

NESRI

National Economic and Social Rights Initiative

Why the New Health Reform Law Fails to Meet Human Rights Standards

Anja Rudiger, Ph.D.

Human Right to Health Program, NESRI

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The Human Right to Health

Governments have an obligation
to respect, protect, and fulfill

our “right to a system of health protection which
provides equality of opportunity for people to enjoy the
highest attainable level of health.”

International Covenant of Economic, Social and Cultural Rights
(legal interpretation, General Comment 14)

Recognition of the Human Right to Health

- Universal Declaration of Human Rights (Article 25) *
- American Declaration on the Rights and Duties of Man (Article 11) *
- Convention on the Elimination of All Forms of Racial Discrimination (Article 5) *
- International Covenant on Economic, Social and Cultural Rights (Article 12)
- Convention on the Elimination of All Forms of Discrimination Against Women (Articles 12 & 14)
- Convention on the Rights of the Child (Article 24)
- Convention on the Rights of Persons with Disabilities (Article 25)

*The U.S. has committed to these Declarations and Conventions

From Civil Rights to Human Rights

Human rights inhere in human beings
↔ **Civil rights** are granted by governments

Civil rights in health care:

- *Effective*: segregation within health care facilities, direct discrimination by providers, language access, etc.
- *Ineffective*: hospital closings, underserved areas, unequal quality of care, lack of culturally competent care, etc.

→ Civil rights: non-discrimination, integration, equality = procedural

→ Human rights: equity and universality = substantive

A Normative Framework for Health Reform

Challenge the prevailing policy paradigm:

- Commodity → human right
- Market competition → public good shared by all
- Individual responsibility → collective responsibility and government obligation

Why the New Health Law Fails to Meet Human Rights Standards

- **Market-based approach:** care is a commodity that is bought and sold
 - **Expansion of for-profit insurance:** mandates people to buy a product from an industry incentivized to maximize profit, not care
 - **Stratification:** separate tiers for different categories of people receiving different levels of care
 - **Health care rationed according to ability to pay,** age, geographical location, employment and immigration status
- Failure to pool all health risks, fully cross-subsidize costs, and guarantee access to care according to people's health needs.

Human Rights Principles and Standards

Health facilities, goods and services must be **accessible**, **available**, **acceptable**, and of good **quality** for everyone, on an equitable basis, everywhere in the country.

- Universality
- Equity
- Accountability

UNIVERSALITY in Health Insurance Reform?

Human Rights Strategy:
Including Everyone in a Universal, Unified System

The New Law's Strategy:
Improving Market Management through
Competition and Choice of Private Insurers

Does the New Law Meet Universality Standards?

- ***Everyone should have guaranteed access to health care, without discrimination or exclusions.***
 - ≠ 23 million people will remain uninsured.
 - ≠ Exclusion of those who can't afford coverage and, in addition, those who can't afford to use their coverage.
 - ≠ Requirement to buy an insurance policy is not a right to receive care: coverage may not fully pay for care (as little as 60% of the cost, not including co-pays) nor cover all needs (e.g. dental care).
 - ≠ Expanded coverage is not matched with more doctors, esp. for Medicaid patients (reimbursement rates not raised permanently).
 - ≠ Exclusion of immigrants (5-year bar to Medicaid/Medicare; undocumented barred from buying coverage in the Exchanges).

- ***Everyone should have access to care based on their health needs, not their ability to pay. Cost must never be a barrier to care.***

- ≠ Public subsidies for the purchase of private insurance for those earning under 400% of the federal poverty line (FPL). Yet costs will continue to remain high: At 250% FPL premium payments will amount to 8.05% of a person's annual income, plus co-pays, deductibles and out-of-pocket costs. At 400% FPL (\$43,000) subsidized premium payments will be 9.5% of income (\$4,115), out-of-pocket costs can reach up to \$4,147 per year, and co-pays and deductibles will be 30% of the insurance plan's value.
- ≠ Out-of-pockets costs of up to \$5,950 per year (\$11,900 families).
- ≠ Older people may have to pay up to 3 times more for coverage.

EQUITY in Health Insurance Reform?

Human Rights Strategy:

Providing Free, Pre-Paid Care as a Public Good

The New Law's Strategy:

Subsidizing Private and Safety Net Coverage

Does the New Law Meet Equity Standards?

- ***Disparities in access to care should be eliminated.***

= Specific provisions on racial health disparities: improvements to language & cultural access, data collection, workforce diversity

≠ Different groups of people will get different coverage (amount, type, price of insurance) and therefore different access to care.

≠ Disparities in access to reproductive health for women will be exacerbated.

≠ Disparities in access for immigrants will be exacerbated.

≠ Many geographical disparities will continue, as it is up to states how to set up Insurance Exchanges.

- ***Publicly financed care should be strengthened and expanded as the strongest vehicle for guaranteeing equal access.***

= Medicaid expanded to everyone with incomes up to 133% FPL (except many immigrants) but low payments to doctors continued.

+ Additional funding for community health centers

≠ No “public option”, no Medicare expansion

→ Entrenchment of private insurance as principal funding mechanism for health care by creating millions of mandated customers. No lever for government to ensure that health needs are prioritized over market incentives.

ACCOUNTABILITY in Health Insurance Reform?

Human Rights Strategy:
Ensuring Accountability to the People

The New Law's Strategy:
Increasing Security for Insurance Policyholders

Does the New Law Meet Accountability Standards?

- *Private companies and public agencies should be held accountable for meeting the populations' health needs.*

= Improved "consumer protections" through stricter regulation of insurance companies (no medical underwriting, minimum benefits, grievance and appeals mechanisms).

≠ No premium price controls, only reviews.

≠ No elimination of insurers' incentives to limit and deny care.

≠ Permits interstate sales of insurance policies which may lead to a race to the bottom.

≠ No full employer mandate to provide coverage or pay for public programs.

→ Health industry is accountable primarily to private interests (e.g. shareholders).

What Reforms Would Meet Human Rights Principles?

- A publicly financed and administered health insurance plan for everyone, guaranteed and continuous through life.
→ principle of universality
- Equitable public financing system with contributions based on ability to pay, not on health care use → principle of equity
- A democratic health care reform process that does not silence the majority of the population who sees health care as a human right
→ principles of participation and accountability

Next Steps for Human Right to Health Care Advocates

- Monitor and report impact of reforms on different communities, using human rights principles and standards.
- Encourage states to maintain or adopt more inclusive policies (immigrants, Medicaid eligibility, application procedures etc.).
- Support local efforts for the human right to health care (e.g. universal health care zones with community health centers as the hub, pilot projects with providers, needs assessments, preserving public hospitals etc.).
- Support state-based campaigns for universal health care, such as state single payer bills in California, Vermont, Minnesota, Pennsylvania, etc., and constitutional amendments for the right to health, e.g. in Montana.