “individual mandate” legally required most Americans without healthcare from an employer, Medicare, or Medicaid to obtain coverage through the individual market meeting certain minimum requirements at the risk of

65. *The Premium Tax Credit-The Basics*, INTERNAL REVENUE SERV., <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics> [<https://perma.cc/2SMN-4RFZ>] (last visited Oct. 10, 2025).

66. CONG. RSCH. SERV., *supra* note 64.

67. GIDEON LUKENS & ELIZABETH ZHANG, CTR. ON BUDGET & POL’Y PRIORITIES, PREMIUM TAX CREDIT IMPROVEMENTS MUST BE EXTENDED TO PREVENT STEEP RISE IN HEALTH CARE COSTS 1–2 (2024), <https://www.cbpp.org/sites/default/files/11-14-24health.pdf> [<https://perma.cc/M3WU-5U5E>].

68. GIDEON LUKENS & ELIZABETH ZHANG, CTR. ON BUDGET & POL’Y PRIORITIES, HEALTH INSURANCE PREMIUM SPIKES IMMINENT AS TAX CREDIT ENHANCEMENTS SET TO EXPIRE 1–2 (2025), <https://www.cbpp.org/sites/default/files/10-29-25health.pdf> [<https://perma.cc/6WG2-F7YP>].

69. CONG. RSCH. SERV., *supra* note 64, at 6.

70. Blumenthal & Squires, *supra* note 5.

71. 26 U.S.C. § 5000A.

pecuniary sanction, with exceptions made only for those below a certain income, unavailability of affordable coverage, and other select hardships.⁷²

Section 1501(a) lays out Congress's findings made in connection with this mandate, noting that "62% of all personal bankruptcies are caused in part by medical expenses," that "administrative costs for private health insurance . . . were [\$90 billion] in 2006, [and] are 26 to 30 percent of premiums," and that "[n]ational health spending is projected to increase from [\$2.5 trillion], or 17.6 percent of the economy, in 2009 to [\$4.7 trillion] in 2019."⁷³ Through the passage of the individual mandate, Congress anticipated certain "substantial[] affects [on] interstate commerce," including that it would "add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services," and "strengthen[] private employer-based coverage," thus not only increasing coverage but "improv[ing] financial security for families."⁷⁴ The individual mandate, however, has since been undermined, as President Donald Trump signed into law a bill reducing the penalty for remaining uninsured to zero dollars, removing the teeth from this portion of the Act.⁷⁵ The result was a preemptive rise in premiums as insurance companies anticipated that people would opt out of insurance without enforcement of the individual mandate, and this was taken into consideration by the companies as they revisited their pricing structures shortly thereafter.⁷⁶

D. Medical Underwriting Prohibition & Removal of Pre-Existing Condition Exclusions

Prior to the enactment of the ACA, insurers often issued individuals higher premiums based on the status of their health, if they issued an individual with pre-existing conditions coverage at all.⁷⁷ In the individual market, applicants had their health status assessed using questionnaires meant to probe the prospective insureds' medical history and would consent to insurers accessing their medical records as they considered whether to issue coverage.⁷⁸ This often led to either (a)

72. 42 U.S.C. § 18081 (2010); MATTHEW BUETTGENS, BOWEN GARRETT, & JOHN HOLAHAN, THE URB. INST., WHY THE INDIVIDUAL MANDATE MATTERS: TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES 2 (2010), <https://www.urban.org/sites/default/files/publication/29456/412280-Why-the-Individual-Mandate-Matters.PDF> [<https://perma.cc/TK3L-DMEY>].

73. 42 U.S.C. § 18091(2)(B), (G), (J).

74. *Id.* § 18091(1), (2)(C), (2)(D), (2)(G).

75. Selena Simmons-Duffin, *Trump Is Trying Hard to Thwart Obamacare. How's That Going?*, NPR: ALL THINGS CONSIDERED (Oct. 14, 2019), <https://www.npr.org/sections/health-shots/2019/10/14/768731628/trump-is-trying-hard-to-thwart-obamacare-hows-that-going> [<https://perma.cc/4WZE-D4MS>].

76. *Id.*

77. SARAH LUECK, CTR. ON BUDGET & POL'Y PRIORITIES, ELIMINATING FEDERAL PROTECTIONS FOR PEOPLE WITH HEALTH CONDITIONS WOULD MEAN RETURN TO DYSFUNCTIONAL PRE-ACA INDIVIDUAL MARKET 1–2 (2020), <https://www.cbpp.org/sites/default/files/atoms/files/5-3-17health.pdf> [<https://perma.cc/K3GD-4LPA>].

78. *Id.* at 3.

applicants being offered premium rates above standard pricing to account for their projected costly healthcare needs, (b) insurers denying applicants coverage altogether because of their pre-existing conditions, or (c) insurers excluding from coverage any treatment related to an individual's pre-existing conditions.⁷⁹ In 2009, 34% of the insureds' coverage offers were above the standard rate, and in 2013, 18% of applications were rejected as a whole due to pre-existing conditions.⁸⁰

As part of the ACA's General Reforms, Sections 2704 and 2705 explicitly prohibit the consideration of pre-existing conditions and health status-related factors when considering an applicant for a policy in a group plan as well as for individual coverage.⁸¹ Insurers are not permitted to consider "(1) health status, (2) medical conditions (including both physical and mental illnesses), (3) claims experience, (4) receipt of medical care, (5) medical history, (6) genetic information, (7) evidence of insurability, (8) disability," or "(9) any other health status-related factor determined appropriate by the Secretary."⁸² The policing of insurance companies' applicant consideration practices expanded the population of those who would be able to access coverage without being penalized for having preexisting conditions, further reinforcing the goals of the ACA.⁸³

E. Medicaid Expansion

Before the ACA was enacted, Medicaid had been administered by the states, with each state deciding its own eligibility requirements and the scope of the plans offered.⁸⁴ The minimum income eligibility was decided state-by-state, which created wide variability in access to care on this basis throughout the country.⁸⁵ Medicaid and CHIP were providing coverage to around 18% of Americans under 65, and some states limited parental eligibility for coverage to individuals with as low as 23% of federal poverty levels.⁸⁶ The ACA effectively mandated the expansion of Medicaid by conditioning states' receipt of all federal Medicaid funding on their adoption of certain new eligibility criteria.⁸⁷ Eligibility was extended to all persons under age 65 who had household income less than or equal to 133% of the

79. *Id.*

80. *Id.*

81. 42 U.S.C. § 300gg-1 to -4.

82. *Id.* § 300gg-4(a).

83. *Id.*

84. Elizabeth Fee, *Signing the U.S. Medicare Act: A Long Political Struggle*, 386 THE LANCET 332, 333 (2015).

85. *Id.*

86. Sarah M. Lyon, Ivor S. Douglas, & Colin R. Cooke, *Medicaid Expansion Under the Affordable Care Act: Implications for Insurance-Related Disparities in Pulmonary, Critical Care, and Sleep*, 4 ANN. AM. THORAC. SOC'Y 661, 662 (2023).

87. Alexander H. Sommer, *State Implementation of the Affordable Care Act*, 15 VIRTUAL MENTOR 603, 603-04 (2013).

Federal Poverty Level,⁸⁸ which obligated states less eager to contribute financially in support of the program to do so in a manner that complied with federal standards in exchange for funding.⁸⁹ Additionally, coverage of the newly eligible individuals would be 100% federally financed at the start, then fall to 95% by 2017, to 94% in 2018, to 93% in 2019, and to 90% in 2020 and beyond.⁹⁰ Medicaid expansion has subsequently reduced the number of uninsured individuals from 45 million to 26 million,⁹¹ with 41 states (District of Columbia included) opting to expand.⁹² This surge in Medicaid coverage can be explained, in large part, by the increased coverage of many low-income employees who lacked coverage through their employers and who were unable to access affordable coverage through the individual market.⁹³ Despite these incremental gains, however, the Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* determined that the Medicaid expansion provision of the ACA—in particular, its conditioning of federal Medicaid funding on states' compliance with the newly established eligibility requirements—was unconstitutional.⁹⁴ The decision still allowed for expanded funding for the states that *do* wish to take on the increased coverage obligation originally intended by the Act.⁹⁵ Each of the key provisions of the ACA have created cognizable improvements to the healthcare infrastructure of the U.S.; however, the shortcomings that still exist reflect the nation's neglect for the principles beyond domestic legislation that should guide the creation of healthcare policy.

88. *Id.*

89. Fee, *supra* note 84, at 333.

90. JESSE CROSS-CALL, CTR. ON BUDGET & POL'Y PRIORITIES, MEDICAID EXPANSION CONTINUES TO BENEFIT STATE BUDGETS, CONTRARY TO CRITICS' CLAIMS 2 (2018), <https://www.cbpp.org/sites/default/files/atoms/files/10-9-18health.pdf> [https://perma.cc/7RS7-WVYR].

91. CTR. ON BUDGET & POL'Y PRIORITIES, POLICY BASICS—INTRODUCTION TO MEDICAID 9 (2025), https://www.cbpp.org/sites/default/files/atoms/files/policybasics-medicaid_0.pdf [https://perma.cc/K8NJ-XH5T].

92. *Status of State Medicaid Expansion Decisions*, KFF, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/> [https://perma.cc/2Z6X-NVY2] (last visited Oct. 10, 2025).

93. POLICY BASICS: INTRODUCTION TO MEDICAID, *supra* note 91, at 9.

94. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 585 (2012).

95. Vasu Sunkara & Sara Rosenbaum, *The Constitution and the Public's Health: The Consequences of the US Supreme Court's Medicaid Decision in NFIB v. Sebelius*, 131 PUB. HEALTH REPS. 844, 845 (2016).

III.

THE ACA FALLS SHORT OF ITS INTERNATIONAL LAW OBLIGATIONS

A. *Healthcare Obligations Under International Law*

In the background of the evolution of U.S. domestic law, the World Health Organization (WHO) declared in its 1946 Constitution that “[h]ealth is a state of physical, mental and social well-being and not merely the absence of disease or infirmity” and that “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” to be protected by the governments of each member state.⁹⁶ That Constitution also codified the right to health by declaring a government-held responsibility to implement adequate health and social measures to carry out the above-stated goals.⁹⁷ The United Nations’ Universal Declaration of Human Rights (UDHR) further establishes certain “fundamental human rights” to be universally protected, and has set the groundwork for the adoption of numerous human rights treaties which have been adopted across the globe.⁹⁸ Article 25 of the Declaration states that all people are entitled to “a standard of living adequate for the health and well-being of himself and of his family,” which includes “medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability,” and other circumstances beyond one’s control that would cause a loss of livelihood.⁹⁹

The United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) is yet another document codifying a human right to health.¹⁰⁰ Article 12 provides that the states that are party to the covenant recognize every person’s “right of . . . enjoyment of the highest attainable standard of physical and mental health,” and dictates that state action to uphold this should include the following:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

96. WORLD HEALTH ORG. CONST. PMBL.; Andrea S. Christopher & Dominic Caruso, *Promoting Health as a Human Right in the Post-ACA United States*, 17 AM. MED. ASS’N J. ETHICS 958, 958 (2015).

97. WORLD HEALTH ORG. CONST. PMBL.

98. G.A. Res. 217 (III) A, *supra* note 7.

99. *Id.* art. 25.

100. G.A. Res. 2200A (XXI), *supra* note 7.

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.¹⁰¹

The U.N. has expanded upon Article 12 in Committee on Economic, Social and Cultural Rights (“CESCR”) General Comment No. 14 to emphasize that its conceptualization of a right to health includes a right of access “to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”¹⁰² The drafting committee identified essential factors contributing to a state’s legitimate guarantee of its occupants’ right to health, including availability, accessibility, and quality, among other factors.¹⁰³ Availability requires that healthcare facilities, goods and services, and programs be of sufficient quantity within a state, commensurate with its resources and level of development.¹⁰⁴ Accessibility requires that these facilities and services be accessible to all without discrimination against minoritized or otherwise marginalized populations.¹⁰⁵ It also provides for safe and feasible access for all, as well as affordability, with payment requirements informed by an understanding of equity.¹⁰⁶ Also underlying the aforementioned requirements is a guarantee that individuals can learn about their health and make informed decisions about their care.¹⁰⁷ Quality demands that facilities, goods, and services are appropriate pursuant to medical and scientific standards.¹⁰⁸

The satisfaction of subsection (d) of Article 12.2 of the ICESCR is critical in evaluating the compliance of the United States with international law. The committee recognizes that satisfaction would require “equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.”¹⁰⁹

The United States was a participant in the drafting and a champion of the adoption of the UDHR, as well as a signatory to the ICECSR.¹¹⁰ Having not yet ratified either renders its relationship to both noncommittal, however, as the

101. *Id.*

102. Comm. on Econ., Soc. and Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), U.N. Doc. E/C.12/2000/4, ¶ 8 (2000) [hereinafter CESCR General Comment 14].

103. *Id.* at ¶ 12.

104. *Id.* at ¶ 12(a).

105. *Id.* at ¶ 12(b).

106. *Id.*

107. *Id.*

108. *Id.* at ¶ 12(d).

109. *Id.* at ¶ 17.

110. Scott Busby, *Whither the United States on Economic, Social, and Cultural Rights?*, CTR. FOR STRATEGIC & INT’L STUD. (Oct. 23, 2024), <https://www.csis.org/analysis/whither-united-states-economic-social-and-cultural-rights> [<https://perma.cc/3GGW-N5RF>].

United States has not consented to be legally bound by these sets of obligations.¹¹¹ In fact, the United States has a history of pulling away from committing itself to the accountability that would flow from its legal assent to the terms of these documents.¹¹² For example, after advocating for the inclusion of certain language and principles to be included during the drafting of the UDHR, the United States shifted to the position of treating the document as a set of “nonbinding aspirations.”¹¹³ Similarly, the ICESCR has sat on the back burner, remaining unaddressed despite having been signed by President Carter and sent to the Senate for ratification.¹¹⁴ Nonetheless, viewing the current system of healthcare operated by the United States through a forward-looking and wishful lens, it is evident that it does not meet the expectations provided by these documents, as will be discussed below. Unfortunately, even the modifications made by the ACA do not carry the system the rest of the way toward that end because the ACA does not change the fact that the United States does not take a rights-based approach to health, made evident by its reliance on a structure that allows healthcare access to remain heavily commodified: contingent on an individual’s status as a laborer and/or their ability to pay.

B. *Where The ACA Falls Short*

Though the Affordable Care Act has been referred to as “universal healthcare,”¹¹⁵ realistically, it falls far short of that title. The ACA mandates and further facilitates the purchase and availability of *insurance* while not actually entitling insurance holders to care¹¹⁶ and still leaving millions of Americans uninsured.¹¹⁷ Generally speaking, the reason so many remain unable to receive the care they need is, in part, because of issues with our current system that remain unaddressed. First, having health insurance does not guarantee an individual’s receipt of care (or adequate care). The ACA preserves a fragmented system in which not every provider accepts every form of insurance, and as a result, even the insured might struggle to find providers who will accept their coverage without

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. Cameron Keng, *ObamaCare (Affordable Care Act) Is Not an Insurance or Healthcare Problem*, FORBES (Oct. 2, 2013), <https://www.forbes.com/sites/cameronkeng/2013/10/02/obamacare-affordable-care-act-is-not-an-insurance-or-healthcare-problem/> [<https://perma.cc/4S8A-QFN6>].

116. *Id.*

117. Max Romano, Opinion, *Obamacare Is Not Universal Health Care [Commentary]*, BALTIMORE SUN (Mar. 26, 2014), <https://www.baltimoresun.com/opinion/bs-ed-obamacare-medicare-20140326-story.html> [<https://perma.cc/5FSY-M6DG>] (“The bottom line is that Obamacare will insure millions, but it will also leave tens of millions of Americans still uninsured.”); 42 U.S.C. § 18091(2)(D) (“The [individual responsibility] requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide.”).

leaving their visit with high out-of-pocket expenses.¹¹⁸ In addition, despite having insurance coverage, low-income policy holders have often found their healthcare needs difficult to meet because of a lack of easy physical access to care providers, requiring significant travel as providers were not always accessible in their communities.¹¹⁹ These shortcomings are captured entirely by the accessibility prong of CESC General Comment No. 14, which highlights the importance of the accessibility of these resources to all, without barriers created by any of the elements of individuals' identities, their location, or their financial status.¹²⁰ That the mass-enrollment in health insurance that the ACA catalyzed can still allow for such discrepancies in access to care is further evidence that the U.S. healthcare system and insurance scheme are not robust enough to provide the level of access anticipated by the aforementioned international covenants. There are limits to the effectiveness of an insurance mandate which preserves several of the existing weaknesses in coverage and care, when the healthcare infrastructure upon which it sits is, itself, so frail.

The Dependent Coverage provision similarly has shortcomings. It was effective in providing another avenue to insurance coverage through an adult child's parents, assuming there was a parent alive with whom the child has a relationship and who has access to insurance themselves. Once young adults age out of coverage, however, certain economic trends make this population more vulnerable to lacking coverage. For example, young adults often enter the workforce starting with entry-level or part-time work or in other roles with smaller employers, many of which are not providers of employer-based health insurance.¹²¹ Additionally, the volatility of the labor market can be difficult on college graduates, as the unemployment rate for recent graduates is nearly the worst it has been in 10 years.¹²² For many, after pursuing higher education (and being left saddled with student loan debt),¹²³ young adults are increasingly left earning a lower salary than

118. Jennifer E. DeVoe, Alia Baez, Heather Angier, Lisa Krois, Christine Edlund, & Patricia A. Carney, *Insurance + Access ≠ Health Care: Typology of Barriers to Health Care Access for Low-Income Families*, 5 ANN. FAM. MED. 511, 515 (2007).

119. *Id.* at 514.

120. See CESC General Comment 14, *supra* note 102, ¶ 12(b).

121. *Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 10, 2024), https://www.cms.gov/CCIIO/Resources/Files/adult_child_fact_sheet [https://perma.cc/LLQ6-HBAD].

122. Shannon Pettypiece, 'A Black Hole': New Graduates Discover a Dismal Job Market, NBC NEWS (Aug. 2, 2025), <https://www.nbcnews.com/business/economy/job-market-report-college-student-graduates-ai-trump-tariffs-rcna221693> [https://perma.cc/LE6W-QZQ3].

123. Melanie Hanson, *Student Loan Debt Statistics*, EDUC. DATA INITIATIVE (Feb. 2, 2026), <https://educationdata.org/student-loan-debt-statistics> [https://perma.cc/UR93-27WA] (explaining that 25% of adults aged 18 to 29 report having student loan debt).

anticipated and are unable to afford the costs of care even *with* coverage.¹²⁴ Thus, it follows that obtaining care would not be an option at all without it. These issues reflect a failure in the United States' implementation of the principles identified in the ICESCR, namely, investing in "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."¹²⁵ Recognizing the contributions of each of these factors to the unsatisfactory rates of coverage among young adults, as well as the difficulty in remedying these conditions (many of which are closely intertwined with market volatility and other unpredictable economic circumstances), the United States would be prudent to create a system of healthcare in which no population is dependent on maintaining qualifying employment, especially not in a market in which young adults increasingly occupy non-qualifying roles.¹²⁶ Given the U.S.'s failure to create such a system, young adults *still* remain amongst those commonly unable to acquire coverage, a systemic pitfall that the ACA unfortunately did not cure.¹²⁷

Despite requiring that individuals and their dependents purchase "minimum essential coverage,"¹²⁸ the ACA did not necessarily address the high cost of coverage, even in the lowest tier offered through the exchange. Prior to the elimination of the penalty for failing to comply with the individual mandate, it was more affordable for some lower-income Americans to pay the penalty than it was to purchase a policy, because the penalty was still less costly than the cheapest available coverage plan.¹²⁹ Many low-income Americans do not qualify for Medicaid either: as of June 2025, in the 10 states that have not implemented Medicaid expansion, low-income adults over the age of 19 typically cannot qualify unless they are pregnant, caregivers for children, disabled, or elderly.¹³⁰ Many in the U.S. without citizenship but with lawful immigration status also do not qualify, and lawful permanent residents—green card holders—have long been prohibited from enrolling in Medicaid for their first five years of residence.¹³¹ Additionally, as a result of the passage of the 2025 Budget Reconciliation Bill, access for qualifying lawful permanent residents is even further restricted as the bill introduces additional limitations on eligibility for Medicaid (and CHIP), both removing coverage from

124. Elisabeth Rosenthal & Hannah Norman, *Why Young Americans Dread Turning 26: Health Insurance Chaos*, KFF HEALTH NEWS (Aug. 11, 2025), <https://kffhealthnews.org/news/article/insurance-cliff-age-26-young-adults-chaos/> [https://perma.cc/6UKW-TMN6].

125. G.A. Res. 2200A (XXI), *supra* note 7, art. 12.2(d).

126. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 121.

127. Rosenthal & Norman, *supra* note 124.

128. *See supra* Part II(C).

129. Rachel Rouben & National Journal, *Why Some Would Rather Pay the Obamacare Penalty Than Buy Insurance*, ATLANTIC (Dec. 9, 2015), <https://www.theatlantic.com/politics/archive/2015/12/why-some-would-rather-pay-the-obamacare-penalty-than-buy-insurance/456372/> [https://perma.cc/VM7H-P7HP].

130. CTR. ON BUDGET & POL'Y PRIORITIES, *supra* note 91, at 4.

131. *Id.*

certain subsets of lawful permanent residents currently present as well as preventing those yet to arrive from being able to access it.¹³² This too reflects a failure to align the U.S. system with the accessibility prong of the CESC General Comment.¹³³

The employer mandate is not sure-fire, either, as it leaves room for many employers to wriggle out of the requirements of the ACA by implementing certain modifications to their businesses and hiring practices. In 2013, a survey by the International Foundation of Employee Benefit Plans revealed that 15% of employers with 50 or more employees and 20% of small employers cut employee hours so that fewer employees would qualify for health insurance under the ACA.¹³⁴ Such action forces hourly workers, who commonly live below the poverty line, to acquire insurance through the public exchange where even with government subsidy, they will likely still shoulder significant costs they would not have had their employers contributed.¹³⁵ Employer discretion to choose what types of plans to offer their employees within the ACA's broad standards is particularly relevant today. Court decisions such as *Burwell v. Hobby Lobby Stores, Inc.* permit employers to refuse to provide employees with reproductive health coverage if the type of care contemplated conflicts with the employer's personal religious beliefs.¹³⁶ Given the ICESCR's identification of "equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care" as factors which would provide for the creation of adequate conditions to assure medical service and attention to all,¹³⁷ it cannot be the case that employers are, for any reason, empowered to decide what extent and kinds of care individuals are to have access to. Employees' access to healthcare cannot properly be made a matter of an employer's personally-held beliefs, religious or otherwise, so as to permit an employer to impose its leadership's ideologies onto its employees and thus deprive

132. Budget Reconciliation Act, Pub. L. No. 119-21, 139 Stat. 72 § 71109(a); Drishti Pillai, *Rolling Back the Big Beautiful Bill's Health Care Provisions Would Not Provide Health Care to Undocumented Immigrants*, KFF (Oct. 2, 2025), <https://www.kff.org/quick-take/rolling-back-the-big-beautiful-bills-health-care-provisions-would-not-provide-health-care-to-undocumented-immigrants/> [https://perma.cc/2653-J6GP]; *Health Provisions in the 2025 Federal Budget Reconciliation Bill*, KFF (July 8, 2025), <https://www.kff.org/medicaid/tracking-the-medicaid-provisions-in-the-2025-budget-bill/> [https://perma.cc/P76W-FBYT].

133. CESC General Comment 14, *supra* note 102, ¶ 12(b).

134. Karen McVeigh, *US Employers Slashing Worker Hours to Avoid Obamacare Insurance Mandate*, GUARDIAN (Sept. 30, 2013), <https://www.theguardian.com/world/2013/sep/30/us-employers-slash-hours-avoid-obamacare> [https://perma.cc/7PLP-2CY3].

135. *Id.*

136. *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 736 (2014).

137. CESC General Comment 14, *supra* note 102, at ¶ 17.

those employees of the ability to express and receive care comporting with their own views and needs.

*C. Consequences of a Primarily Employment-Based System of
Healthcare Access*

The coupling of healthcare with qualifying employment has created several problematic incentive structures and unique phenomena that offend the principles expressed in the Universal Declaration of Human Rights. In particular, the principle requiring that individuals be secure in their access to care in the event of unemployment and other circumstances beyond their control would seem to suggest that tying coverage to employment creates significant unpredictability where the ability to maintain steady employment can be market-dependent or otherwise connected to environmental and economic factors due to no fault of the individuals impacted.¹³⁸ Moreover, the U.S. system is incompatible with the principles of the Universal Declaration of Human Rights at a baseline level due to the fact that it is predicated on individuals contributing economically to society, implicitly requiring that those who want coverage either attain a certain kind of employment deemed worthy, or be associated with someone who has done so.¹³⁹ Nonetheless, it is critical to analyze the U.S. system's incompatibility with international law insofar as these premises form the foundation of the current system.

First, employment-based health coverage creates an environment in which people often decide to remain in jobs that they would otherwise leave if they were able to find comparable and affordable insurance—a phenomenon called “job-lock.”¹⁴⁰ Job-lock discourages Americans from early retirement regardless of their readiness if they are below age 65, cannot afford insurance on the individual market, fall out of Medicaid eligibility, and/or their employer does not offer retiree health insurance.¹⁴¹ Job-lock can also create circumstances such that individuals continue to work because their partner does not have employer-based insurance.¹⁴² Further, it encourages many of those with serious illnesses requiring expensive care to continue to work in order to maintain their access to coverage.¹⁴³

138. See Jeneen Interlandi, Opinion, *Employer-Based Health Care, Meet Massive Unemployment*, N.Y. TIMES (June 29, 2020), <https://www.nytimes.com/2020/06/29/opinion/sunday/coronavirus-medicare-for-all.html> [https://perma.cc/ZS2A-6TND].

139. See *supra* Part I.

140. Deborah Gordon & Akshaya Kannan, Opinion, *It's Time to Say Goodbye to Employment-Based Health Insurance*, HILL (May 28, 2020), <https://thehill.com/opinion/healthcare/499907-its-time-to-say-goodbye-to-employment-based-health-insurance/> [https://perma.cc/3J67-E9JU].

141. Austin Frakt, *If Obamacare Exits, Some May Need to Rethink Early Retirement*, N.Y. TIMES: UPSHOT (Feb. 27, 2017), <https://www.nytimes.com/2017/02/27/upshot/if-obamacare-exits-some-may-need-to-rethink-early-retirement.html> [https://perma.cc/HQ6S-F229].

142. *Id.*

143. *Id.*

With comparable and affordable coverage available separate from one's employment, health insurance-related job-lock would likely not exist.

Second, times of national economic weakness also threaten the stability of employment-based health insurance, with the COVID-19 pandemic serving as a principal example. Considering employer-sponsored health insurance is the most commonly held form of insurance among Americans, unemployment levels hitting 14.7% during April 2020 was extremely troubling during a time of acute need for health services.¹⁴⁴ Many, but not all, temporarily laid off or furloughed employees retained their coverage because of the relationship they maintained to their employer by way of their temporary leave.¹⁴⁵ Permanent layoffs, however, increased from 2.6 million to 4.1 million by August 2020, leaving even more individuals without coverage as a deadly pandemic spread.¹⁴⁶

There were disparities in who was most impacted by pandemic-related job loss as well.¹⁴⁷ Employees in manufacturing—an industry with an extremely high rate of employer-sponsored insurance utilization (66%)—made up 12% of unemployed workers in June 2020 despite representing 10% of employment prior to the pandemic.¹⁴⁸ Over six million dependents were impacted by the job loss of their guardians between February and June 2020.¹⁴⁹ Workers approximately age 35 to 54 lost employment and were affected by the loss in employer-sponsored insurance at the highest rates, while also being the most likely to have had insurance covering their dependents and partners.¹⁵⁰ From the start of the pandemic to June 2020, an estimated 7.7 million workers lost the employment that provided their healthcare—an eight percent reduction in total employment-based insurance coverage.¹⁵¹

Third, developments in labor also help to highlight several concerns regarding the structure of American health insurance. Automation is a threat to individuals' ability to obtain health insurance, as researchers predict that by 2030, artificial intelligence could be responsible for the performance of 20 million jobs in the manufacturing industry across the globe.¹⁵² This equates to 1.5 million in the U.S.

144. PAUL FRONSTIN & STEPHEN A. WOODBURY, COMMONWEALTH FUND, HOW MANY AMERICANS HAVE LOST JOBS WITH EMPLOYER HEALTH COVERAGE DURING THE PANDEMIC? 2 (2020), https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_esicovidloss-8oct20.pdf?sfvrsn=f0763a2f_6 [<https://perma.cc/23P5-VGKZ>].

145. *See id.*

146. *Id.*

147. *Id.* at 4.

148. *Id.* at 3.

149. *Id.* at 3.

150. *Id.* at 6.

151. *Id.* at 7.

152. Chloe Taylor, *Robots Could Take Over 20 Million Jobs by 2030, Study Claims*, CNBC (June 26, 2019), <https://www.cnbc.com/2019/06/26/robots-could-take-over-20-million-jobs-by-2030-study-claims.html> [<https://perma.cc/E77Q-4U3F>].

and is predicted to cause massive job loss, particularly in lower-income local economies.¹⁵³ Professor Cynthia Estlund highlights the perverse incentive employers have to employ less by automating more to escape the employer mandate of the ACA and the importance of moving away from a system of access that hinges so heavily on full-time and otherwise eligible employment.¹⁵⁴ Taking these projections into consideration, it would be wise for national leadership to take seriously the interplay of this possibility with the current landscape of American healthcare and to take action to create and protect reliable access to coverage unaffected by any significant changes in the American labor market.¹⁵⁵

The rise of the gig economy and prevalence of independent and freelance workforces also poses a challenge with respect to gig employers like Uber, Lyft, and Instacart who are protective of their workers' independent contractor status and therefore hesitant to offer any benefits that may threaten that status.¹⁵⁶ Certain of the mainstream labor platforms, like Uber and Postmates, have established partnerships with benefits startups to aid workers in their search for coverage.¹⁵⁷ These companies have not done much beyond that out of the concern that providing robust benefits will inadvertently lead to their workers becoming legally classified as employees, which will, in turn, cost these companies more once they are obligated to provide the full scope of employee benefits that those individuals would be entitled to.¹⁵⁸ While gig work and independent contracting can be attractive for their flexibility among other reasons, the lack of benefits entitlement (despite workers often logging full-time hours) will leave the portion of those in this sector relying on gig work for their full-time employment uninsured if a non-traditional benefits model system such as one of portable benefits is established.¹⁵⁹ A portable benefits system would allow for employer-contributed benefits to travel between jobs with the worker,¹⁶⁰ unless, of course, these workers are also employed full-time by an additional employer offering coverage upon which they

153. *Id.*

154. CYNTHIA ESTLUND, AUTOMATION ANXIETY: WHY AND HOW TO SAVE WORK 115-16 (2021).

155. *Id.*

156. Jennifer Sherer & Margaret Poydock, *Flexible Work Without Exploitation*, ECON. POL'Y INST. (Feb. 23, 2023), <https://www.epi.org/publication/state-misclassification-of-workers/> [<https://perma.cc/QW97-JKUH>].

157. Lydia DePillis, *Gig Economy Workers Need Benefits. These Companies are Popping up to Help*, CNN BUSINESS (Aug. 23, 2018), <https://money.cnn.com/2018/08/23/technology/gig-economy-worker-benefits/index.html> [<https://perma.cc/6R2H-5MZ9>].

158. *Id.*

159. Jonathan Gruber, *How Should We Provide Benefits to Gig Workers?*, BROOKINGS, (June 13, 2024), <https://www.brookings.edu/articles/how-should-we-provide-benefits-to-gig-workers/> [<https://perma.cc/TUL5-KQHA>].

160. Laura Padin, *Why Workers Need Real Portable Benefits*, NAT'L EMP. L. PROJECT (Mar. 24, 2025), <https://www.nelp.org/insights-research/why-workers-need-real-portable-benefits/> [<https://perma.cc/S5H5-3BFH>].

can rely. This would be crucial in protecting workers' ability to seek new employment within the gig economy without any concern that they will lose access to their benefits.¹⁶¹

Although insurance status does not necessarily guarantee care, having insurance is nonetheless a predictor of the quality and access to care, and race-related discrepancies in access to employer-based coverage are prevalent,¹⁶² stemming from the various difficulties Black, Indigenous, Latinx, and other communities of color have, throughout history, had to overcome to obtain employment. As of 2018, according to a Kaiser Family Foundation study of United States census data, 66% of white individuals had employer-sponsored insurance, as compared to 46% of Black individuals and 41% of Latinx individuals.¹⁶³ Moreover, it certainly does not bode well that race consistently plays a major role in hiring processes, with little improvement seen in hiring discrimination in several decades despite that many applicants, regardless of race, are similarly qualified for roles.¹⁶⁴ The lesser likelihood that Black and brown people secure employment that provides them with coverage compared to their white counterparts exposes yet another flaw in the employer-based insurance structure.¹⁶⁵ Exacerbating this problem is the fact that Black and brown workers have been far more likely to be in roles considered "essential," which means working on the front lines and putting their health at risk during events like the COVID-19 pandemic, for example, all while these roles are less likely to provide them with insurance.¹⁶⁶ As it stands, the system of employer-based health insurance has continued to uphold the structural racism which makes up the fabric of America. Reconsidering the status of healthcare as a human right rather than a privilege would provide a strong jumping point from which the U.S. could begin to address each of the aforementioned shortcomings created and/or maintained by the principles underlying the current system.

161. *Id.*

162. Bobbi M. Bittker, *Racial and Ethnic Disparities in Employer-Sponsored Health Coverage*, ABA: HUM. RTS. MAG. (Sept. 7, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/racial-and-ethnic-disparities-in-employer-sponsored-health-coverage/ [<https://perma.cc/8T3W-U8H9>].

163. *Id.*

164. Lincoln Quillian, Devah Pager, Arnfinn H. Midtbøen, & Ole Hexel, *Hiring Discrimination Against Black Americans Hasn't Declined in 25 Years*, HARV. BUS. REV. (Oct. 11, 2017), <https://hbr.org/2017/10/hiring-discrimination-against-black-americans-hasnt-declined-in-25-years> [<https://perma.cc/Y9ZQ-FJND>].

165. Rosemarie Day & Deb Gordon, Opinion, *Employer-Sponsored Health Insurance Contributes to Structural Racism*, HILL (Sept. 5, 2020), <https://thehill.com/news/515184-employer-sponsored-health-insurance-contributes-to-structural-racism/> [<https://perma.cc/PH3A-Z3ZG>].

166. *Id.*

IV.

EMBRACING A LEGAL ENTITLEMENT TO HEALTHCARE IN THE U.S.

A. A Universal Basic Services Approach to Healthcare as a Solution

One means of establishing a right to health and more effectively protecting access to care in the U.S. would be through the establishment of a single-payer system. Single-payer healthcare can be summarized as a system of insurance administered by a single entity—the payer—which collects spending money from public funding sources and individualized affordability-based taxes to fund every U.S. resident’s *unconditional* access to any medically necessary healthcare services.¹⁶⁷ In a single-payer system, there are not multiple insurance companies competing for clientele, and the pot of available funds from which the payer allocates payment for services eliminates insurance premiums and other financial barriers such as co-pays and deductibles, while still allowing individuals to choose the providers and facilities from which they receive care.¹⁶⁸ Representatives Jayapal and Dingell’s House Resolution titled “Medicare for All Act of 2021”—H.R. 1976—proposed creating a single payer national health program.¹⁶⁹ This program called for the provision of all medically necessary care meeting certain minimum standards for every person residing in the U.S., regardless of immigration status, to be funded by “global” and “operating” budgets created based on the expected revenues and expenses for a designated period,¹⁷⁰ similar to the way the U.S. currently funds other public resources; for example, fire departments and other emergency services.¹⁷¹ H.R. 1976 would also establish an Office of Health Equity to study health outcomes and barriers to care in order to make the necessary adjustments to healthcare infrastructure and practices to address these disparities¹⁷²—a critical means of measuring the population’s needs and the inefficiencies of the current system. Creating a care entitlement will also require greater investment in feasibility measures, which H.R. 1976 contemplates, as such an entitlement will be ineffectual without investment in the provision and protection of physical access to that care.¹⁷³ This includes, for example, the compilation,

167. *About Single Payer*, PHYSICIANS FOR A NAT’L HEALTH PROGRAM, <https://pnhp.org/what-is-single-payer/> [https://perma.cc/9EAK-DMTA] (last visited Oct. 11, 2025).

168. *Id.*; Andrea S. Christopher, *Single Payer Healthcare: Pluses, Minuses, and What it Means for You*, HARV. HEALTH PUBL’G (June 27, 2016) <https://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-201606279835> [https://perma.cc/8M3Y-FM74].

169. Medicare for All Act of 2021, H.R. 1976, 117th Cong. §§ 201, 611 (2021).

170. *See id.*

171. *Medicare for All Act of 2021*, PHYSICIANS FOR A NAT’L HEALTH PROGRAM (2021), https://pnhp.org/system/assets/uploads/2021/03/HouseBill2021_OnePager.pdf [https://perma.cc/N5DQ-MNLF].

172. *Id.*

173. *Id.*

monitoring, and analysis of data concerning geographical limitations to care and transportation weaknesses causing discrepancies in access.¹⁷⁴

A single-payer system contrasts with the current healthcare market where, as it stands, around 30 million individuals in the U.S. are uninsured, and for those with insurance, not all medically necessary services are covered by every health insurance plan.¹⁷⁵ There are also limits to the providers that policyholders can see for care covered by their insurance, which creates differences in the quality and kinds of care accessible,¹⁷⁶ and the fragmentation of the system makes it infeasible for costs to be controlled at every level.¹⁷⁷

B. Canada as a Comparator

The United States could look to its northern neighbor and signatory to the aforementioned international covenants for one example of a considerably successful universal single-payer healthcare system, particularly given its economic, financial, and cultural similarities to the U.S.¹⁷⁸ Americans would undoubtedly enjoy the primary benefits that Canadians currently do: fewer limitations on access to care, lower costs, and more freedom of choice.¹⁷⁹ Canada's system was also born out of similar disapproval for the existing system and its failure to provide access to care which motivated the various organized groups in the U.S. throughout the 20th century.¹⁸⁰

Canada currently employs a health insurance program run by its government that provides each person with a medical benefits package, with each province operating its plan slightly differently.¹⁸¹ Historically, the provinces were

174. *Id.* § 615.

175. *A Superior System: Single Payer Legislation vs. Affordable Care Act*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <https://pnhp.org/system/assets/drupal/A%20Superior%20System%20-%202013.pdf> [<https://perma.cc/EE7U-F4P9>] (last visited Mar. 22, 2026).

176. *See, e.g.*, Teresa A. Coughlin, Haley Samuel-Jakubos, Graeme Peterson, & Sharon K. Long, *Many Insured Adults Report Problems Trying to Find New Health Care Providers*, THE URB. INST. (Aug. 14, 2020), <https://www.urban.org/urban-wire/many-insured-adults-report-problems-trying-find-new-health-care-providers> [<https://perma.cc/DH5C-X6PU>].

177. *See* Drew Altman, *Our Fragmented Approach to Healthcare Costs*, KFF (Dec. 4, 2014), <https://www.kff.org/from-drew-altman/our-fragmented-approach-to-health-care-costs/> [<https://perma.cc/3E3W-PSP2>].

178. Goran Ridic, Suzanne Gleason, & Ognjen Ridic, *Comparisons of Health Care Systems in the United States, Germany and Canada*, 24 MATER. SOCIOMED. 112, 112 (2012) (describing Canada and the United States' similar economic institutions and similar healthcare spending at certain points in time prior to Canada's transition to the single-payer system).

179. Laura Santhanam, *How Canada Got Universal Health Care and What the U.S. Could Learn*, PBS NEWS (Aug. 31, 2020), <https://www.pbs.org/newshour/health/how-canada-got-universal-health-care-and-what-the-u-s-could-learn> [<https://perma.cc/5XAE-5M54>].

180. *Id.*; *see supra* Part I.

181. Ridic, Gleason & Ridic, *supra* note 178; Santhanam, *supra* note 179 (noting that undocumented immigrants are not provided coverage under the provinces' plans).

explicitly made the primary authorities over hospitals and were presumed to have primary authority over the healthcare services offered in each, with no uniformity.¹⁸² In the early 1900s, Thomas Clement Douglas nearly lost a limb as the result of a health condition his family could not afford to treat.¹⁸³ He went on to become the Social Democratic Premier of Saskatchewan and put in place a universal public health insurance program covering hospital care and physician services in the province, funded by provincial taxes.¹⁸⁴ Eventually, this system was adopted by the federal government and implemented throughout the rest of the country.¹⁸⁵ Over the course of many years and incremental steps in policy development, the Canada Health Act was passed.¹⁸⁶ Its basic tenets are public administration, comprehensiveness, universality, portability, and accessibility.¹⁸⁷ Public administration requires plans to be operated not for profit by a public authority.¹⁸⁸ Comprehensiveness requires that plans cover all insured health services provided by hospitals, physicians, or dentists.¹⁸⁹ Universality prohibits any preferential treatment based on individuals' ability to pay privately for their care.¹⁹⁰ Portability requires that insured residents be able to keep their coverage when moving throughout the country.¹⁹¹ Lastly, accessibility prohibits user fees from being charged for services that are insured publicly—funded by general tax revenues—such as doctor or hospital visits.¹⁹²

Canada's current system of delivery is largely defined by the 1984 Canada Health Act: all residents enjoy health coverage with zero out of pocket costs and private health insurance for covered services is unlawful in order to protect the integrity of the system.¹⁹³ However, Canadians are permitted to use, and do have, supplemental private insurance for uncovered services such as dental care.¹⁹⁴ Canada's system is financed in three tiers: the first tier including medically necessary hospital and physician services, the second including outpatient prescription drugs, home care, and institutional care, and the third including dental and vision

182. Danielle Martin, Ashley P. Miller, Amélie Quesnel-Vallée, Nadine R. Caron, Milkis Vissandjée, & Gregory P. Marchildon, *Canada's Universal Health-Care System: Achieving Its Potential*, 391 LANCET 1718, 1719 (2018), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7138369/> [https://perma.cc/F7KP-TKV5].

183. *Id.*

184. *Id.*

185. Santhanam, *supra* note 179, at 1.

186. Martin, Miller, Quesnel-Vallée, Caron, Vissandjée, & Marchildon, *supra* note 182, at 1720.

187. Canada Health Act, R.S.C. 1985, c. C-6, s. 7–11.

188. *Id.* at s. 8.

189. *Id.* at s. 9.

190. *Id.* at s. 10.

191. *Id.* at s. 11.

192. *Id.* at s. 12.

193. Ridic, Gleason, & Ridic, *supra* note 178, at 112–13.

194. *Id.*

care and outpatient physiotherapy.¹⁹⁵ Tier one is financed through general tax revenues and provided free to all Canadians; tier two is financed through public and private insurance as well as out of pocket payments; and tier three is financed almost entirely privately.¹⁹⁶ Physician reimbursement involves only the government and the provider—not patients—and costs are controlled with the use of an annual global budget (similar to that advocated in H.R. 1976) as well as predetermined physician fees, with the Canadian ministry funding the larger part of this spending.¹⁹⁷ In order to receive federal contribution, each province must satisfy the five basic tenets discussed above.¹⁹⁸ Given the foregoing factors, Canadians generally do not need to consider the possibility that a procedure or course of treatment will be the reason that they go bankrupt, or that job insecurity will create instability in their access to healthcare as well.

While H.R. 1976 died in Congress, its provisions can still become law if re-introduced in another bill. In the future, lawmakers and advocates attempting to advance a universal solution to healthcare would do a great service to this cause by prioritizing values similar to the five pillars that serve as the foundation for the Canadian system,¹⁹⁹ and H.R. 1976 shared these strengths. The universality prong would straightforwardly be satisfied, as the bill created an entitlement for “[e]very individual who is a resident of the United States,” without discrimination.²⁰⁰ Comprehensiveness would be satisfied, as individuals would be entitled to insured healthcare as well as “health-related services,” all of which would have been covered under the plan.²⁰¹ The bill proposed eliminating barriers to care, including by eliminating any required payment for benefits provided under the Act and providing services of equal quality and accessibility across geographic regions, in satisfaction of the accessibility prong.²⁰² Portability would have been satisfied, as the bill proposed that “[a]ny individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act” without any geographical limitations within the U.S., thus allowing for residents to find care from state to state.²⁰³ Lastly, the bill proposed eliminating profit from the provision of healthcare and a prohibition on providers using federal funds for capital expenditures or profit.²⁰⁴ It also proposed the Secretary

195. Martin, Miller, Quesnel-Vallée, Caron, Vissandjée, & Marchildon, *supra* note 182, at 1721.

196. *Id.*

197. Ridic, Gleason, & Ridic, *supra* note 178, at 113.

198. Santhanam, *supra* note 179.

199. Canada Health Act, R.S.C. 1985, c. C-6, s. 7–11.

200. Medicare for All Act of 2021, H.R. 1976, 117th Cong. § 102 (2021).

201. *Id.* § 101.

202. *See id.* §§ 101–102, 104.

203. *Id.* § 201.

204. *See id.* § 614.

of Health and Human Services as the administrator of the proposed system, satisfying the public administration prong.²⁰⁵

C. Counterarguments

The Canadian experience offers several lessons in the tradeoffs tied to the adoption of a single-payer system. First, when the cost of a necessity is eliminated, the demand for that product or service will almost inevitably rise.²⁰⁶ Wait times for certain procedures have become extraordinarily high, and there have been unfortunate instances in which patients pass away waiting for treatment.²⁰⁷ Additionally, access to available operating rooms and medical imaging technology can be made more scarce, leaving doctors to prioritize patient treatment based on their judgments of which patients are most in need relative to others.²⁰⁸ To attempt to address this issue, the Canadian system has taken to limiting access to certain kinds of care for efficiency's sake—in particular, post-acute care—which thus creates longer wait times for patients in need of care *after* serious injuries or illnesses.²⁰⁹ Admittedly, it is plausible that increasing access to care in the U.S. will similarly put additional pressure on its healthcare infrastructure, challenging its capacity and necessitating the creation of new ways to apportion what may become scarce resources.²¹⁰ Nevertheless, increased affordability creating increased demand and backlogs in access to care is arguably preferable to the status quo in the United States, which currently denies access to these resources on the basis of individuals' ability to pay, a condition violative of the principles provided by the aforementioned international covenants which the United States' has acknowledged (even if only aspirationally).

The American Association of Nurse Practitioners (AANP) conducted a study revealing that in 2023, “more than 40% of respondents have experienced a ‘longer than reasonable’ wait for healthcare.”²¹¹ Of those surveyed, 26% reported that they had waited more than two months to see a healthcare provider, and almost half of those who experienced unreasonable wait times gave up seeking care at all.²¹² In Canada, the median national wait time for specialty care referrals

205. See generally Medicare for All Act of 2021, H.R. 1976, 117th Cong. (2021) (identifying the Secretary of the Department of Health and Human Services to provide the mechanisms for implementation of this Act).

206. Ridic, Gleason, & Ridic, *supra* note 178, at 113.

207. *Id.*

208. Peter Cram, Irfan Dhalla, & Janice L. Kwan, *Trade-Offs: Pros and Cons of Being a Doctor and Patient in Canada*, 32 J. GEN. INTERNAL MED. 563, 563–64 (2016).

209. *Id.*

210. See Cram, Dhalla, & Kwan, *supra* note 208, at 563–64.

211. *Two in Five Americans Report Unreasonable Health Care Wait Times*, AM. ASS'N NURSE PRACS. (Jul. 12, 2023), <https://www.aanp.org/news-feed/two-in-five-americans-report-unreasonable-health-care-wait-times> [<https://perma.cc/8MCH-4UHG>].

212. *Id.*

between January 2014 and December 2016 was 78 days.²¹³ Certainly, it is foreseeable that wait times in the United States would increase with the elimination of some of the barriers to care; however, this might more justifiably be an argument for federal investment in the expansion of healthcare infrastructure and the physician workforce to increase the availability of providers and facilities from which care can be received. While the enactment of the ACA has brought about clear benefits with respect to access to healthcare,²¹⁴ the expansion of health insurance enrollment has exacerbated the nation's ongoing primary care and physician shortage.²¹⁵ There are regional differences in such access as well: much of the country's rural and inner-city populations are particularly under-resourced.²¹⁶

Such a set of initiatives—facilitating the formation of a single-payer system—would align directly with the requirements of the ICESCR as expressed in CESCR General Comment No. 14, calling for all individuals' "equal and timely access to basic preventive, curative, rehabilitative health services and health education."²¹⁷ Balancing the options here becomes a matter of whether we are willing to let people live knowing they will likely never receive care due to their financial limitations, or knowing that the care they seek is both realistically within their scope of access and foreseeable in the near future given the reduction or elimination of prominent hurdles. Further, accepting the former also means turning a blind eye to the prevalence of negative health outcomes that result from individuals' lack of access to coverage and care. Studies have confirmed a correlation between lack of coverage and unmet medical needs, the degree of illness progression at diagnosis,²¹⁸ and premature death.²¹⁹ Correlation also shows that adults without health coverage are more likely to fall victim to premature death than adults with coverage.²²⁰ Additionally, the experience of losing insurance has been linked to a

213. Claire Liddy, Isabella Moroz, Ewan Affleck, Emma Boulay, Sarah Cook, Lois Crowe, Neil Drimer, Laurie Ireland, Pamela Jarrett, Susan MacDonald, Derek McLellan, Ariana Mihan, Nico Miraftab, Véronique Nabelsi, Christopher Russell, Alex Singer, & Erin Keely, *How Long Are Canadians Waiting to Access Specialty Care? Retrospective Study from a Primary Care Perspective*, 66 CAN. FAM. PHYSICIAN 434, 434 (2020).

214. *See supra* Part III.

215. *See* Yanlai Ma, David Armstrong, Gaetano J. Forte, & Hao Yu, *Effects of the ACA Medicaid Expansion on the Compensation of New Primary Care Physicians*, 5 AM. HEALTH & DRUG BENEFITS 636, 639 (2022).

216. *Id.*

217. CESCR General Comment 14, *supra* note 103, ¶ 17.

218. Stefan Timmermans, Laura A. Orrico, & Jasmine Smith, *Spillover Effects of an Uninsured Population*, 55 J. HEALTH & SOC. BEHAV. 360, 361–62 (2014), <https://escholarship.org/uc/item/9cz3q5kt> [<https://perma.cc/8KWG-Q7AQ>].

219. Andrew P. Wilper, Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bor, & David U. Himmelstein, *Health Insurance and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2291–93 (2009).

220. INST. OF MED. COMM. ON THE CONSEQUENCES OF UNINSURANCE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 81–82 (2002).

decline in health status over time.²²¹ Zero or less extensive coverage has also proven negatively impactful, particularly where adults were affected by chronic health conditions.²²² Particularly with respect to adults 65 and older, having been insured in the past continuously provided for more positive health outcomes than those experienced by adults of similar age who had been previously uninsured.²²³ The positive and significant impact of health insurance on health outcomes provides robust support for the proposition that the United States' satisfaction of its obligation to uphold a right to health and feasible access to care would call for the investment in and expansion of coverage and care rather than the preservation of barriers which perpetuate the discrepancies in American health outcomes.

Another challenge to the implementation of a single-payer plan is the administrative burden of creating a government entity and then eliminating current coverage to transition into the new system. The implementation of the ACA saw difficulty in the informational aspect of a healthcare overhaul: alerting individuals to a program and their entitlements and then enrolling them in said program is onerous.²²⁴ H.R. 1976, however, recognized that transitioning into a new system requires time and would have such a transition occur over a two-year period.²²⁵ Implementing such a change will undoubtedly require expertise, thoughtfulness, and a strategy, but to argue against making a potentially widely beneficial decision on the basis of administrative difficulty would suggest that the ease and comfort of maintaining the status quo is more important than the critical evolution of the programs and policies that are so salient to the lives of many.

Moral hazard is another argument commonly invoked in the face of the expansion of any social safety net or other government-run program helping to ensure certain minimum standards of living.²²⁶ Some fear that with a decrease in the cost of obtaining certain products or services comes the incentive to increase the

221. *Id.* at 57–66.

222. J. Michael McWilliams, *Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications*, 87 MILBANK Q. 443, 475–80 (2009); see INST. OF MED. COMM. ON THE CONSEQUENCES OF UNINSURANCE, *supra* note 220, at 57–66.

223. McWilliams, *supra* note 222, at 469–72.

224. See LINDA J. BLUMBERG & JOHN HOLAHAN, THE URB. INST., THE PROS AND CONS OF SINGLE-PAYER HEALTH PLANS 3, 6 (2019), https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf [<https://perma.cc/7T9X-KHY3>].

225. Medicare for All Act of 2021, H.R. 1976, 117th Cong. §§ 106, 1001, 1002 (2021).

226. See, e.g., Liran Einav & Amy Finkelstein, *Moral Hazard in Health Insurance: What We Know and How We Know It*, 16 J. EUR. ECON. ASS'N 957, 958 (2018), <https://academic.oup.com/jeea/article/16/4/957/4992078> [<https://perma.cc/97KG-ADQ2>]; “Moral Hazard: The Myth of the Need for Rationing,” PHYSICIANS FOR NAT’L HEALTH PROGRAM, http://www.pnhp.org/single_payer_resources/moral_hazard_the_myth_of_the_need_for_rationing.php [<https://perma.cc/G2RT-72W3>] (last visited July 20, 2025); Shaila Dewan, *Moral Hazard: A Tempest-Tossed Idea*, N.Y. TIMES (Feb. 25, 2012), <https://www.nytimes.com/2012/02/26/business/moral-hazard-as-the-flip-side-of-self-reliance.html> [<https://perma.cc/MK9R-6CHH>] (“Moral hazard has long been used to explain why social safety nets like welfare, unemployment insurance and workers’ compensation should be less generous.”).

use of said product or service in a wasteful or abusive manner.²²⁷ A study on the Canadian city of Winnipeg, Manitoba and its residents' use of healthcare services in 1999 and 2000 revealed that most people still used very little healthcare based on their health status and that low-income and high-income residents made similar physician expenditures after the implementation of a universal system.²²⁸ This would suggest that moral hazard is not as negatively impactful as some make it seem.²²⁹ Proposals for the expansion of social safety net-type programs have also historically been framed as handouts by several of those in leadership, with much of the stigma also stemming from the perpetuation of the racist and misleading narratives of minoritized populations driving up the cost of welfare spending.²³⁰ President Reagan sought to diminish national support for welfare, invoking stereotypes about Black laziness and undeservedness which fostered resentment in white Americans relating to the contribution of their tax dollars to Black aid.²³¹ The reality is that more white Americans than anyone—white non-college educated people ages eighteen to sixty-four—are consistently among those advantaged by government safety net programs,²³² but these myths are still alive today and used to discourage national support for similar programs.²³³ Continuously causing people to accept such falsities for their truth—which certainly impacts societal understandings of similarly structured programs beyond just standard welfare programs²³⁴—only goes to restrict the bounds of what services could benefit

227. See Einav & Finkelstein, *supra* note 226, at 957–58.

228. Noralou P. Roos, Evelyn Forget, Randy Walld, & Leonard MacWilliam, *Does Universal Comprehensive Insurance Encourage Unnecessary Use? Evidence from Manitoba Says “No,”* 170 CAN. MED. ASS’N J. 209, 209–12 (2004).

229. *Id.* at 209–11.

230. See, e.g., Clare Bond Potter, Opinion, *The Shadow of Ronald Reagan Is Costing Us Dearly*, N.Y. TIMES (Nov. 11, 2021), <https://www.nytimes.com/2021/11/11/opinion/reagan-social-welfare.html> [<https://perma.cc/9LJ8-5KDZ>]; Bill Clinton, Opinion, *How We Ended Welfare, Together*, N.Y. TIMES (Aug. 22, 2006), <https://www.nytimes.com/2006/08/22/opinion/22clinton.html> [<https://perma.cc/7FTR-VWMF>] (reiterating his promise to “end welfare as we know it,” and “to make welfare a second chance, not a way of life” by implementing more demanding eligibility requirements); Alma Carten, *How Racism Has Shaped Welfare Policy in America Since 1935*, THE CONVERSATION (Aug. 21, 2016), <https://theconversation.com/how-racism-has-shaped-welfare-policy-in-america-since-1935-63574> [<https://perma.cc/CX34-X88A>].

231. Potter, *supra* note 230; Carten, *supra* note 230.

232. Ryan Sit, *Trump Thinks Only Black People Are on Welfare, But Really, White Americans Receive Most Benefits*, NEWSWEEK (May 25, 2018), <https://www.newsweek.com/donald-trump-welfare-black-white-780252> [<https://perma.cc/6SUM-6A4N>].

233. Omekongo Dibinga, *The Welfare Queen Myth: How Racist Stereotypes Still Shape America’s War on Poverty*, FULCRUM (Nov. 18, 2025), <https://thefulcrum.us/economy/welfare-queen-myth> [<https://perma.cc/6ZA6-8W4G>]; Naomi Bethune, *The ‘Welfare Queen’ Is Back, but She Never Quite Left*, AM. PROSPECT (Nov. 14, 2025), <https://prospect.org/2025/11/14/snap-welfare-queen/> [<https://perma.cc/F6DU-L5JF>]; Carl Hulse, *Reagan Invoked the ‘Welfare Queen.’ The New G.O.P. Target Is a Lazy Gamer*, N.Y. TIMES (Jun. 10, 2025), <https://www.nytimes.com/2025/06/10/us/politics/republicans-medicaid-cuts.html> [<https://perma.cc/6E2U-XDWE>].

234. See Bethune, *supra* note 233.

the entirety of the American public as the country continues to be tight-fisted when it comes to public welfare expenditures.

CONCLUSION

In such a wealthy nation, monetary resources should be distributed to ensure equitable access to the highest quality of care feasible and for as many as possible. While it may be difficult to predict with exactness whether the U.S. welcoming the establishment of a single-payer system is likely to create many pitfalls different from those that consumers already experience under the current system, it seems much more certain that that doing so would create significant benefits that those same consumers have likely never experienced as participants in the American system. While the Affordable Care Act was a major step in the right direction of recognizing the importance of increasing health insurance enrollment in the U.S., it falls short of creating an entitlement to *care* because of its existence within the fragmented and profit-based system which has adopted no such priority. One of the major strengths of single-payer systems is the prioritization of care as a public service rather than a good that one can privately acquire if they can afford it. Abandoning the commodification of healthcare will be the first step toward a healthier United States, and the widespread mobilization of scholars, healthcare professionals, legislators, and others in support of this cause will be critical toward reclaiming the humanity of the American healthcare system in which we recognize that the welfare and dignity of *all* human beings is a major contributing factor to a healthy and functioning society. Healthcare should be a given, rather than something to be earned, and no one individual is more or less deserving of adequate care as compared to any other. Keeping these principles in mind, lawmakers can feasibly, *finally*, create an American entitlement to healthcare, reaching the culmination of what several Presidential administrations started but have not yet successfully completed. Such a shift from a profit-driven to a human-centered approach will undoubtedly have a lasting impact on American health for decades to come.