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**THE CONSTITUTIONAL AND ECONOMIC IMPACT OF  
HEALTHCARE SYSTEM REFORM IN THE USA: THE PATIENT  
PROTECTION AND AFFORDABLE CARE ACT REVISITED**

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## INTRODUCTION

US economy provides for a series of unique features within its institutional and economic framework as its economic, social and legal attributes display a significantly more vivid picture of the key elements of its evolutionary paradigm than is the case in many of the most developed economies of the world today. In no measure lacking merit for a notion of such repute is the health care system of USA. Great many key legal cornerstones of its framework and (consequent) economic extremes thus display a highly unorthodox picture in several aspects.

While USA boasts considerably higher health care expenditures in virtually every respect when compared to other highly-developed economies, it, nevertheless, transcends a much more morose figure when it comes to the state of the overall population health. It trails most comparable economies by vast margins in a number of categories, life expectancy, child obesity, and amenable mortality being only a few of them, with a somewhat brighter - albeit not an exemplary one by any means - state of things in categories such as alcohol consumption, cancer survival rates, and the doctor-patient relationship and communication quality (Rice, Rosenau, Unruh, & Barnes, 2013). Also, evident disparities with respect to quality health care access within the nation itself persist, with worrisome variations regarding ethnicity, gender and income-based cohorts apparent but in no respect trailing incongruities that are, among other, geographical and migration status-related. And the sullen account of the current (and decades-long persisting) account of matters in the US health care system seems to persevere, with no obvious improvements accountable in the recent past with respect to the great many divergences, in spite of the fact that US health professionals are extremely-well trained, their hospitals among the best equipped in the world, and their technological advancement leading the way globally (Dolgin & Dietrich, 2011). The one obvious difference between the US and other developed economies' health care systems' attributes is the absence of a national universal system of health coverage in USA.

Due to the heavily federalist division of powers in the field of health care services and the consequent strong role private sector interest groups and rent-seeking stakeholders play in the US health care system (Derickson, 2005), the government's inability to remedy or at least significantly alleviate stacking problems (until recently the most plaguing one being transcended in the form of 50 million uninsured persons) has become increasingly more apparent, manifesting itself in the clear skewness in the distribution of the uninsured towards those with lower effective incomes (Rice et al., 2013). The much needed set-up of a (low-quality) back-up system for the poor, near-poor and the working-poor cohorts of the population, along with the publicly-subsidized care for the elderly, has, however, resulted in huge (and further increasing) cost shifting, where taxpayers and/or the insured subsidize those lacking health insurance by effectively covering the fallouts in costs, consequently driving up the premiums and the costs of health coverage, thus creating a poisonous spiral of inflating costs (Reid, 2009).

The aforementioned failures clearly reflect the USA-specific inherently complex, and above all, unsuccessful efforts at improving the state of the health of the population at (preferably) lower cost. A landmark reform of the system from the economic, health, and social perspective has thus been much overdue.

On March 23, 2010, the Patient Protection and Affordable Care Act (hereafter: ACA, or Act), the most comprehensive reform of the US health care system up-to-date, was signed into law. The ACA aims to transform the non-group insurance market by mandating that majority of its residents obtain health care coverage, significantly expands public insurance via the Medicaid program, and heavily subsidizes private insurance coverage. It also purports to raise additional revenues from a variety of new taxes, and reduces and reorganizes spending under the nation's largest health insurance plan, Medicare. Pending full implementation, the ACA purports to lead to a dramatically different US health care landscape (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006).

The purpose of the thesis is to first provide a meaningful insight into the chief attributes with respect to the organizational structure, the paradigm evolution and the international comparison of the US health care system features, thus providing effective groundwork for the relevant analysis of the modified-ACA implementation effects on selected categories. Analysis thus rests divided into two integral parts: (i) the first, addressing the constitutional aspects of the ACA enactment by analyzing its implementation from the standpoint of the axioms of US federalism with regards to the (potential) necessity of federal regulatory authority imposition in the realm of interstate (non)commercial matters, and reviewing the scope of matter-related judicial activism, both of the above delivered by way of in-depth analysis of relevant statutory provisions' interpretation and thereof arising case law, and (ii) the second, dealing primarily with the economic aspects of the health care reform, chiefly by highlighting the estimated (near-)immediate effects of ACA provisions' full implementation on selected economic categories, as well as by reviewing the resulting changes with respect to the effective health care coverage expansion and the US income distribution . As means to achieving reliable conclusions, the following hypothesis sets are introduced and challenged:

**H1:** Evident disparities in the access to health care in USA exist.

Upon acceptance, conditional hypotheses are as follows:

- (i) Disparities are predominantly the consequence of the absence of universal health care availability.
- (ii) The existence of Medicare and Medicaid programs is the key reason for the persisting nature of the working-poor's lack of health care coverage.



**H2:** The ACA-mandated Medicaid expansion and the individual requirement mandate are unconstitutional, and as such represent a breach of federal powers with respect to the provisions of the Commerce Clause of the Constitution.

Upon acceptance, conditional hypotheses are as follows:

- (i) The individual requirement mandate is nominally construed as a penalty, and as such cannot be brought to effect under the provisions of the Taxing and Spending Clause.
- (ii) The unconstitutionality of individual requirement mandate and/or Medicaid expansion cannot be severed from the remainder of the bill, thus effectively rendering the whole of ACA unconstitutional.
- (iii) There should be a judicially set rule defining the difference between encouragement and coercion with respect to federal government's financial leveraging of the states in cases of federally-imposed changes to the state-administered but predominantly federally-financed programs.

**H3:** ACA will markedly worsen the federal government's fiscal position relative to the previous law as it will significantly increase federal spending.

Upon acceptance, conditional hypothesis is as follows:

- (i) The estimated considerable inflow of newly insured persons will prompt substantial increases in medical services' utilization, further increasing health care costs and hindering access to quality services.

**H4:** Respective states' deferral/rejection of entry into the new ACA-mandated Medicaid scheme will prompt comparatively smaller decreases in the share of uninsured persons when compared to states opting to enter the new scheme.

**H5:** ACA implementation will change the net incomes of citizens at all income levels. Upon acceptance, conditional hypotheses are as follows:

- (i) The individual requirement mandate provision will effectively impose new taxes on the middle class and high-earners but will at the same time prompt the increase of net incomes of comparatively poorer individuals.
- (ii) ACA enactment will bring about greater net income marginal benefits to the younger cohort than to the prime age citizens.

The methodology of the thesis is based on description, analysis, and finally synthesis of the presented data in order to sustain relevant findings. In line with the intricately dual nature of the primary research aspects of the thesis, the constitutionality-addressing part is in large

part based on the selected US jurisprudence, federal case law and various other legal sources as to facilitate adequate constitutionality analysis. Additionally, specific segments of the Supreme Court of The United States (hereafter: SCOTUS, or Court) opinion in the *National Federation of Independent Business v. Sebelius* (2012) case are used extensively as to provide better insight into the possible implications for future US health care system modifications with regard to the scope of federal power as defined by the Commerce Clause of the Constitution. Conversely, the economic overview of the likely consequences and immediate effects with respect to the selected economic categories is backed by secondary statistical data and descriptive analysis of the estimated effects. Also, extensive use of relevant literature and findings of relevant studies dealing with income distribution, fiscal implications of insurance coverage effects, is featured, thus providing a meaningful insight into the relevance of ACA implementation with respect to the abovementioned economic categories. Conclusion is drawn from the probable effects in both aspects, presenting the implications for the likely future workings of the health care system in USA.

Due to the still-ongoing implementation of ACA, the economic analysis its enactment cannot yet base its findings on real effects. Even though both short- and long-run forecasts provide some additional information, they are, nevertheless, highly dependent on a number of correlated factors, rendering a precise estimation unattainable as of yet. Additionally, the judicial reversal of ACA-mandated federal "coercive" power with respect to the states' which decline to take part in the newly expanded Medicaid program, has resulted in several states denying to enter the new scheme, thus bringing about yet another highly variable crucial element when analyzing overall economic effects of ACA. Research inhibitions thus dictate reliance on historical findings in addition to the usage of up-to-date data in order to sustain reliable analysis.

Four chapters make up the thesis. Initial chapter first embarks upon the brief explanation of the constitutional structure of USA and its federal outlays, continuing on with a rough sketch of the US system of health care framework and its evolutionary development.

Second chapter initially provides a detailed account of the key health expenditures- and population health-related features of USA in the recent decades' run-up until today, further strengthening the overall illustrative effect in the following pages by adding on an international comparison as to add another perspective to the overall in-take. The chapter concludes by addressing the recent ACA-enactment and highlighting its key provisions.

Third chapter addresses the constitutionality of the most contested ACA provisions by initially putting forward the evolution of the relevant jurisprudence, thus adequately facilitating the understanding of the legal challenges put forward to ACA. The second part of the respective chapter deals with the SCOTUS opinion in the *National Federation of Independent Business v. Sebelius* (2012) case, dissecting it by selected relevant segments and addressing the rationale behind each as it produces and explains viable respective objections.

Fourth chapter encapsulates the estimated direct economic impacts of ACA implementation. The extensively addressed forecasted budgetary implications are followed

by estimates of ACA net effects with respect to the US overall health spending trend in the near future. Next follow the estimated health insurance coverage effects, which provide a telling insight into the differing forecasted net changes with respect to different cohorts of persons. Lastly, income distribution effects are addressed, presenting different scenarios with regard to the initial income definition.

Conclusion clusters the chief findings of the thesis by way of addressing the hypotheses' contentions, and wraps up by offering a potential insight into the future of the thesis-addressed problem development.

## **1 SELECTED FEATURES OF US CONSTITUTIONAL STRUCTURE AND US HEALTH CARE REFORM**

The United States of America is a federal constitutional democracy, where the decision-making authority rests divided between the federal government and the state governments of the constituting 50 states. Power is shared among the executive, the legislative, and the judicial branch of the government. The President of the USA (hereafter: president) is the head of the executive branch and is elected every four years but limited to serve a maximum of two four-year terms. The United States Congress (hereafter: Congress) represents the bicameral legislative branch of the federal government by comprising the Senate (made up of two members per state, each elected for a six-year term in office, 100 members in total) and the House of Representatives (altogether consisting of 435 two-year term in office serving members, with the membership share of each state derived approximately by the respective state's population).

The judicial branch of the federal government is made up of SCOTUS, which has nine members, called Justices (hereafter: J.), who are appointed upon presidential nomination and confirmed by Congress for life, and various federal district and appellate courts, all of which stand subordinated to SCOTUS in judicial matters of federal nature. At the state level, each of the states has a popularly elected governor heading the state executive branch. The term of the governor is in all states, except in New Hampshire and Vermont, limited to four years. All of the states' legislatures, with the exception of Nebraska, are bicameral. States further vest local power in local municipal authorities as dictated by laws of the respective state. The Constitution of the United States delegates the original jurisdiction with respect to the interpretation and application of state laws to the appointed judiciaries of the states, each headed by respective State Supreme Court.

### **1.1 Nature of US Federalism and the Role of SCOTUS**

The Constitution of the United States determines the workings of US federalism by designating to both the federal government and the states the specific responsibilities and obligations by way of the X. Amendment to the United States Constitution (hereafter: Constitution), an integral part of The Bill of Rights, ratified in 1791 (Rice et al., 2013). In addition, the “residual powers clause” in the X. Amendment to the U.S. Constitution mandates that *“the powers not delegated to the United States by the Constitution, nor*

*prohibited by it to the States, are reserved to the States respectively, or to the people*” (U.S. Const. amend. X). The exact interpretation of the residual powers clause has throughout history been defined anew by relevant case law as delivered by the judiciary. Consequently have for more than two centuries the invested powers shifted regularly between the federal and state governments. SCOTUS, acting as the chief interpreter of the relevant provisions of the Constitution and thus as the effective enabler of the expansion of powers, rose up to play an instrumental role in the development and mediation of the power sharing processes between the federal and state levels. For example, SCOTUS *Plessy v. Ferguson* (1896) ruling effectively facilitated racial segregation on the state level, only to be subsequently thrown out by the unanimous *Brown v. Board of Education* (1954) opinion. To a degree of even greater importance in the field of federalist and commercial matters was the so-called SCOTUS-facilitated Lochner Era<sup>1</sup>, which greatly forwarded governmental decentralization; in turn increasing the power of the states. The latter was subsequently, nonetheless, greatly reversed and even marginalized by the vast expansion of the federal authority during and after the onset of The Great Depression (hereafter: great depression) by a series of landmark decisions of the Hughes and later the Stone Court. Following an unprecedented liberal streak of the groundbreaking SCOTUS opinions in the post-World War II (hereafter: WWII) era, the last three decades have again seen a gradual resurgence of state power at the expense of federal power, a feature ascribable mainly to the increasingly more conservative leaning of SCOTUS and at times almost uniformly political rulings of the Court.

## 1.2 US Health Care System Overview

In a similarly federalist fashion, public administrative powers in the US health care sector are also divided between the federal and respective state governments. US health care system can thus be perceived as a *"set of multiple systems that operate independently, and, at times, in collaboration with each other"* (Rice et al., 2013, p. 25).

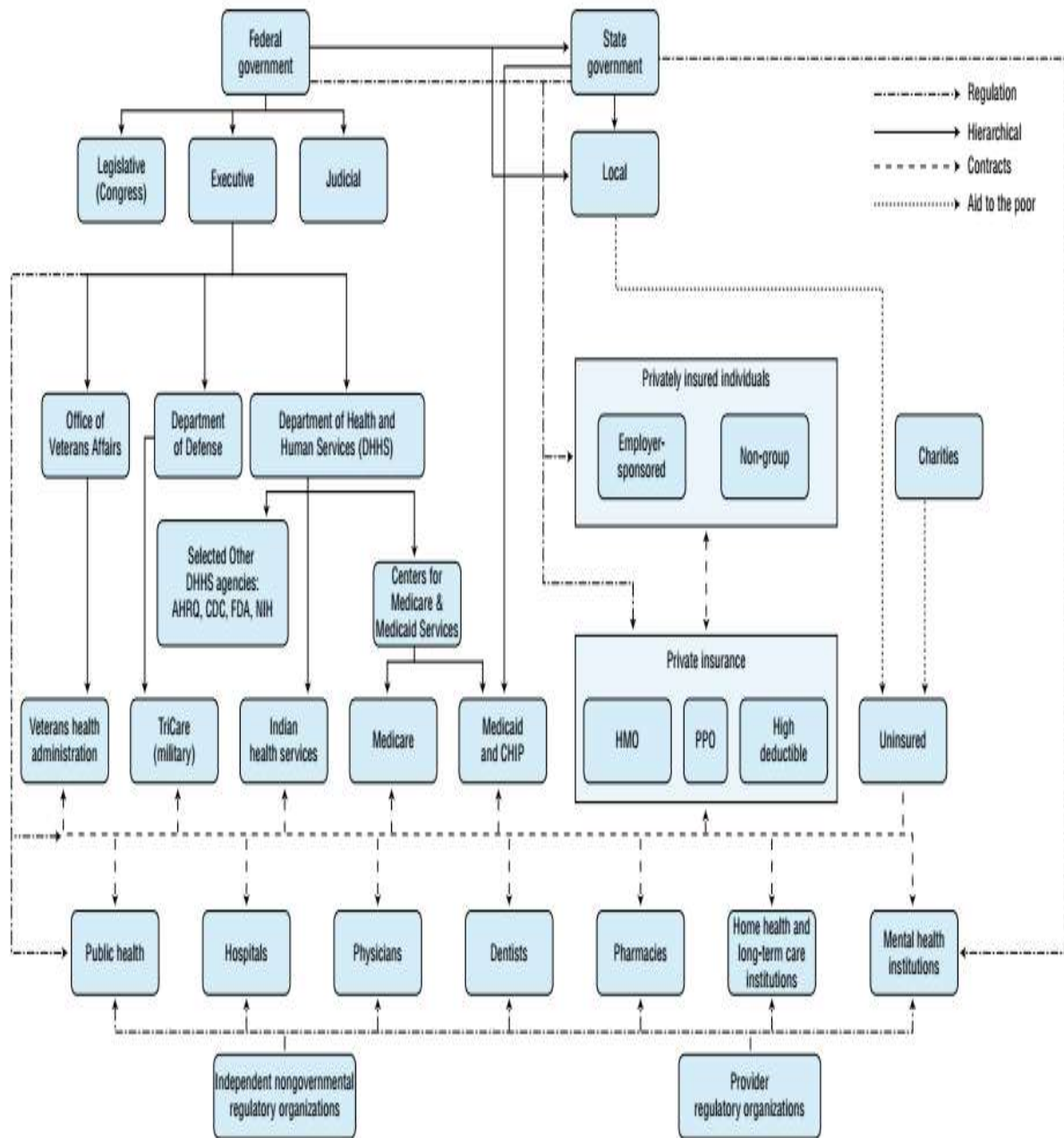
Rice et al. (2013) argue that private sector interest groups and rent-seeking stakeholders play a considerably stronger role in the US health care paradigm when compared to majority of other highly developed economies. It was, after all, the private sector that embarked upon the spearheading of the health care system development as early as the 1930s, surpassing by over three decades the landmark federal government health coverage programs, Medicare and Medicaid (Rice et al., 2013). Medicare provides insurance for individuals above the age of 65 (elderly) years and for some cohorts of the disabled, while Medicaid generally facilitates health care services for the economically vulnerable individuals and households. Both governmental and private parties acquire health services from health care providers, which are subject to regulatory provisions as defined and

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<sup>1</sup> A popular name for the period in US legal history in which SCOTUS made frequent use of the so-called "substantive due process" doctrine as to be able to strike down federal mandates that were perceived as an infringement upon the freedom of contract (Bernstein, 2005). The name is analogue to the *Lochner v. New York* (1905) landmark case that marked the era's commencement (*Lochner v. New York*, 198 U.S. 45, 1905).

administered by the federal, state and local authorities, as well as by private business entities with regulatory powers designated to them by the public authorities (Rice et al., 2013). The framework of the US health care system as shown in Figure 1 thus comprises four key players: (i) government, (ii) insurers, (iii) providers, and (iv) public and private regulators (Rice et al., 2013).

Figure 1. Organization of US health care system in 2013



Source: Rice et al., *United States of America: Health system review, 2013*, p. 27, Fig. 2.1.

Government actors are made up of parties on three levels - federal, state and local. With respect to the executive branch of the federal authority, the United States Department of

Health and Human Services (hereafter: HHS) is arguably the largest and most encapsulating of the administrative parties. Under HHS umbrella operate numerous public agencies, among them the Centers for Medicare and Medicaid Services (hereafter: CMS), which is delegated the responsibility for the day-to-day running of the Medicare and Medicaid programs, the Children's Health Insurance Program (hereafter: CHIP), the Food and Drug Administration (hereafter: FDA) and the National Institutes of Health (hereafter: NIH) (Rice et al., 2013; HHS, 2012).

Public purchasers, again, include both federal and state agents, of which the largest public purchaser by far is the Medicare program, the aim of which is to provide almost universal health care coverage for those aged above 65, some of the disabled and those with end-stage renal disease (U.S. Census Bureau, 2010). State governments exercise a degree of discretionary power at administrating Medicaid and CHIP programs but are, however, subject to federal regulations, since it is the federal funds that represent the bulk of the financial input with regard to financing the two programs in question, covering primarily poor mothers and their children (U.S. Census Bureau, 2010; Rice et al., 2013). Nevertheless, Medicaid also covers disabled adults, subsidizes long-term care services in the event of individuals running out of their own assets, and - congruently with Medicare - low-income individuals above the age of 65. State and local governments are effectively involved in the provision of health care services in a number of different capacities that strive to facilitate the poor and/or the near-poor and other disadvantaged individuals and households in obtaining health care (Rice et al., 2013), chief among them being the operating of public hospitals, the facilitation of health care services by way of operating health care departments under their respective jurisdiction, as well as the administration of various other public health activities (Rice et al., 2013; HHS, n.d.).

In an analogue manner as is the case of public purchasers, private business entities and individuals obtain health care as well. Private health care insurance falls predominantly into three categories: (i) health maintenance organizations (hereafter: HMO), (ii) preferred provider organizations (hereafter: PPO) and high-deductible plans (Rice et al., 2013). An overwhelming majority of US citizens with private insurance obtain it via his/her employer, with less than 10 percent of the insured having obtained it individually as of 2009 (Rice et al., 2013). Nevertheless, in the corresponding year there were over 50 million US citizens lacking any kind of health care coverage, thus constituting almost 17 percent of the total US census and approximately one fifth of all non-aged adults (U.S. Census Bureau, 2010). Nevertheless, there is a back-up mechanism of public and community clinics in place in order to provide health care services to the uninsured - and, if need be, the underinsured - even though the quality of the services it provides varies greatly (Rice et al., 2013).

Regulation of the US health care system also takes place on three distinct levels: federal, state and private. Vast majority of the federally administered regulation falls within the scope of the HHS powers (HHS, n.d.).

### 1.3 Federal Health Care Reform Efforts

Subject to the evolving constitutional interpretation, the organization of health care coverage in USA was almost exclusively in the domain of the states ever since the founding of the nation in 1776 until well into the 20th century. The earliest comprehensive, yet limited, federal health care proposal level was the so called Bill for the Benefit of the Indigent Insane in 1854, which sought to establish asylums for the indigent insane, the blind and the deaf (Downs, 2012). The bill was, however, vetoed by president Franklin Pierce, who perceived social welfare as the sole responsibility of the states and consequently outside the scope of federal power. Following the American Civil War, federal government did, however, establish the first federally funded system of medical care in the war-torn territory of the former Confederacy (Derickson, 2005), as it constructed 40 hospitals and thus enable the treatment of well over a million of sick and dying former slaves. The system did not, however, last long, as it was abolished by 1870 due to fierce opposition of the local population and the states (Derickson, 2005).

According to Walt, Schiffman, Schneider, Murray, Brugha and Gilson (2008), it was the onset of the industrial sickness coverage which by the end of the 19th century employers made possible to acquire for their employees that stands arguably as the most influential of the economic origins of the current US health care paradigm, as it was relatively cheap and thus affordable for the industrial workers to purchase. In the absence of any generalized industry scheme, the small scale and the already-existing administrative capacities kept costs low. The purchasers were almost exclusively employees of the same company, an attribute acting well as an effective regulation mechanism to prevent the already sick individuals from joining in subsequently (Walt et al., 2008). Furthermore, Derickson (1997) contends that the relatively early start of such employer-based sickness schemes explains why the mechanism of public health care coverage never really took off in USA at the time when the United Kingdom (hereafter: UK), along with most of the countries of Western Europe, had already been moving toward socialized schemes.

Nevertheless, in the first two decades of the 20th century, as majority of the industrialized European countries were laying the groundwork necessary for the set-up of universal publicly-administered health care coverage programs, progressivism was on the rise and gaining influence in USA as well (Elshtain, 2002). Noteworthy efforts commenced with the Socialist Party's public endorsement of the idea of a federal scheme to cover individuals in cases of accidents, unemployment, sickness, and old age. The Progressive party took part as well, calling for federal regulation of, among other matters, interstate corporate entities, but also for the conservation of natural resources and the advancement of women's rights, all of the aforementioned standing out as radically new concepts at the time (Engel, 2002). It also rigorously fought for the prohibition of child labor, the imposition of minimum wages for female workers, mandatory compensation for work-related accidents and diseases, and *"the general protection of home life against the hazards of sickness, irregular employment and old age through the adoption of a system of social*

*insurance*" (Navarro, 1989a, p. 387). In the aftermath of the fierce state-by-state campaign for the adoption of employee compensation bills, it turned its attention to sickness insurance, "*the next great step in social legislation*" (Numbers, 1978, p. 52). However, following the entry of USA into World War I (hereafter: WWI) and especially after the communist takeover in Russia, most states quickly lost interest and the momentum was lost (Birn, Brown, Fee, & Lear, 2003), prompting a two decade-long erosion of any noteworthy popular support for compulsory health care coverage, lasting well into the great depression. Even then, in spite of president Franklin D. Roosevelt's stern moving forward with the key New Deal legislation, health insurance was, however, deliberately excluded, chiefly due to the adverse opposition of organized medicine and its allies (Birn et al., 2003). As time passed, universal health care coverage, nonetheless, kept gaining increasingly larger share of public focus and in 1948 president Truman officially endorsed the notion of a federally-run universal health care coverage. But the looming and ever more increasing paranoia of the Cold War ideology and the conservative-backed populist witch hunts prompted a formidable antireform movement that successfully inhibited health care reform efforts at all levels (Derickson, 1997).

In the absence of any noteworthy political alternative, privately organized health insurance coverage grew exponentially, a feature best encapsulated by the growth of the number of individuals with some sort of private health care coverage in the 1940s and 1950s (69 million individuals obtained some sort of health care insurance anew in the 1939-1950 period, soaring from 6 million to 75 million) (Birn et al., 2003). Aside from the fact that employer contributions to employee health care coverage plans were not considered taxable income for the employees (Gabel, 1999), there were also economies of scale evident in purchasing via a group, with premiums tending to decrease due to reduced concern with respect to the problem of adverse selection. The aforementioned attributes all worked in favor of private sector-based health care coverage and thus greatly help in explaining the hasty pace at which private health coverage grew at the time (Cunningham, 2011). With no systematic public program to provide health care insurance until the mid-1960s, demand could only be facilitated through the employer-based system of health care coverage. Consequently, according to Rice et al. (2013), by the end of the 1950s, three quarters of US citizens had obtained some sort of health care insurance, although only 27 percent of their total medical expenditures were effectively covered by it. The additional problem lay in the fact that retired cohort and those lacking full-time employment were seldom not left out the scheme (Birn et al., 2003).

By the late 1950s, popular pressure started focusing increasingly more on the health-related needs of the elder population. Political reformists thus established the so called "Medicare strategy" and strove to tie it to the campaign advocating a set-up of a national program of hospital coverage for those above the age of 65 (Marmor, 2000). Organized labor soon lent its support, same as did a wide range of public health and social welfare stakeholders (Marmor, 2000). Not before long, however, fervent resistance arose from the health providers, the insurance sector, conservative political organizations and numerous



politicians. Nevertheless, in March 1965, the first federal health coverage programs, Medicare and Medicaid, were established (Campion, 1984). At its inception *"Medicare was divided into two parts, of which (i) Part A: Hospital Insurance effectively stood for social insurance, funded by payroll taxes on the working population, while (ii) Part B: Supplemental Medical Insurance, covered outpatient and physicians' visits, and, although voluntary, was purchased by nearly all seniors since 75 percent of the premiums was paid from the general federal revenues. Medicaid, in contrast, reflected a welfare model in that only those who met both income and certain categorical eligibility requirements could receive the coverage, which was largely provided free of charge"* (Rice et al., 2013, p. 35).

Soon after the passage of Medicare and Medicaid, invigorated by the successful implementation, calls for universal health care coverage arose and became increasingly louder (Davis, 1975). Among them was a proposition by Congressman Ronald Dellums, who introduced what was in many ways the most far reaching measure in a bill, effectively calling for a national health care service, a rough predecessor to the subsequent ACA (Starr, 1982). However, due to the worsening economic outlook and the rampant stagflation accompanying the oil shocks of the 1970s but also owing to the alarming increases in health care costs, none of the proposals gained significant political ground (Birn et al., 2003). The arrival of the Reagan administration to Washington, however, transcended totally different ideas, focusing mainly on the reduction of federal regulatory intervention and the downsizing of the already existing social programs. While Medicaid program experienced a number of painful cuts, Medicare remained in large part unhindered, mostly due to the political mobilization of the elderly (Birn et al., 2003). According to Navarro (1989b), however, strong grassroots support for national health care reform is to be credited with ultimately leading to president Clinton's reform efforts in 1993 and 1994 (Hecl, 1995). In spite of the latter's failure, numerous popular grassroots movements advocating universal health coverage *"engaged in political activities, small and large, including mass demonstrations, lobbying members of Congress and other elected officials and campaigns for state and local referenda"* (Birn et al., 2003, p. 91).

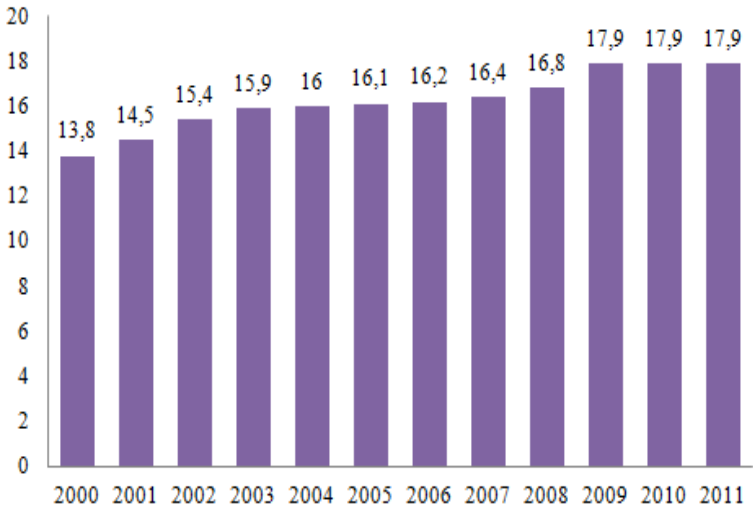
## **2 SELECTED ECONOMIC INDICATORS OF US HEALTH CARE**

Despite the numerous reform efforts by various civil groups and society stakeholders, by the end of the 20th century USA had (un)successfully established a distinct position among the developed economies with respect to its effective failure in providing health care coverage and effective health care services to a vast number of its residents (Reid, 2009). Large parts of the population thus experienced lacking or even no health care services because they were unable to afford health care coverage but were too well off to be eligible for government assistance, de-facto constituting the so called working-poor class, with many more facing bankruptcy as a direct result of the stacking medical bills (Reid, 2009).

## 2.1 Overall Health Care Expenditures

The situation comes across as an almost surreal one in the light of the fact that USA actually boasts considerably higher health care expenditures than any other country with respect to both absolute and per capita indicators (in 2011, US total health care expenditures exceeded US\$2.7 trillion as real per capita expenditures increased to 17.9 percent of GDP (Fig. 2), an over 300 percent increase over the 1970-2011 period). Additionally, according to Truffer, Klemm, Wolfe and Rennie (2010), US health care spending is estimated to increase to approximately US\$4.5 trillion by 2019 and thus altogether comprise roughly 19.3 percent of GDP in the corresponding year.

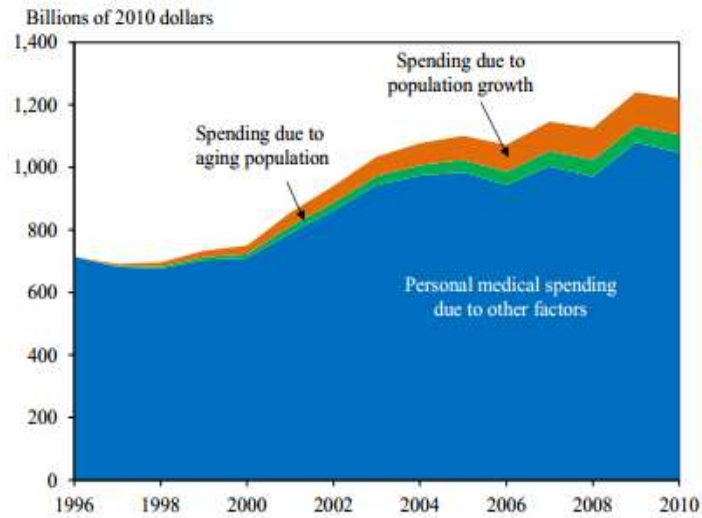
Figure 2. US total health care expenditures as percentage of GDP in 2000-2011 period



Source: Truffer et al., 2010 *Financial Outlook For Medicaid*, 2010, p. 19.

The spiraling increase in health care costs is in part attributable to the demographic changes (Rice et al., 2013). Of the real increase in spending on personal care in the 1996-2010 period, such as, for example, prescription drugs, office-based visits and hospitalizations, 11.5 percent is down to the changing age structure of the population, with additional 22.8 percent ascribable to the increase in the size of the population (Fig. 3) (White House, 2013). Moreover, CMS (2011a) estimates population aging is likely to turn into an increasingly more important driver of the spiraling health care expenditures in the coming years, as by 2030 one in five US citizens is estimated to be aged above 65 (costs in 2011 were approximately three times greater for those aged 65 and over than for younger individuals (HHS, 2011c), compared to only one in eight in 2011 (CMS, 2011a). Nevertheless, the greatest portion of US health care spending increase has historically not been directly attributable purely to population growth and/or its ageing, thus reflecting the overwhelming importance of increases in the use of medical services and inflation-exceeding increases of unit costs with respect to the issue at hand, as depicted in Figure 3 (Rice et al., 2013; HHS, 2011c).

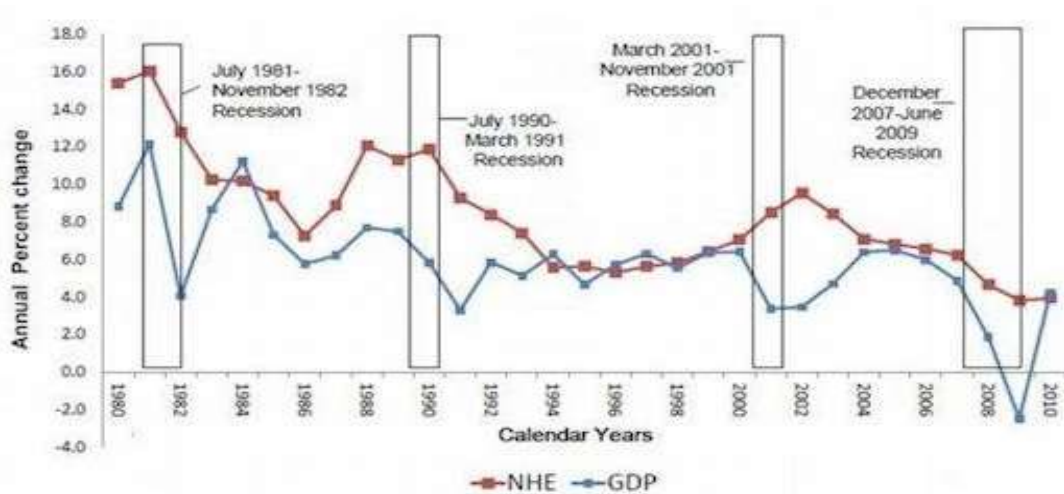
Figure 3. Contribution of population growth and population ageing to US total health care expenditures in 1996-2010 period (in billion 2010 US\$)



Source: White House, *Reducing costs and improving the quality of health care*, 2013, p. 163, Fig. 5-2.

Historically, the growth of US total health care spending has outpaced that of GDP, even though the rates over the last four decades have declined in growth (Fig. 4). Rice et al. (2013) identify as the main "culprit" for reduced growth rates - particularly in the 1990s - the proliferation of restrictive managed care practices. The decline in the rate of growth since the mid-2000s seems more puzzling, however. Partly it is almost certainly related to the impending financial constraints, since it is impossible to sustain health care expenditure growth in times of a largely stagnant national economy in the long run (CMS, 2012), a point additionally backed by the increase in the number of those lacking coverage, the growth in insurance premiums and the rise in cost-sharing requirements (Rice et al., 2013).

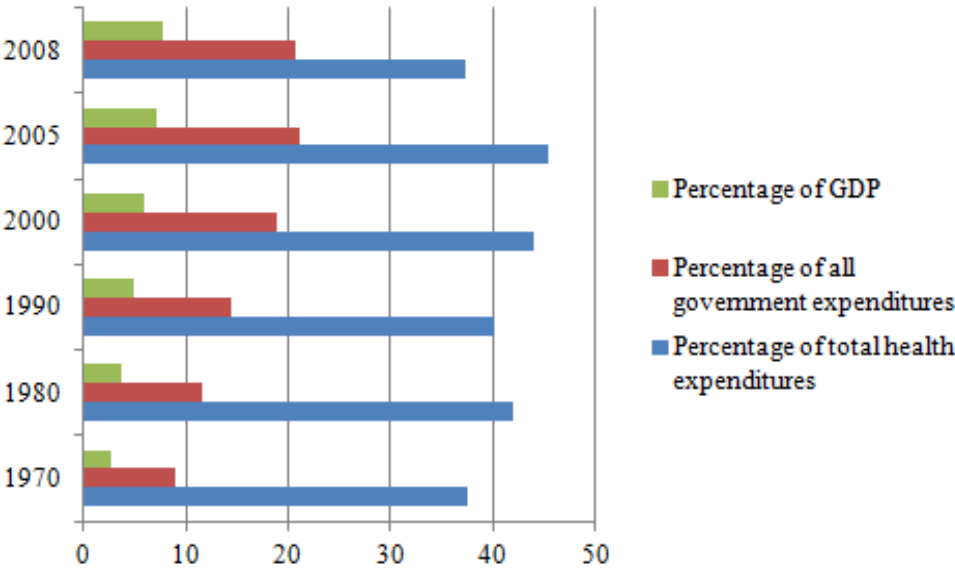
Figure 4. GDP and US total health care expenditures (NHE) growth (in US\$) in 1980-2010 period



Source: CMS, *National health expenditures tables*, 2012, p. 2, Table 2.

US public sector alone has also manifested evident increases in health care spending in the 1970-2008 period (Fig. 5). Compared to 1970, the public share of total national health expenditures in 2008 increased by 9.8 percentage points, from 37.5 up to 47.3 percentage points (CMS, 2012) as the proportion of health care expenditures in the total government spending rose from 8.9 percent in 1970 to 20.7 percent in 2008, prompting the share of GDP with respect to government spending on health care to almost triple since 1970 (CMS, 2012).

Figure 5. Respective percentages of US public health care expenditures by selected years



Source: CMS, National health expenditures tables, 2012, pp. 2-4.

### 2.2 Underlying Reasons for the Spurring Growth of Health Care Expenditures

One possible explanation for the spurring growth of US health care expenditures pertains that the past long-term growth of wages in the health care industry has not been accompanied by corresponding technological progress which would enable the facilitation of labor-reducing measures (RAND, 2010). The theory of the so-called “cost disease” notes that *“labor-saving technological progress has led to significant increases in labor productivity and hence wage growth in parts of the national economy”* (Baumol & Bowen, 1966, p. 303), an attribute notably more frequent in the manufacturing sector than in the service sector. To remain competitive with respect to employee acquisition and retention, the comparably more labor-intensive industries are consequently forced to increase their wages. Due to their lower productivity growth, this *“results in an increase in the relative cost of output in these labor-intensive industries, as higher costs are passed on to consumers in the form of higher product prices”* (Baumol & Bowen, 1966, p. 305; Nordhaus, 2008). Nordhaus (2008) proves that labor-intensive sectors generally exhibited increasing relative prices in the 1948-2001 period but also finds that shifts in labor from industries marked by extensive labor-saving technological progress to those that remained

relatively labor-intensive resulted in the decrease in the total productivity growth, owing to the fact that the share of labor-intensive sectors in the overall output has risen steadily from the 1950s onward (Nordhaus, 2008). Nevertheless, US health care sector indeed has experienced substantial technological progress, as radical new therapies, devices and procedures have been introduced over the years, allowing for a number of medical conditions to be treated with considerably greater effect than ever before (RAND, 2010). On the down side, even though some of the impressive technological advancements in the health care sector have been channeled to labor-saving measures, most of its results have, however, proven to be of effectively complementary nature to the expensive specialist labor. Thus, even though technological breakthroughs in clinical effectiveness inarguably have led to notable increases in medical productivity, they have simultaneously caused the cost per treatment to balloon as well (RAND, 2010).

Smith, Newhouse and Freeland (2009) find that - instead of facilitating a relatively non-variable demand for health care services at a lower cost - technological advancement has significantly contributed to an overall increase in its demand. Hall and Jones (2007) argue that, after having achieved a certain satisfactory level of consumption, individuals opt to spend their extra income on health care services to accommodate possible life extension rather than on additional consumption in the present. Consequently, in times of economic conjecture people are more likely to spend increasingly more on health care services in comparison to other commodities (Hall & Jones, 2007). According to Smith et al. (2009), this purportedly massive income effect on the demand for health care services is also manifest via the enlargement of institutional mechanisms. They find that income growth significantly affects health care spending growth, primarily by way of actions of public players on behalf of the large health coverage pools (Smith et al., 2009).

In contrast to the impressive growth in all aspects of medical productivity, not all increases in medical expenditures are necessarily productive. Of the numerous sources of spending inefficiencies in the health care sector, several stand out as key sources of waste, starting with the one contending that not all patients are uniformly provided with necessary health care due to the sheer complexity and the consequent fragmentation of the system of its delivery, in turn leading to complications and readmissions, particularly for those suffering from chronic illnesses (Cutler & McClellan, 2001). According to McGlynn, Asch, Adams, Keeseey, Hicks, DeCristofaro and Kerr (2003), the problems of duplicated care and unnecessary cases of over-treatment stand even further worsened by the existence of the widespread payment mechanism that determines physicians' pay based on the number of admissions and/or medical services rendered. In that respect, over-extensive use of medical equipment comes at a particularly high cost (McGlynn et al., 2003). Moreover, the failure to provide medical services according to the generally adopted "best practices" contributes to apparent inefficiencies as well (Skinner, Fisher, & Wennberg, 2005). Fraudulent payment practices, chiefly in the form of false insurance claims, also add up to the inefficiency of the system by producing yet additional waste. They are not, however, limited to fraudulent payments alone, but spill over to the costs imposed by the

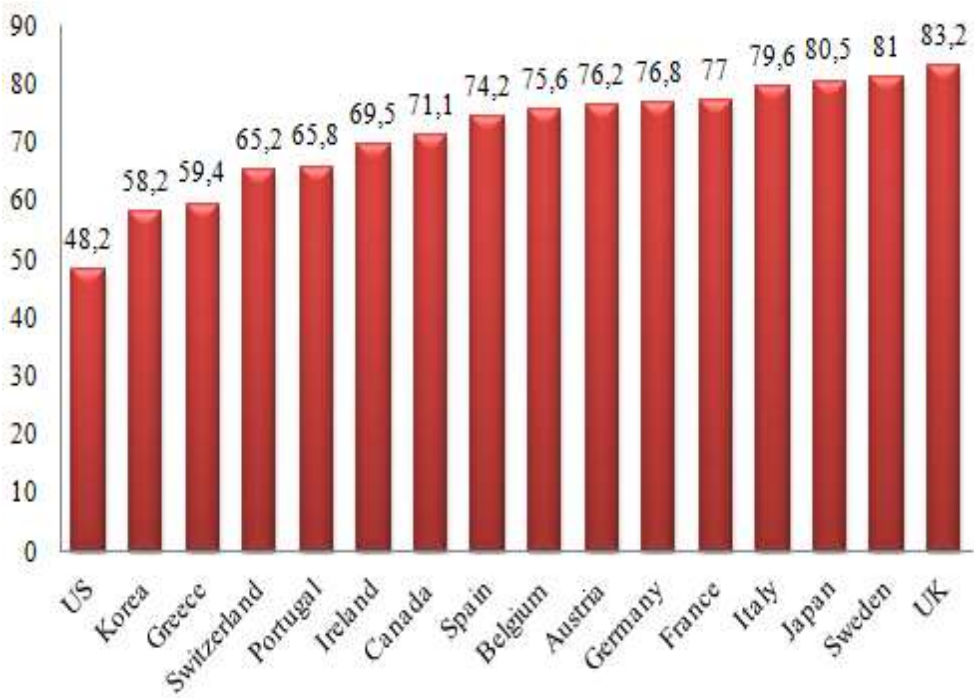
administrative burden imposed on the non-fraudulent providers who are thus made to adhere to the consequent regulatory checks and requirements (McGlynn et al., 2005).

Berwick and Hackbarth (2012) estimate that all of the aforementioned system imperfections combined accounted for between 13 and 26 percent of US total health spending in 2011.

**2.3 International Comparison by Selected Indicators**

The share of US public health care expenditures with respect to all public expenditures in 2010, as illustrated in Figure 6, was considerably lower than that of any of the other high-income OECD countries (after the 48.2 percent figure for USA, the next smallest share was that of Republic of Korea at 58.2 percent, followed by Greece at 59.4 percent), with OECD median in 2010 standing at considerably higher 75.6 percent, with the UK, Japan and some West European countries standing even above it (OECD, 2011a, 2011b).

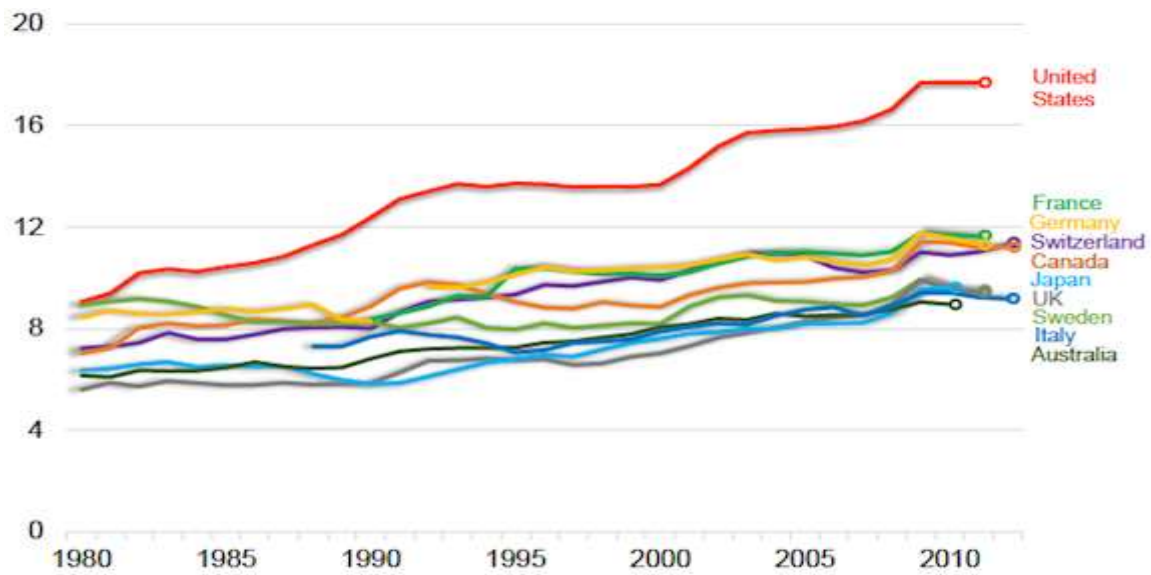
Figure 6. Public health care expenditures as percentage of total health care expenditures in 2010 in selected countries



Source: OECD, Health at a Glance 2011 - OECD Indicators, 2011a, p. 148.

Conversely, total health care spending in USA as share of GDP has consistently exceeded that of other OECD economies since 1970 (Fig. 7), and the gap has been growing even larger (in 2010, total health care expenditures of the majority of developed economies accounted for between 7 percent and 11 percent of GDP with the sole exceptions of Canada, France, Germany, and Switzerland just exceeding 11 percent, compared to almost 18 percent for USA (OECD, 2013a, 2013b).

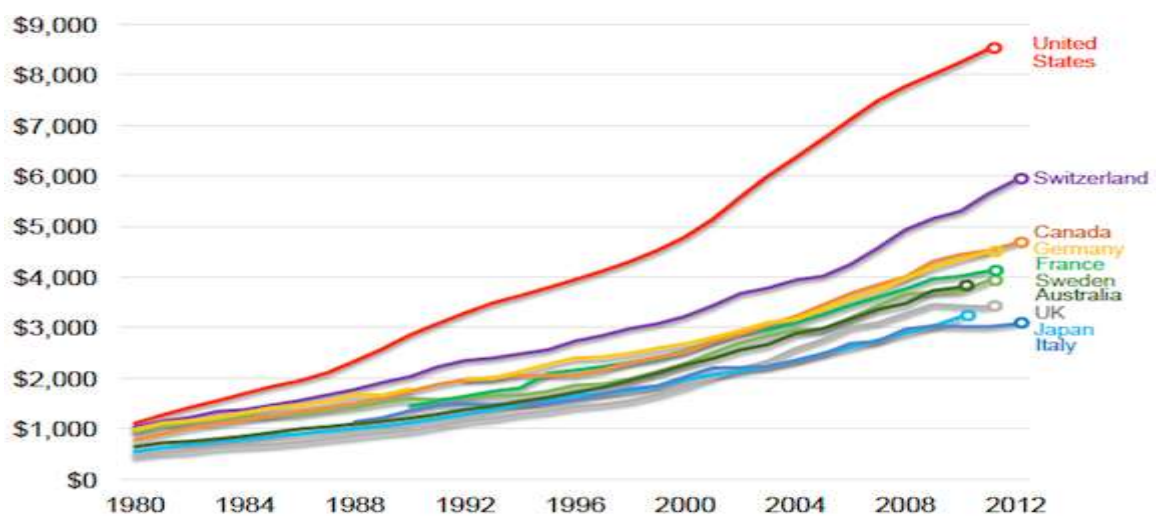
Figure 7. Total health expenditures as percentage of GDP in 1980-2012 period in selected countries



Source: OECD, *Health at a Glance 2013 - OECD Indicators*, 2013a, p. 157, Fig. 7.2.1.

Per capita health spending in USA has increased tremendously over the past four decades (measured in US\$ PPP dollars) (Fig. 8). This increase, however, is equivalent to or even below those experienced by Australia, France, Ireland, Norway, Spain and the UK in the corresponding period (OECD, 2013a, 2013b). Nonetheless, standing at US\$8508 in 2011, USA still spent 157 percent more per capita than was the OECD median, which stood at US\$3309, and approximately 51 percent more than the second highest country in that respect, Switzerland at US\$5643 (Fig. 8) (OECD, 2013a, 2013b).

Figure 8. Total health expenditures per capita (in US\$ PPP) in 1980-2012 period in selected countries



Source: OECD, *Health at a Glance 2013 - OECD Indicators*, 2013a, p. 155, Fig. 7.1.1.

And even though USA has exhibited marked increases in life expectancy and clear reductions in most types of mortality over the recent decades, other high-income countries have demonstrated similar trends, some with even evidently hastier improvements in that regard. USA has thus not improved its relative standing and continues to stagnate with respect to indicators such as overall life expectancy, infant mortality and potential years of life lost. While USA does boast one of the lowest smoking rates, it is on the other hand crippled by the highest obesity rate in the world as of 2012 (OECD, 2013a; Rice et al., 2013).

US life expectancy at birth has steadily increased, rising from 70.8 years in 1970 to 77.9 in 2007 (Table 1). The increase in males (12 percent) fairly surpasses that in females (8 percent), though, owing in greatest part to increased health awareness and improved working conditions (Brooks, Walsh, Mardon, Lewis, & Clawson, 2002). Age-adjusted mortality has declined by 38 percent in the corresponding period, landing at 760.2 deaths per 100,000 inhabitants in 2007 (Table 1) (HHS, 2011a).

Table 1. Life expectancy (in years) and mortality rates (per 100,000 persons) in USA by selected years

	1970	1980	1990	2000	2005	2006	2007
<b>Life expectancy at birth</b>							
All persons	70.8	73.7	75.2	76.8	77.4	77.7	77.9
Male	67.1	70.0	71.8	74.1	74.9	75.1	75.4
Female	74.7	77.4	78.8	79.3	79.9	80.2	80.4
<b>Age-adjusted death rate per 100,000 population</b>							
All persons	1222.6	1039.1	938.7	869.0	798.8	776.5	760.2
Male	1542.1	1348.1	1202.8	1053.8	951.1	924.8	905.6
Female	971.4	817.9	750.9	731.4	677.6	657.8	643.4

Source: HHS, *Healthy People 2020 Final Review, 2011a, section 16-3.*

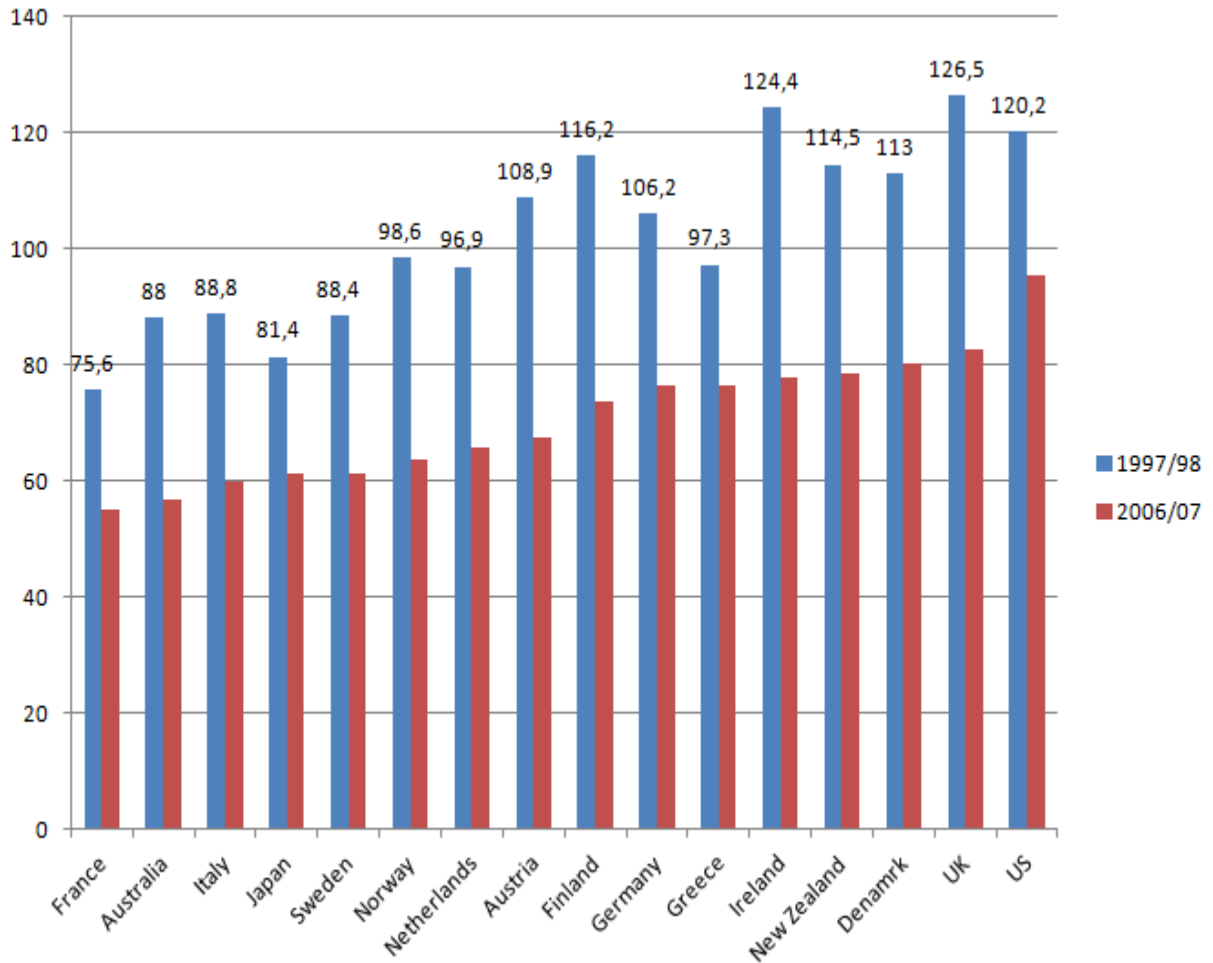
In the 2006-2007 period, USA had the highest rate among the most developed countries with respect to amenable mortality<sup>2</sup>, surpassing France, the country with the lowest figure, by approximately 75 percent (Fig. 9) (Rice et al., 2013), and the UK, the second worst country in that respect, by as much as 16 percent. Even though US rate had decreased by over 20 percent in the previous nine years, other countries’ rates declined more quickly (see Fig. 8). For example, Ireland, which had had a higher rate than USA in the 1997-1998 period, experienced the greatest decline (42 percent) among all of the most developed countries (Fig. 9) (Rice et al., 2013). Schoenbaum, Schoen, Nicholson and Cantor (2011, p. 416) attribute the lackluster US performance compared to other countries with respect to amenable mortality rates by blaming “a high rate of uninsured and a fragmented delivery system with relatively weak primary care and poor coordination of care between providers and sites.” Muenning and Glied (2010, pp. 2111-2) reject the contention that the relatively

<sup>2</sup> Defined by Nolte and McKee, (2011, p. 2103) as “premature deaths from causes that should not occur in the presence of timely and effective health care.”



"more socioeconomically diverse population than in other countries" stands out as the the party to blame by pointing out that "fifteen-year survival for non-Hispanic whites is deteriorating more rapidly relative to other comparison nations than is survival for Americans overall [and that] high homicide and accident rates also do not appear to explain poor US performance in health outcome measures."

Figure 9. Mortality amenable to health care in 1997-1998 and 2006-2007 periods in selected countries (in deaths per 100,000 persons)

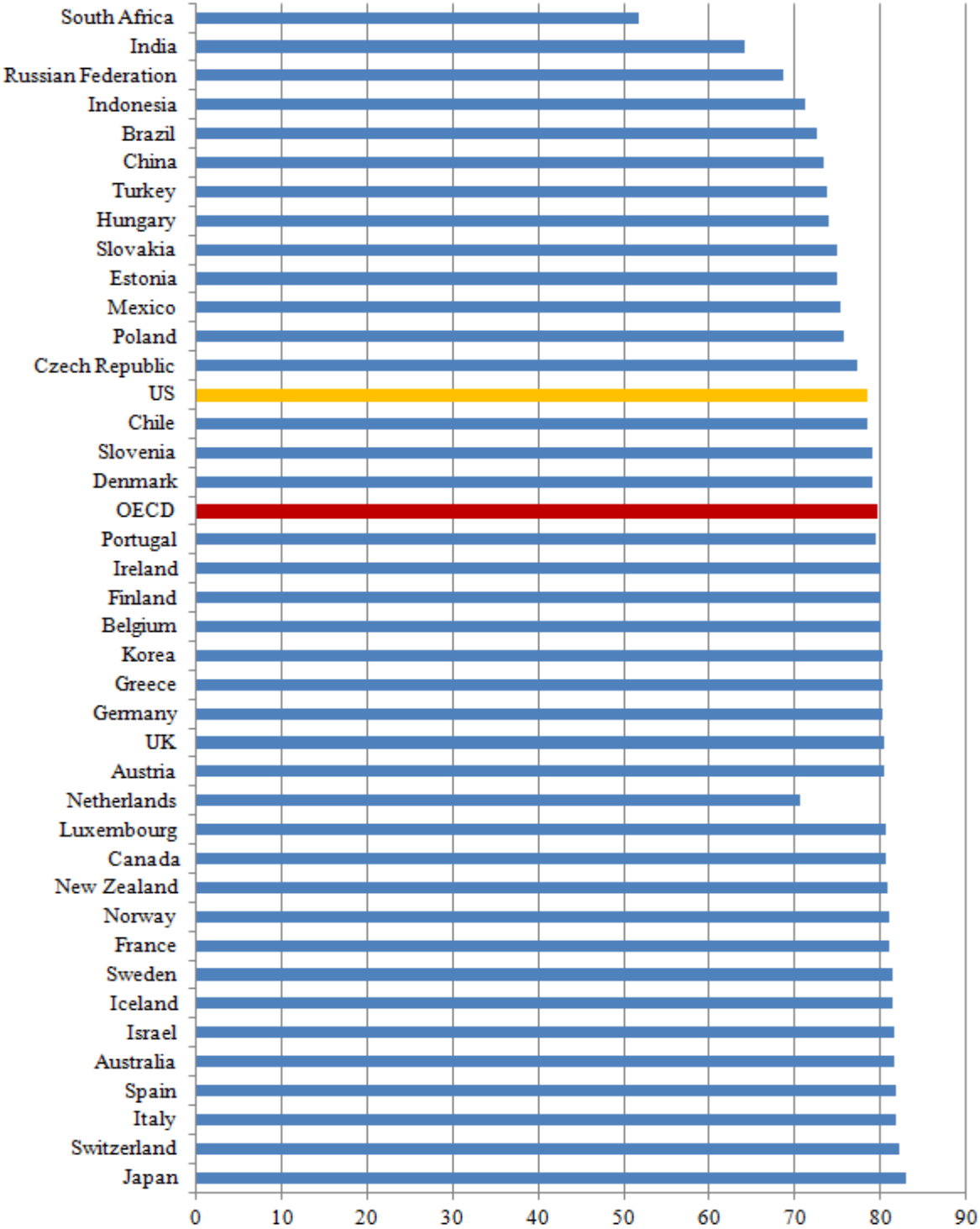


Source: Rice et al., *United States of America: Health system review, 2013*, p. 340.

USA was ranked sixth lowest of the 28 high-income OECD countries in terms of life expectancy in 2009, standing at 78.2 years, lagging behind Chile at 78.4 years (Fig. 10) (OECD, 2011a). The only developed countries positioned lower were the former East European socialist countries: the Czech Republic, Estonia, Hungary, Poland and Slovakia (OECD, 2011a). Also, the relative position of USA has worsened over time as US citizens have gained precious little in terms of additional years gained to life expectancy (Fig. 11). In this regard, USA is only positioned ahead of some of the most developed European countries which already boast some of the highest life expectancies at birth (Norway, Sweden, Netherlands, Denmark) and, again, the post-transitional countries of Eastern

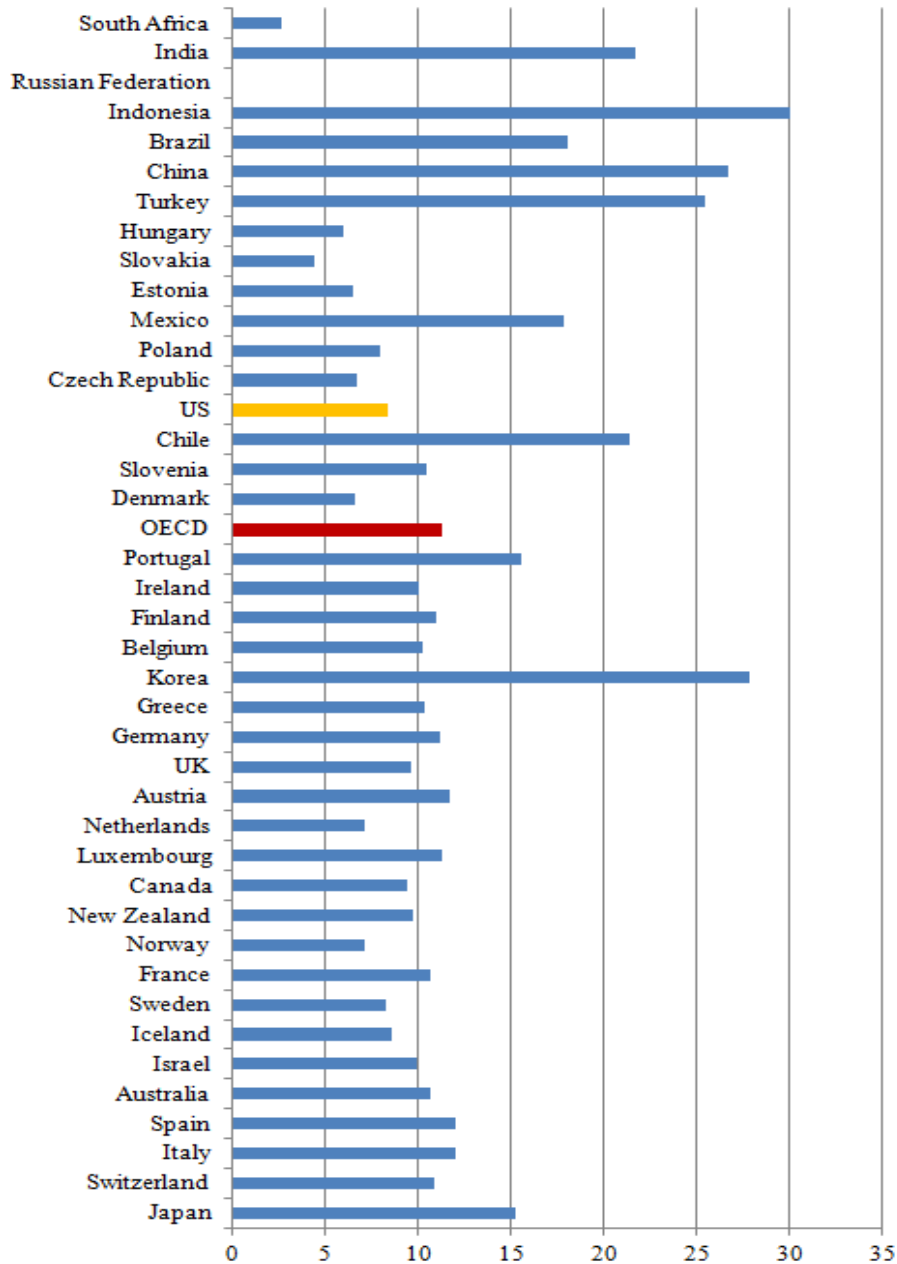
Europe (OECD, 2011a). In 1980, for example, US life expectancy stood approximately at the OECD median, exceeding that of countries such as Austria, Belgium, Germany and the UK, all of which have by 2009 greatly surpassed USA (OECD, 2011a).

Figure 10. Life expectancy at birth in 2009 in selected countries (in years)



Source: OECD, Health at a Glance 2011 - OECD Indicators, 2011a, p. 7.

Figure 11. Additional years gained with respect to life expectancy at birth in 1960-2009 period in selected countries



Source: OECD, *Health at a Glance 2011 - OECD Indicators, 2011a*, p. 8.

A similar pattern persists regarding US infant mortality rate. Overall death rates per 1000 live births declined by 36 percent in the 1985-2006 period, to 6.7 (Table 2), with approximately the same respective decreases in both neonatal and post-neonatal categories (HHS, 2011b). There are, however, notable differences with respect to ethnicity, with rates for Whites (3.7, and 1.9, respectively), Hispanics/Latinos (3.7, and 1.7, respectively) and Asians/Pacific Islanders (3.2, and 1.4, respectively) significantly lower than those for Blacks/Africans (8.7, and 4.2, respectively) (Table 2). Rates for the latter were thus almost three times higher than those for Whites in 2009 (HHS, 2011b).

Table 2. Total infant, neonatal and post-neonatal mortality rates in USA by selected years  
(in deaths per 1,000 live births)

	1985	1990	1995	2000	2005	2006
	<b>Infant deaths per 1000 live births</b>					
<b>All Mothers</b>	10.4	8.9	7.6	6.9	6.9	6.7
White	8.6	7.2	6.3	5.7	5.8	5.6
Black or African American	18.3	16.9	14.7	13.6	13.6	13.3
Hispanic or Latina	8.8	7.5	6.3	5.6	5.6	5.4
Asian or Pacific Islander	7.8	6.6	5.3	4.9	4.9	4.5
American Indian or Alaska Native	13.1	13.1	9.0	8.3	8.1	8.3
	<b>Neonatal deaths per 1000 live births</b>					
<b>All Mothers</b>	6.8	5.7	4.9	4.6	4.5	4.5
White	5.8	4.6	4.2	3.8	3.8	3.7
Black or African American	12.3	11.1	9.6	9.1	8.9	8.7
Hispanic or Latina	5.7	4.8	4.1	3.8	3.9	3.7
Asian or Pacific Islander	4.8	3.9	3.4	3.4	3.4	3.2
American Indian or Alaska Native	6.1	6.1	4.0	4.4	4.0	4.3
	<b>Post-neonatal deaths per 1000 live births</b>					
<b>All Mothers</b>	3.6	3.2	3.6	2.3	2.3	2.3
White	3.2	3.7	2.2	1.9	2.0	1.9
Black or African American	6.3	5.9	5.0	4.3	4.3	4.2
Hispanic or Latina	3.2	2.7	2.1	1.8	1.8	1.7
Asian or Pacific Islander	2.9	2.7	1.9	1.4	1.5	1.4
American Indian or Alaska Native	7.0	7.0	5.1	3.9	4.0	4.0

Source: HHS, *Maternal and Child Health: Neonatal And Post-neonatal Mortality, 2011b*, p. 27.

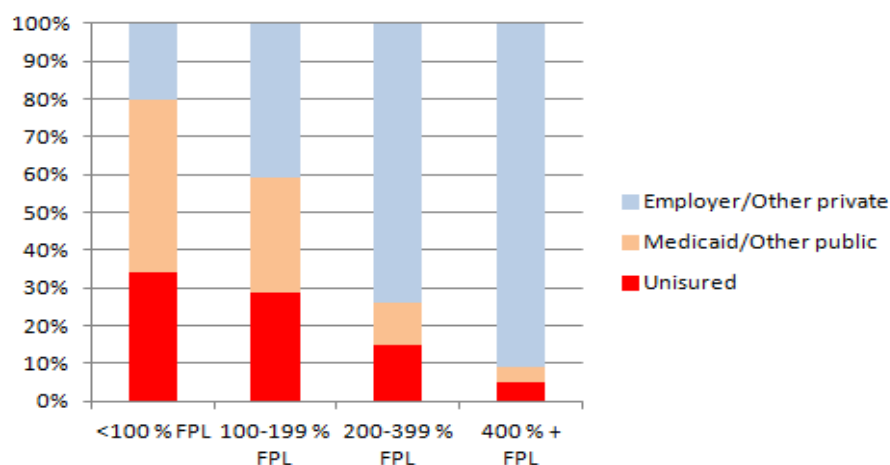
## 2.4 Microeconomic Distortions

In 2009, there were 50.7 million US citizens uninsured at a particular point in time within the year, thus constituting 16.7 percent of the total US census and approximately 20 percent of those under the age of 65 years (non-elderly) (U.S. Census Bureau, 2010; Congressional Budget Office (hereafter: CBO), 2010). This signaled a considerable worsening of the situation when compared to approximately 40 million uninsured just 10 years earlier – a 25 percent increase in comparison to just a 10 percent increase in total population (U.S. Census Bureau, 2010). According to Rice et al. (2013, p. 324), *"one factor attributable for the rise in the uninsured can be traced to growth in health care costs and, in most recent years, a declining economy. Higher costs simultaneously reduce employer-sponsored coverage and make insurance increasingly difficult for employees and other individuals to afford. An indication of the impact of the declining economy is the fact that the number of uninsured rose by nearly 4.5 million between 2008 and 2009 – from 15.4 percent to 16.7 percent in a single year."* Another factor is suspect to lie in the transformation of the nature of employment in USA, as *"[since the 1960s] there has been a decline in manufacturing jobs and an increase in retail. Accompanying this was a gradual shift towards smaller employers, further fueling a continuing downward trend in*

unionization in the private sector, further coupled by the shifts from full-time to part-time jobs, and from employment to contractual employment relationship - all of which has contributed to higher proportion of the uninsured" (Swartz, 2006, p. 179).

In 2008, health care service sector received no compensation for US\$43 billion worth of the US\$116 billion in medical care it administered (Law & Hansen, 2010), a fallout in cost compensation that had to be covered by those who were able to pay reliably - the government and the private insurance companies, the two subjects who invariably transfer(ed) the burden of health care subsidization on to the taxpayers and/or insured individuals (in 2009, private health insurers, the federal government and respective state governments financed almost 85 percent of the medical care administered to US residents (CBO, 2011)). Congress estimated that this cost-shifting "increases family [insurance] premiums by on average over US\$1,000 a year" (Law & Hansen, 2010, p. 78; Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006). Higher premiums, in turn, drive up the costs of health insurance, making it less affordable, forcing more people to go without insurance and leading to further cost-shifting. Even J. Ginsburg noted in her dissenting opinion in *National Federation of Independent Business v. Sebelius* (2012) that "because those without insurance generally lack access to preventative care, they do not receive treatment for diagnosed early on" (*National Federation of Independent Business v. Sebelius*, 567 U. S. \_\_\_\_, 2012, opinion of Ginsburg, J., p. 46). According to Henry J. Kaiser Family Foundation (hereafter: Kaiser Family Foundation) (2012), the direct result of the system's key attributes and the latter's recent evolution is the clear skewness of the distribution of the uninsured towards those with lower effective incomes (Fig. 12). In 2009, 34 percent of the non-elderly with incomes below the federal poverty level (hereafter: FPL) were uninsured, and 29 percent of those between 100 percent and 200 percent of FPL, compared to just 5 percent of those whose income exceeded 400 percent of FPL (Rice et al., 2013).

Figure 12. Health insurance coverage of the non-elderly in USA in 2010 by income level (as percentage of FPL)



Source: Rice et al., *United States of America: Health system review, 2013*, p. 123, Table 3.4.

US health care coverage rates vary greatly with respect to ethnicity as well (among the non-elderly cohort, approximately 14 percent of non-Hispanic whites, 21 percent of African Americans and 17 percent of Asian Americans had no form of health care insurance as of 2009, compared to 32 percent of Hispanics (Rice et al., 2013; HHS, 2010). Zuckerman, Waidmann and Lawton (2011) highlight the high correlation of immigration status to the absence of health care insurance. In 2007, 14.4 percent of native-born US citizens were uninsured, as were 19.8 percent of naturalized citizens. In contrast, 34.7 percent of legal permanent residents lacked insurance coverage along with 57.0 percent of undocumented immigrants (Zuckerman et al., 2011). Swartz (2006, p. 41) states that: *"Non-citizen immigrants cannot be easily classified with respect to socioeconomic status. Most, however, do not have as much formal education as citizens and have lower wages, often at jobs that do not offer health insurance coverage ... the growth in the number of less educated immigrants in the past twenty years has to be seen as contributing to the imbalance between the demand for and supply of unskilled workers, enabling firms to hire low-wage workers without offering employer-sponsored insurance."*

Effective incomes, employment opportunities and the state-nature of Medicaid eligibility are, conversely, the chief contributor to differences in health care coverage with regards to geographical location (Rice et al. 2013). The uninsured rates for the non-elderly in 2010 were thus nearly twice as high in the comparably poorer southern part of USA (21.2 percent) as in the richer north-eastern part (11.4 percent), with the Midwest at 14.6 percent and the West at 19.2 percent (Rice et al., 2013). Variations by state in the corresponding year were much higher, with rates ranging from less than 10 percent in Hawaii and Massachusetts to a nation-high of 28 percent in Texas (Kaiser Family Foundation, 2011).

US health care system has been and still remains difficult to characterize, in greatest of parts due to the enormous disparities when considering the level of services rendered to different cohorts of persons. Rule of thumb, a great majority of developed countries provide equal universal health coverage to its citizens, regardless of gender, income status, ethnicity, and/or age. Access to health care in USA, however, reflects clear inequalities. In spite of health care professionals in USA being extremely well-educated, its hospitals being well-equipped and domestic companies manufacturing advanced medical technology that competes successfully on the world market, USA was, for example, still ranked at the very bottom among developed nations in life expectancy at birth (OECD, 2011a; Dolgin & Dietrich, 2011). According to Reid (2009), failures such as the aforementioned, and, moreover, government's inability to remedy them, reflect USA-specific inherently intricate and overly complicated network of separate systems for providing health care insurance. For many of the employed under the age of 65, employers share the burden of health care insurance costs, thus making up a system, which in a nutshell resembles that of some of the developed West European economies. Those aged above 65 are covered by Medicare, resembling in that respect the national health insurance system of Canada (Reid, 2009). For military personnel and veterans and Native Americans, the system depends on government hospitals and government-employed physicians, similarly to the National Health Service in

the UK or the health insurance system in Slovenia. But for the part of population that until recently mostly lacked health care coverage (50.7 million people in 2009 (CBO, 2010)), there was effectively no system in place, as majority of the medical care was to be paid for at the time of service by the patient (Dolgin & Dietrich, 2011). Even though patients without insurance could not be denied emergency care at most hospitals, they were held responsible for the cost of that care (Reid, 2009). The aforementioned features of the US health care system have thus proven to be extraordinarily expensive but, nevertheless, overwhelmingly ineffective for millions of its citizens - the central problem being the millions of uninsured.

## 2.5 "Patient Protection and Affordable Care Act" Goals and Key Provisions

ACA adoption reflected the broad public goals of the Democratic administration and the liberal caucus supporting it. Its passing, nonetheless, disguised the deep divisions within the society as to how quality and affordable health care for all could best be achieved. According to Rice et al. (2013) three reform priorities at the time of ACA adoption are clearly distinguishable: (i) access, (ii) cost and (iii) quality.

### 2.5.1 Reform Priorities

At the time of the initial ACA formulation in 2008, it was estimated that 43.8 million people (14.7 percent) were uninsured, with some 55.9 million (18.7 percent) having been uninsured for at least a part of the year, and 31.7 million (10.6 percent) having been uninsured in the excess of one year (Connors & Gostin, 2010). Thereby, an expansion in both public and private health care coverage eligibility presented itself as the necessary vehicle to facilitate greater health care accessibility, essentially forming a reform pincer movement of sorts, composed of three essential parts - (i) **the mandated insurance coverage requirement**, backed by government subsidies for the near-poor uninsured who were and/or are ineligible for Medicaid enrollment, (ii) **the employer-based insurance expansion** with respect to the private sector-firms with more than 50 full-time employees (Mulligan, 2013), and (iii) **the broadening of Medicaid eligibility** (Connors & Gostin, 2010; Dolgin & Dietrich, 2011; Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006). Another problem was manifest in the form of underinsurance, estimated to affect approximately 25 million individuals and displaying an upward trend (Schoen, Doty, Robertson, & Collins, 2011). According to Connors and Gostin (2010, p. 2522): *"Essential Health Benefits policies and the requirement of 60 percent actuarial value were [thus] important aspects of the ACA policy to deal with underinsurance. Improved access required an immediate end to the practice of cancelling insurance in case of rescission."*

Additionally, the alarming rate of the health care cost growth, regarding both public expenditures as well as total spending, presented an important issue. The key ACA

objective in this regard was that it strove to reduce US health care spending in the long run aside from not further contributing to the already large US deficit (Oberlander, 2011).

The third focus of ACA came in the form of quality of health care (Nolte & McKee, 2011) as *"geographical variations of health-care costs and practice differences across USA raised the question of what constitutes best practice and what is appropriate health care"* (Schoenbaum et al., 2011, p. 413). Schoen et al. additionally find that *"as much as 30 percent of health care did not improve patient health fuelled calls for both cost savings and quality improvement"* (2011, p. 1765), whereas McGlynn et al. (2003) even contend that as little as 55 percent of patients in USA received care that follows "best practices."

### **2.5.2 Selected Provisions**

Clearly aiming at a very broad horizon, ACA thus included numerous provisions affecting not only private and public health care insurance but employers, providers and consumers as well. The implementation dates for respective provisions vary, although full implementation is estimated to take place by 2020 (Rice et al., 2013). The selected landmark provisions of ACA are as follows (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006):

- (i) The insurance requirement that individuals and families obtain health care insurance under the sanction of financial penalty, unless the most affordable premium exceeds 8 percent of individual's income;
- (ii) The establishment of federal and state-based health insurance marketplaces (hereafter: health care exchanges, or exchanges). Health insurers are obliged to offer a variety of specified benefit packages that must cover essential health care services;
- (iii) Introduction of subsidies stimulating the purchase of health care insurance for individuals and families with effective income above 100 percent and below 400 percent of FPL, respectively;
- (iv) Insurers are obliged to provide a guaranteed issue of a policy to any applicant and to renew that policy. The charging of higher premiums based on health status or pre-existing conditions, except if clearly stated exceptions apply, is prohibited;
- (v) States that choose to accept federal subsidies are obliged to expand Medicaid coverage to individuals with effective incomes below 138 percent of FPL;
- (vi) Employers with 50 or more full-time employees are obliged to offer the latter health insurance coverage or face financial penalty.



### 3 CONSTITUTIONAL ASPECTS OF PPACA

The passage of ACA gave way to an almost unprecedented flow of concerns within the public with regard to sustaining the class structure of the society, hence questioning the (intrusively) evolving paradigm of federal power expansion and the subsequent increase of the latter's control over the everyday life of its subjects. A substantial portion of US society viewed the passage of ACA as the hallmark of the narrowing of choice and a clear infringement upon personal liberties. Additionally, some corporate interests, concerned in particular with the expansion of federal regulatory powers and worried about the likelihood of tax increases to facilitate ACA funding, actively encouraged opposition to the Act amongst the public (Dolgin & Dietrich, 2011). Even though large parts of the vocal opposition to the ACA enactment nominally stood for the sanctity of the right to contract and thus disdained ACA's supposed quelling of business freedom, the insurance industry was, quite surprisingly in many respects, not to be found among those opposing the Act.

According to Dolgin and Dietrich (2011), the latter phenomenon is attributable to the inclusion of the individual mandate among the provisions of ACA with the predominant goal of supplying the insurance industry with a large inflow of (healthy) new customers.<sup>3</sup> Thus, even as it expanded coverage, ACA protected the system of private insurance that has long paid for the bulk of the portion of those US healthcare costs which the government has not financed (Collier, 2010). The individual mandate thus proved of essential value to the insurance industry's acceptance of ACA. Also worth noting is the fact that the mandate would have been made largely obsolete had Congress opted to add a government-run public option to private insurance options (Leonard, 2010). However, upon abandonment of the public option by Congress, concerns of the insurance industry trumped the general lack of support for the mandate among other stakeholders. The individual mandate provided the protection the insurance industry demanded in light of new regulation that ACA was about to place on it. With that protection in hand, the industry decided to restrain itself from lobbying against the Act (Dolgin & Dietrich, 2011). Nevertheless, the individual mandate provisions has since become the overwhelmingly representative symbol of everything opponents dislike about ACA.

Consequent efforts to suspend, mediate and/or derail the implementation of ACA have since its signing-in moved forward swiftly in Congress, in some of the states, and above all, in the courts, as the Act was immediately challenged in dozens of federal law suits. In the vast majority of these challenges, opponents tended to highlight a specific pattern of questionable provisions of the bill, with economic considerations roughly echoing the call

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<sup>3</sup> Dolgin and Dietrich (2011, p. 56) explain: "...[the industry] accepted potentially costly changes such as the prohibition on the preclusion of applicants with pre-existing conditions, the prohibition on life-time limits on essential health benefits, and the provision of coverage for certain preventive services without cost sharing. In return, it stands to gain a large number of young, healthy customers."

for the bill to be repealed or left unfunded, since, contrary to the position of the CBO (2010), it threatened to further increase the already worrisomely high budget deficit (Krugman, 2011), and constitutional objections chiefly questioning the existence of the necessary constitutionally granted powers to the federal authority to enable it to introduce the controversial individual mandate provision. As that very provision was perceived by some as constituting both a direct infringement upon personal liberties of the people as much as a violation of states' rights by epitomizing the supposedly clear overstepping of the limits of Congressional authority extended through the Commerce Clause of the U.S. Constitution (hereafter: commerce clause) to the federal legislature, the final say of the judiciary on the scope and effect of the commerce clause was called for (Dolgin & Dietrich, 2011).

Even though the plaintiffs in the cases challenging the constitutionality of ACA have since not exclusively focused on the allegation that the individual mandate provision exceeds powers granted to Congress under the commerce clause, the latter challenge, however, proved key to assessing the scope of federal power and the thereof arising feasibility of ACA with the provisions of the Constitution.

### **3.1 The Commerce Clause Meaning and Evolution**

The commerce clause delegates to the Congress an enumerated power listed in Article I of the U.S. Constitution, stating that: "*[The Congress shall have Power] to regulate Commerce with foreign Nations, and among the several states, and with the Indian tribes*" (U.S. Const. art I, § 8, cl. 3, 1789). Federal courts and commentators have more often than not opted to address each of the three composing areas of commerce power as separate but not mutually exclusive, and have colloquially referred to them as (i) the Foreign Commerce Clause, (ii) the Interstate Commerce Clause, and (iii) the Indian Commerce Clause (Miller & Cross, 2007). With respect to the question of the ACA constitutionality, (ii) was examined.

SCOTUS has also frequently pointed out the significance of the commerce clause in several of its opinions, most notably in its *Gonzales v. Raich* (2005) ruling, in which it held: "*[The Commerce Clause] emerged as the Framers' response to the central problem giving rise to the Constitution itself: the absence of any federal commerce power under the Articles of Confederation. For the first century of our history, the primary use of the Clause was to preclude the kind of discriminatory state legislation that had once been permissible. Then, in response to rapid industrial development and an increasingly interdependent national economy, Congress ushered in a new era of federal regulation under the commerce power, beginning with the enactment of the Interstate Commerce Act in 1887 and the Sherman Antitrust Act in 1890*" (*Gonzales v. Raich*, 545 U.S. 1, 2005, p. 8).

By representing one of the most significant powers delegated to Congress by the Constitution, its limits with respect to scope and depth have over the course of history been the subject of intense judicial, and effectively to an even higher degree, political controversy. Consequently, the judicial take on and the subsequent interpretation of the commerce clause has defined the balance of power between the federal government and the states but has, nonetheless, also shaped the relationship between the judiciary on one side and the executive and legislative authorities of USA on the other, albeit in an indirect manner.

### 3.1.1 Early View

As early as in 1803 did Chief Justice (hereafter: C.J.) John Marshall rule in *Gibbons v. Ogden* (1824) that the definition of interstate commerce inherently encapsulates interstate navigation as well, by writing for the Court that: "*Commerce, undoubtedly is traffic, but it is something more - it is intercourse ... [A] power to regulate navigation is as expressly granted, as if that term had been added to the word 'commerce' ... [T]he power of Congress does not stop at the jurisdictional lines of the several states. It would be a very useless power if it could not pass those lines*" (*Gibbons v. Ogden*, 22 U.S. 1, 1824, p. 44). SCOTUS ruling in *Gibbons* (1824) contained language supporting a fundamentally important take on the commerce clause applicability, namely, the contention that the electorate, per-se, acts in the role of the primary and ultimate limit-imposer with respect to the scope of Congressional power as enumerated in the commerce clause, by holding: "*The wisdom and the discretion of Congress, their identity with the people, and the influence which their constituents possess at elections, are, in this, as in many other instances, as that, for example, of declaring war, the sole restraints on which they have relied, to secure them from its abuse. They are the restraints on which the people must often rely solely, in all representative governments*" (*Gibbons*, 22 U.S., 1824, p. 46). In *Gibbons* (1824), the plaintiff Ogden contended that river traffic did not constitute "*commerce*" as is defined by the commerce clause, further arguing that Congress could therefore not infringe upon New York's granting of an exclusive monopoly within its own borders, leaving the federal authorities with the lone power to control (river) traffic only and exclusively as it crossed the state line(s) (Bork & Troy, 2002; *Gibbons*, 22 U.S., 1824). According to Ogden, federal authorities could thus not invalidate his state-granted monopoly, provided he transported passengers within the respective state only. SCOTUS, however, found that Congress, nevertheless, could invalidate his monopoly owing to the fact that it operated on a navigation channel that served interstate commerce as well (Tribe, 1988).

For more than a century since, SCOTUS perceived the commerce clause predominantly as an effective limit on those state legislation provisions that purported to discriminate against interstate commerce, and did not address the extent of the power of federal authority enumerated within (Tribe, 1988). The Court did, however, hold that "*certain categories of activity such as production, manufacturing, and mining were within the province of state governments, and thus were beyond the power of Congress under the Commerce Clause.*"

When Congress began to engage in economic regulation on a national scale, the Court's dormant Commerce Clause<sup>4</sup> decisions influenced its approach to Congressional regulation" (*United States v. Alfonso D. Lopez, Jr.*, 514 U.S. 549, 1995, p. 567). In line with the dormant commerce clause jurisprudence, SCOTUS held that even though Congress had the power to regulate commerce, it could not regulate commercial activities that are overwhelmingly intrastate by nature. In *Kidd v. Pearson* (1888), SCOTUS thus reversed a federal provision prohibiting the manufacture of such liquors that were to be shipped across state lines (*Kidd v. Pearson*, 128 U.S. 1, 1888), with similar decisions being delivered by the Court in various other fields of commercial activity not long after. In *Swift & Co. v. United States* (1905), however, the Court ruled that the commerce clause did include the meat-packaging industry, since "in spite of latter's activity being geographically local by nature, it displayed an important effect on the current of commerce," and was therefore subject to regulation under the commerce clause (*Swift & Co. v. United States*, 196 U.S. 375, 1905, p. 400). Applying analogue criteria, SCOTUS halted price colluding in *Stafford v. Wallace* (1922), where it upheld the federal Packers and Stockyards Act, which regulated the Chicago meatpacking industry, due to it constituting an integral part of the chain which facilitated the interstate commerce of beef, ranging all the way from the ranchers to the dinner tables" (*Stafford v. Wallace*, 258 U.S. 495, 1922; Packers and Stockyards Act of 1921, 7 U.S.C. §§ 181-229b, 2012).

### 3.1.2 The New Deal Switch

The onset of the great depression in the 1930s fueled the commencement of the accelerated federal government intervention policy in the realm of commercial affairs, aiming steadily for a direct clash with the contemporary judicial interpretation of the commerce clause provisions. In 1935, as the efforts to implement the New Deal policies reached their peak, SCOTUS exhibited ardent judicial restraint when faced with the option of facilitating the interventionist policies of Congress and the federal executive authority. First, in *A.L.A. Schechter Poultry Corporation v. United States* (1935), the Court unanimously ruled that the Congress-imposed provisions regulating the poultry industry constituted - with respect to the non-delegation doctrine - an invalid use of the power of Congress under the commerce clause, effectively rendering the National Industry Recovery Act, a key element of the New Deal, unconstitutional (*A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 1935). In *Carter v. Carter Coal Company* (1936), SCOTUS invalidated the

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<sup>4</sup> Also known as "the negative commerce clause" (hereafter "dormant clause"), it is a legal doctrine inferred from the commerce clause. The rationale of the dormant commerce clause is that the power of the states to pass legislation regulating intrastate commerce may improperly burden or discriminate against interstate commerce (Williams, 2005). Ipso-facto, the provisions of the commerce clause are "self-executing" and apply "even in the absence of a conflict between state and federal statutes" when possibility of the hampering of interstate commerce arises (Williams, 2005, p. 178). Congress may, however, "allow states to pass legislation that would otherwise be forbidden by the dormant Commerce Clause" (Williams, 2005, p. 183). In the words of J. O'Connor: "The central rationale for the rule against discrimination is to prohibit state or municipal laws whose object is local economic protectionism, laws that would excite those jealousies and retaliatory measures the Constitution was designed to prevent" (*C&A Carbone, Inc. v. Town of Clarkstown, New York*, 511 U.S. 383, 1994, p. 411).

cornerstone piece of the New Deal's regulatory provisions on mining, arguing that the latter was not "*commerce*" as defined by the commerce clause (*Carter v. Carter Coal Co.*, 298 U.S. 238, 1936, p. 255). The two aforementioned landmark rulings came only as a top-up to the already extensive list of federal social legislation provisions, including minimum wage laws, laws prohibiting child labor and agricultural relief laws, that were thrown out by SCOTUS during the *Lochner* era. The frustration with the SCOTUS invalidation of key New Deal policies was such that president Franklin D. Roosevelt even considered "packing" the Court.<sup>5</sup>

However, the "switch" of J. Owen Roberts in 1937 in *West Coast Hotel Co. v. Parrish* (1937) marked the onset of the era, characterized by considerably broader perception of federal power under the commerce clause. The majority in *West Coast Hotel Co. v. Parrish* (1937) surprisingly found a Washington state minimum wage law constitutional, effectively abandoning prior jurisprudence and de-facto ending the *Lochner* era (*West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 1937). From that point on (and in no small part due to new judicial appointments to the Court as several conservative justices retired over a relatively short time span) SCOTUS ardent opposition to the policies of the New Deal was practically over. In *United States v. Darby Lumber Co.* (1941), SCOTUS upheld the Fair Labor Standards Act which introduced the regulation of the production of goods shipped across state lines by concluding that the X. Amendment to the U.S. Constitution "*is but a truism*" and is therefore "*not to be considered as an independent limitation on Congressional power*" (*United States v. Darby Lumber Co.*, 312 U.S. 100, 1941, p. 133; Fair Labor Standards Act of 1938, 29 U.S.C. §8, 2006).

By formulating this new doctrine and thus effectively introducing a considerable shift in its jurisprudence, both the fundamental scope and the consequent effect of the commerce clause provisions were greatly broadened, opening the door to possibilities of extensive federal regulation of interstate commerce. SCOTUS went even further as it found the federal price regulation of intrastate milk commerce constitutional by stating in *United States v. Wrightwood Dairy Co.* (1942): "*[The commerce power] is not confined in its exercise to the regulation of commerce among the states. It extends to those activities intrastate which so affect interstate commerce, or the exertion of the power of Congress over it, as to make regulation of them appropriate means to the attainment of a legitimate end, the effective execution of the granted power to regulate interstate commerce. [...] The power of Congress over interstate commerce is plenary and complete in itself, may be exercised to its utmost extent, and acknowledges no limitations other than are prescribed in the Constitution. [...] It follows that no form of state activity can constitutionally thwart the regulatory power granted by the commerce clause to Congress. Hence, the reach of that power extends to those intrastate activities which in a substantial way interfere with or*

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<sup>5</sup> The Judicial Procedures Reform Bill of 1937 would have enabled the president to nominate additional justices to SCOTUS by way of granting him "*the power to appoint an additional justice to the Court for every sitting Justice over the age of 70 years and 6 months. The purpose was to obtain favorable rulings regarding the New Deal legislation that SCOTUS had previously ruled unconstitutional*" (McKenna, 2002, p. 99-100).

*obstruct the exercise of the granted power"* (*United States v. Wrightwood Dairy Co.* 315 U.S. 110, 1942, p. 147). In *Wickard v. Filburn* (1942), the Court established the constitutionality of the Agricultural Adjustment Act, which "*sought to stabilize wide fluctuations in the market price for wheat. The Court found that Congress could apply national quotas to wheat grown on one's own land, for one's own consumption, because the total of such local production and consumption could potentially be sufficiently large as to impact the overall national goal of stabilizing prices"* (White, 2000, p. 412; *Wickard v. Filburn*, 317 U.S. 111, 1942; Agricultural Adjustment Act of 1938, 35 U.S.C. § 1281, 2006). The Court thus de-facto nullified more than a century of judicial restraint by stating that "*whether the subject of the regulation in question was 'production', 'consumption', or 'marketing' is, therefore, not material for purposes of deciding the question of federal power before us"* (*Wickard*, 317 U.S., 1942, p. 126). The Court thus reiterated C.J. Marshall's opinion in *Gibbons* (1824): "*... he made emphatic the embracing and penetrating nature of this power by warning that effective restraints on its exercise must proceed from political, rather than from judicial, processes"* (*Wickard*, 317 U.S., 1942, p. 128), while also stating that "*the conflicts of economic interest between the regulated and those who advantage by it are wisely left under our system to resolution by the Congress under its more flexible and responsible legislative process. Such conflicts rarely lend themselves to judicial determination. And with the wisdom, workability, or fairness, of the plan of regulation, we have nothing to do"* (*Wickard*, 317 U.S., 1942, p. 130). In a nutshell, SCOTUS contended that the electoral process was to have the final say with respect to the matters of commercial nature and whether the Congress-passed legislation impacted commerce appropriately, fundamentally altering the interpretation of the commerce clause (*Wickard*, 317 U.S., 1942).

### **3.1.3 The New Federalist Approach**

Almost six decades after the *West Coast Hotel Co.* (1937) ruling and the subsequent SCOTUS-facilitated expansion of federal power, The Court, yet gain, began restoring limits to the scope of the commerce clause effect (Tribe, 1988). In *United States v. Alfonso D. Lopez, Jr.* (1995) (hereafter: *United States v. Lopez*), SCOTUS dealt with the conviction of a high school student for carrying a concealed firearm on school grounds, thus violating the Gun-Free School Zones Act, which made it a federal offense "*for any individual to consciously possess a firearm at a place that that particular individual knows or has reasonable cause to believe is a school zone"* (Gun-Free School Zones Act of 1990, 18 U.S.C. § 922, 2006; *United States v. Lopez*, 514 U.S. 549, 1995). The legislation posed several challenging problems with respect to the commerce clause jurisprudence, especially in the light of the fairly weak logical connection between education (being an almost exclusively local activity) and the federal act addressing gun violence, as sanctioned by the commerce clause. SCOTUS, however, argued that if the ratio of *Wickard*

(1942) ruling<sup>6</sup> were to be applied to acts of gun violence (claiming that crime adversely impacted educational processes), a forthcoming conclusion that crime in schools substantially affects commerce (and may therefore be federally regulated) would clear the path to a quite possible complete nationalization of the local police forces, while the court system could simply do away with the criminal courts, since all crime was to arguably display some sort of impact on commerce (*Lopez*, 514 U.S., 1995). The ruling majority opined: "*Section 922(q) is a criminal statute that by its terms has nothing to do with 'commerce' or any sort of economic enterprise, however broadly one might define those terms. Section 922(q) is not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated. It cannot, therefore, be sustained under our cases upholding regulations of activities that arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce*" (*Lopez*, 514 U.S., 1995, p. 577).

Also in *Lopez* (1995), the Court pointed out the "*three broad categories of activity that Congress may regulate under its commerce power*" as had been identified by previous SCOTUS rulings: (i) it may "*regulate the use of the channels of interstate commerce*", (ii) it is "*empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities*", (iii) [its] "*commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce (i.e., those activities that substantially affect interstate commerce)*" (*Lopez*, 514 U.S., 1995, pp. 558-9, 585). According to *Lopez* (1995), the federal government was not granted the constitutional power to regulate matters that are relatively unconnected to commerce. This was the first time in over a half of century that the Court had struck down an interstate commerce provision due to its exceeding of Congressional commerce-regulating authority. J. Thomas, in a separate concurring opinion, even argued that "*allowing Congress to regulate intrastate, noncommercial activity under the commerce clause would confer upon Congress a general 'police power' over the entire nation*" (*Lopez*, 514 U.S., 1995, p. 579).

The *Lopez* (1995) ruling was further clarified in *United States v. Morrison* (2000), in which SCOTUS reversed § 40302 of the Violence Against Women Act, which allowed for the "*civil liability for perpetration of a gender-based violent crime*" (Violence Against Women Act of 1994, 42 U.S.C. § 1398, 2006), although without any "*jurisdictional requirement of a connection to interstate commerce or commercial activity*" (*United States v. Morrison*, 529 U.S. 598, 2000, p. 630). In a similar fashion, SCOTUS was presented with the case of the federally prosecuted criminalization of a conduct of overwhelmingly local nature. And again, in the same way as in *Lopez* (1995), SCOTUS found the government to

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<sup>6</sup> The court in *Wickard* (1942) ruled that federal authorities could "*exercise its commerce clause power to regulate local economic activities in ways that the state authorities were in no position to regulate,*" when the former was the sole agent with the ability to effectively control the national supply of a certain commodity (in this case, wheat) (*Wickard*, 317 U.S., 1942, p. 134).

be unable to argue to a satisfactory degree that state imposed regulation alone would prove ineffective when addressing the conduct at hand (*Morrison*, 529 U.S., 2000) by reiterating that in both *Lopez* (1995) and *Morrison* (2000) "*the noneconomic, criminal nature of the conduct at issue was central to our decision*" (*Morrison*, 529 U.S., 2000, p. 621). Furthermore, SCOTUS univocally exclaimed that in neither of the two cases was there an "*express jurisdictional element which might limit its reach (to those instances that) have an explicit connection with or effect on interstate commerce*" (*Morrison*, 529 U.S., 2000, p. 623). In both cases, Congress went about criminalizing activity that was highly non-commercial in nature but lacked clear jurisdictional element to ascertain the possible connection between respective criminal activities and interstate commerce (Miller & Cross, 2007; *Morrison*, 529 U.S., 2000).

### **3.1.4 Rational Basis Review**

The evolving level of scrutiny applied by federal courts to the cases involving commerce clause-related provisions are to be considered in the context of the so-called "rational basis review" (Miller & Cross, 2007), which dictates that judiciary be obliged to display a level of deference (give a benefit-of-a-doubt, essentially) to the political preferences of the people. In so many words, rational basis review requires federal courts to "*uphold legislation if there are rational facts and reasons that could support judgments of the Congress, even if the judges and justices would come to different conclusions*" (Miller & Cross, 2007, p. 284). Tribe (1988) points out that "*since 1937, in applying the factual test in Jones & Laughlin to hold a broad range of activities sufficiently related to interstate commerce, SCOTUS has exercised little independent judgment, choosing instead to defer to the expressed or implied findings of Congress to the effect that regulated activities have the requisite economic 'effect'. Such findings have been upheld whenever they could be said to rest upon some rational basis*" (Tribe, 1988, p. 309). C.J. Rehnquist also echoed this point in his opinion in *Lopez* (1995) by stating: "*Since [Wickard], the Court has ... undertaken to decide whether a rational basis existed for concluding that a regulated activity sufficiently affected interstate commerce*" (*Lopez*, 514 U.S., 1995, quoted from *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 1964, pp. 252–3).

Rational basis review generally commences by way of "*establishing the factual predicate upon which the exercise of the power of Congress is based*" (Tribe, 1988, p. 330). "*This factual basis might come from a variety of sources. It might come from factual determinations made by Congress, passed in the legislation itself, or found in the Congressional Reports issued to accompany the legislation*" (Tribe, 1988, p. 331). Nevertheless, according to SCOTUS opinion in *Morrison* (2000), the fact that Congress deems a particular activity as such to affect commerce does not inhibit further examination. However, if the legislators are established (by the courts) to have "*had a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce*" (Tribe, 1988, p. 341), any legislature passed in this respect is to remain standing. In accordance with this ratio, SCOTUS backed up the federal prohibition of medical-purpose marijuana



cultivation in *Gonzales* (2005) by finding that it was not within its abilities to "*rationaly conclude that this growth might make enforcement of drug laws more difficult by creating an otherwise lawful source of marijuana that could be diverted into the illicit market*" (*Gonzales*, 545 U.S., 2005, p. 21; Tribe, 1988)

### **3.2 Lower Federal Court Proceedings**

Within a year of the ACA-signing in, 28 states had joined in or filed separate suits challenging the Act and five federal district courts had reached decisions on the merits of the respective cases (Dolgin & Dietrich, 2011). Of those cases that reached their lower-court epilogue, three federal judges upheld the statute and the individual mandate, whereas two others invalidated the individual mandate as unconstitutional, of which one opted to invalidate the Act as a whole (Aizenman & Goldstein, 2011; Dolgin & Dietrich, 2011). Despite the final decision-making authority resting with SCOTUS, several precedents in aforementioned court proceedings provide determinative guidance.

#### **3.2.1 Thomas More Law Center v. Obama**

In October 2010, District Court Judge (hereafter: judge) George Caram Steeh, for the U.S. District Court in the Eastern District of Michigan, rendered the first substantive judicial response in a case challenging the constitutionality of ACA provisions (Dolgin & Dietrich, 2011). A Michigan public interest law firm and a group of individuals joined as plaintiffs in *Thomas More Law Center v. Obama* (2010). The individual plaintiffs contended that "*they did not have, and did not choose to purchase, health insurance and, further, that they objected to paying a penalty 'tax' because such money would become part of the government's general revenues and could thus be used to fund medical abortions*" (*Thomas More Law Center v. Obama*, 720 F. Supp 2d 882, 2010), thus arguing that requiring people without health care coverage to purchase insurance exceeded the power granted to Congress under the commerce clause (*Thomas More Law Center*, 720 F. Supp 2d, 2010). They further questioned the ACA penalization of (perceived) inaction in the form of the failure to buy health insurance. This, they contended, was not within the reach of the commerce clause. In the words of Randy Barnett on behalf of the plaintiffs in an amicus brief, submitted to the 6th Circuit Court of Appeals: "*If allowed to stand, the individual mandate would collapse the traditional distinction between acts and omissions by characterizing a failure to act as a "decision" not to act—thereby transforming inactivity into activity by linguistic alchemy. It would also then collapse the distinction between economic and noneconomic activity by characterizing an activity as "economic" not based on the type of activity it is but on whether it has any economic effect*" (*Thomas More Law Center v. Obama*, No. 10-2388, WL 2556039, 2011).

Judge Steeh, however, rejected the plaintiffs' claim, concluding that the "*unique character of the health care market*" (*Thomas More Law Center*, 720 F. Supp 2d, 2010, p. 893) made it almost, if not surely, impossible to decide never to participate in that market, explaining

that: "*The health care market is unlike other markets. No one can guarantee his or her health, or ensure that he or she will never participate in the health care market. Indeed, the opposite is nearly always true. The question is how participants in the health care market pay for medical expenses – through insurance, or through an attempt to pay out of pocket with a backstop of uncompensated care funded by third parties. This phenomenon of cost-shifting is what makes the health care market unique. Far from 'inactivity', by choosing to forgo insurance plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now through the purchase of insurance, collectively shifting billions of dollars, \$43 billion in 2008, onto other market participants... The plaintiffs have not opted out of the health care services market because, as living, breathing beings, who do not oppose medical services on religious grounds, they cannot opt out of this market. As inseparable and integral members of the health care services market, plaintiffs have made a choice regarding the method of payment for the services they expect to receive. The government makes the apropos analogy of paying by credit card rather than by check. How participants in the health care services market pay for such services has a documented impact on interstate commerce. Obviously, this market reality forms the rational basis for Congressional action designed to reduce the number of uninsureds*" (Thomas More Law Center, 720 F. Supp 2d, 2010, pp. 894-5).

### **3.2.2 Liberty University v. Geithner**

In the second federal district court decision rejecting the challenge to the Act's constitutionality, *Liberty University v. Geithner* (2010), judge Norman Moon, writing for the District Court in Lynchburg, Virginia, upheld the ACA and various specific provisions contained within in the face of a challenge brought by the Liberty University and others (*Liberty University v. Geithner*, 753 F. Supp. 2d 611, 2010; Dolgin & Dietrich, 2011). The plaintiffs argued, among other things, that as a "Christian organization," they objected to the possibility that the penalties they would be subject to pay under ACA (if opting not to obtain health care coverage) might be used "to fund or support abortions in violation of [Liberty's] sincerely held religious beliefs" (*Liberty University*, 753 F. Supp. 2d, 2010, p. 619). Further, the plaintiffs questioned the constitutionality of the respective provisions that require individuals to buy insurance under the threat of financial penalty, and large employers to provide health care coverage themselves (*Liberty University*, 753 F. Supp. 2d, 2010, p. 620). The plaintiffs also claimed, same as had the plaintiffs in *Thomas More Law Center* (2010) (Dolgin & Dietrich, 2011) that the individual mandate provision of ACA exceeded Congressional authority under the commerce clause. They argued that individual mandate's requiring people to purchase health care coverage and the penalty exacted on those who opted not to do so, did not adequately involve commercial activity. Moreover, they also argued that the individual mandate penalized inactivity in the form of not buying health care coverage, rather than activity, and thereby fell outside the scope of the commerce clause (*Liberty University*, 753 F. Supp. 2d, 2010, pp. 631-3).

Judge Moon rejected Liberty University's concerns with respect to abortion as the plaintiffs have in his opinion not raised a plausible claim that the Act burdens religious practice by failing "*to allege how any payments required under the Act ... would be used to fund abortion. Indeed, the Act contains strict safeguards at multiple levels to prevent federal funds from being used to pay for abortion services beyond those in cases of rape or incest, or where the life of the woman would be endangered*" (*Liberty University v.*, 753 F. Supp. 2d, 2010, pp. 642-3). Judge Moon also responded to the plaintiff's allegation that Congress is without authority to "*require large employers to provide health care coverage for employees*" by referring them to the long history of SCOTUS support for congressional regulation of employment conditions (Dolgin & Dietrich, 2011, p. 64). With respect to the decision to purchase or not purchase health care coverage, judge Moon concluded it was an economic decision since "*[it] in the aggregate substantially affects the interstate health care market*" (*Liberty University*, 753 F. Supp. 2d, 2010, p. 633). Effectively in an analogue manner as in the *Thomas More Law Center* (2010), judge Moon determined that the decision to forego health care insurance is "*'an economic decision' about how and when to pay for health care and is thus activity - not 'inactivity'*" (*Thomas More Law Center*, 720 F. Supp 2d, 2010, p. 894).

### **3.2.3 Mead v. Holder**

Judge Gladys Kessler, writing for the U.S. District Court in the District of Columbia in *Mead v. Holder* (2011) followed the rationale of judges Steeh and Moon in rejecting the plaintiffs' challenge to the constitutionality of ACA, and, more particularly, to the challenge of the individual mandate (*Mead v. Holder*, 766 F. Supp. 2d 16, 2011). Individual federal taxpayers acting as plaintiffs in *Mead* (2011) argued that they could afford to purchase health care coverage but choose not to do so. Thus they claimed that ACA's imposition of a penalty on those who continue to forego health care insurance would deliver them into harm (*Mead*, 766 F. Supp. 2d, 2011). Judge Kessler, in her validation of ACA, initially noted that Congress has clear authority to regulate interstate insurance markets (*Mead*, 766 F. Supp. 2d, 2011) and that a decision to purchase or not purchase health care insurance is "*economic*" (*Mead*, 766 F. Supp. 2d, 2011, p. 30). She rejected as essentially "*semantic*" the plaintiffs' claim that ACA regulated "*inactivity*" rather than "*activity*" and further concluded that it is virtually impossible for an individual to "*remain outside of the health care market altogether*" (*Mead*, 766 F. Supp. 2d, 2011, pp. 36-9).

### **3.2.4 Virginia ex rel. Cuccinelli v. Sebelius and Florida v. United States Department of Health and Human Services**

Two federal district courts, however, concluded that the ACA-imposed individual mandate provision exceeded congressional authority. In the first of these two cases, a Virginia federal district court judge concluded in December 2010 that Congress lacked the constitutional warrant to impose the mandate (*Virginia ex rel. Cuccinelli v. Sebelius*, 728

F. Supp. 2d 768, 2010). In the second, decided in early 2011, a federal district court judge in Florida concluded in an analogue manner that the individual mandate exceeded Congressional authority, and went even further by concluding that the centrality and the crucial nature of the individual mandate to the Act as a whole necessitated the court's invalidating the Act (*Florida v. United States Department of Health and Human Services*, No. 3:10-cv-91-RV/EMT, WL285683, 2011). In spite of both the Virginia and the Florida district courts finding unconstitutional elements among the provisions of the act, their rulings, however, differ greatly with respect to the severity of legal remedies with respect to ACA unconstitutionality. Due to potentially more sweeping consequences of the ruling and since it arguably reveals more about the ideology underpinning the efforts to invalidate ACA, greater focus in the following sections is allocated to *Florida v. United States Department of Health and Human Services* (2011).

In *Virginia ex rel. Cuccinelli v. Sebelius* (2010), judge Henry Hudson, writing for the U.S. District Court in the Eastern District of Virginia, concluded that the individual mandate provision in the ACA exceeded congressional authority but that that particular provision (H.R.3590, § 1501 - Requirement to maintain Essential Minimum Coverage, 2009) could be severed from the Act, leaving all parts with the exception of those making “*specific reference*” to § 1501, in place (*Virginia ex rel. Cuccinelli*, 728 F. Supp. 2d, 2010; H.R.3590, § 1501, 2010). The court's decision rested on the conclusion that the individual mandate penalized inactivity, not activity, and therefore fell outside the authority granted to the Congress by the commerce clause to regulate activities affecting interstate commerce. Judge Hudson also rejected the government's contention that Congress had the authority under its taxing power to penalize those who failed to obtain health care coverage (*Virginia ex rel. Cuccinelli*, 728 F. Supp. 2d, 2010), ruling that the argument in question rested on the erroneous presumption that the mandate involved imposition of a tax, not a penalty, on those who did not obtain health care coverage (Dolgin & Dietrich, 2011; *Virginia ex rel. Cuccinelli*, 728 F. Supp. 2d, 2010).

In *Florida* (2011), judge Roger Vinson went along a considerably more radical route as he invalidated the individual mandate and concluded that the “*inextricable*” connection between the mandate and other provisions of the ACA necessitated his invalidating of all of the law's provisions (*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 36). Judge Vinson expressly grounded his analysis of the individual mandate in a view of the Constitution as constructed in the years of the founding of USA (Dolgin & Dietrich, 2011). Further, he concluded that the Constitution's Necessary and Proper clause<sup>7</sup> (hereafter: necessary and proper clause) could not facilitate the keeping of the individual mandate since the mandate was not “*being used to implement or facilitate enforcement of the Act's insurance industry reforms*” but “*to avoid the adverse consequences of the Act itself*”

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<sup>7</sup> Also known as “the elastic clause,” it is a provision in Article I of the U.S. Constitution, where it reads: “The Congress shall have Power ... To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof” (U.S. Const. art. I, § 8, cl. 18, 1789).

(*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 31). Judge Vinson also rather unreservedly noted that the defendants' vision of the necessary and proper clause was "surely ... not what the Founders anticipated" (*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 31).

He also noted on several occasions in his opinion that invalidating the individual mandate was necessary to safeguard the vision of the Constitution that inspired those who chose to embark upon the creating and interpreting of the document (Dolgin & Dietrich, 2011). Judge Vinson further explained that in his view the case before him was "*not really about our health care system at all*" but "*[it] is principally about our federalist system*" (*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 1). In judge Vinson's opinion, "*it would therefore signal a radical departure from existing case law*" (*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 33) to hold that the federal authority can regulate inactivity under the provisions of the commerce clause.

If federal authority was, however, granted the power to compel an otherwise passive individual "*into a commercial transaction with a third party merely by asserting that compelling the actual transaction is itself commercial and economic in nature, and substantially affects interstate commerce,*" a rudimentary conclusion on the scope of federal power coming close to being unlimited would surely follow (*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 32; Dolgin & Dietrich, 2011). Judge Vinson concluded that "*the individual mandate was an essential and indispensable part of the health reform efforts, and that Congress did not believe other parts of the Act could (or it would want them to) survive independently. I must conclude that the individual mandate and the remaining provisions are all inextricably bound together in purpose and must stand or fall as a single unit*" (*Florida*, No. 3:10-cv-91-RV/EMT, WL285683, 2011, p. 39).

### **3.3 SCOTUS Opinion**

Following judge Vinson's ruling, the HHS appealed to the 11th Circuit Court of Appeals, where a three-judge panel affirmed the district court's findings in part and reversed them in part (Kendall, 2011). The government then promptly petitioned SCOTUS to review the 11th Circuit's ruling and on November 14th, 2011, SCOTUS granted certiorari to portions of three cross-appeals to the 11th Circuit's opinion: two, respectively, by the states (*Florida v. United States Department of Health and Human Services*) and the federal government (*United States Department of Health and Human Services v. Florida*), and one by the National Federation of Independent Business (*National Federation of Independent Business. v. Sebelius*).<sup>8</sup> The three appeals were thus to be heard as a joint case under the

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<sup>8</sup> Thomas More Law Center in the meanwhile appealed to the 6th Circuit Court of Appeals in Cincinnati, Ohio, which concluded that minimum coverage provision constitutes a valid exercise of legislative power by the Congress under the commerce clause (Levey & Savage, 2011), vividly picturing a clear chasm in the legal community with respect to the perception of ACA constitutionality.

name *National Federation of Independent Business v. Sebelius* (hereafter: *NFIB v. Sebelius*) (2012).

SCOTUS ruling was fragmented on several of the issues in question. Large portions of the majority opinion of the Court were thus delivered by plurality, and written by C.J. John Roberts, joined by a different number of justices in respective aspects of the opinion to make up the final plurality. The Court first ruled that the individual mandate is not precluded by the Anti-Injunction Act<sup>9</sup>, due to the formal labeling of it as a "penalty," and not as a "tax," effectively preventing it from being evaluated under the Anti-Injunction Act. Four of the nine justices, however, although agreeing with respect to the Anti-Injunction Act non-applicability in this case, came to that conclusion, however, by holding that the individual mandate was not a tax, per-se, rendering the labeling of the latter immaterial (*NFIB*, 567 U.S. \_\_\_\_, 2012, opinion of Roberts, C.J., pp. 3-11).

The dissection of the opinion of the Court with respect to other instrumental provisions of the ACA and the concerns arising from it is discussed in the following pages.

### **3.3.1 The Commerce Clause Applicability**

C.J. Roberts, although in overall effective terms largely affirming the post-New Deal standards for evaluating the power of Congress under the commerce clause, noted in his opinion (in this respective part of it joined by justices Scalia, Kennedy, Thomas and Alito) that "*the power to 'regulate Commerce' does not include the power to create it*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 17; Law, 2012). He noted that prior cases "*uniformly describe the power as reaching 'activity'*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 18), and further explained that "*Congress has never attempted to rely on [the Commerce] power to compel individuals not engaged in commerce to purchase an unwanted product*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 19). The majority of five justices therefore held that by "*construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority,*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 22), essentially warning that, were the commerce clause to allow Congress to require the purchase of health insurance, the federal power would have increased tremendously.

The Court clearly distinguished the ACA-imposed "*requirement to buy health insurance from previous cases where there was already some sort of existing economic activity that the federal government then either regulated or prohibited*" (*NFIB*, 567 U.S., 2012,

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<sup>9</sup> The Tax Anti-Injunction Act of 1986 is a federal law that mandates 14 specified exceptions in which "*no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed*" (Tax Anti-Injunction Act of 1986, 26 U.S.C. § 7421(a), 2006). According to *Flora v. United States* (1958), it "*requires a person resisting the assessment of a U.S. federal tax to first pay the full amount of tax asserted by the Internal Revenue Service and then file a formal administrative claim for refund with the IRS*" (357 U.S. 63, 1958, p. 99).

opinion of Roberts, C.J., p. 19; Shapiro, 2013). More precisely, in the *Wickard* (1942) case, SCOTUS found the federal provision prohibiting farmers from exceeding administratively set agricultural quotas (but also mandating the selling of respective yields at afore-set prices) constitutional (*Wickard*, 317 U.S., 1942, p. 133). In line with such logic, if one opts to establish and/or run a company, federal authorities can require him/her to adhere to workplace-related laws, meet sanitary standards, refrain from polluting of the environment, and in other ways satisfy the set regulation criteria. In a nutshell, the "*federal government under modern doctrine can regulate even certain types of purely local economic activity when (in the aggregate) that local activity has substantial effects on the interstate commerce*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 20). The federal government also has the power to inhibit certain economic activities by way of prohibition, criminalization, punishment, etc. (Shapiro, 2013), as put forward in *Gonzales* (2005), in which the plaintiffs argued that "*their growth and consumption of marijuana for certain medicinal purposes, as allowed under the California state law, would not subject them to federal prosecution under the Controlled Substances Act*" (Shapiro, 2013, p. 7; Controlled Substances Act of 1970, 21 U.S.C. § 801 et. seq., 2006). Even though the plaintiffs were "*neither buying nor selling the marijuana nor were they transporting it across state lines*", SCOTUS ultimately ruled that, since their activity, albeit not commercial in nature, "*had an aggregate effect on illegal interstate commerce*," it consequently fell within the scope of federal jurisdiction (*Gonzales*, 545 U.S., 2005, pp. 32-3). J. Antonin Scalia, in his concurrence to the *Gonzales* (2005) ruling, espoused an almost Hamiltonian take on the extent of federal authority by stating that the federal authority "*can reach even noneconomic activity that, if left alone, can undermine a duly authorized national regulatory scheme*" (*Gonzales*, 545 U.S., 2005, p. 40).

In short, SCOTUS agreed with the plaintiffs that Congress was effectively forcing people "*to engage in an activity*" or "*to conduct a transaction*" that they would otherwise not necessarily be pursuing (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., pp. 26, 28). Even though the individual mandate constituted "*a part of a broader national regulatory scheme*," it went too far for the majority of the justices, as encapsulated in the words of the SCOTUS ruling: "*The language of the Constitution reflects the natural understanding that the power to regulate assumes there is already something to be regulated*"... "*As expansive as our cases construing the scope of the commerce power have been, they all have one thing in common: They uniformly describe the power as reaching [economic] 'activity'*"... "*The Framers gave Congress the powers to regulate commerce, not to compel it*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., pp. 29, p. 30-1). The Court rounded up its position by stating that the commerce clause "*isn't a general license to regulate an individual from cradle to grave, simply because he will predictably engage in particular transactions*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 31), thus clearly adopting "*[the] articulation of the limiting principle to federal power under the commerce clause as suggested by the plaintiffs*" (Shapiro, 2013, p. 8), effectively going further in its narrow view of the extent of the commerce clause powers than did the lower federal courts that ruled against the government in related cases (Shapiro 2013). Four justices along with C.J.

Roberts thus contended that the commerce clause provisions did not justify the imposition of the individual requirement to buy health insurance since *“the mandating of economic activity”* is unprecedented and impermissibly *“converts the Commerce Clause into a general authority to direct the economy”* ... *“The Commerce Clause is not a general license to regulate an individual from cradle to grave, simply because he will predictably engage in particular transactions”* (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 26; Law, 2012). With respect to the objection that people are extremely likely to enter the health care market at some point in their lives, C.J. Roberts replied: *“Everyone will likely participate in the markets for food, clothing, transportation, shelter, or energy; that does not authorize Congress to direct them to purchase particular products in those or other markets today”* (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 28).

J. Ginsburg, writing for the four remaining justices, would have affirmed the standing that the commerce clause authorizes Congress to require individuals to purchase health insurance (NFIB, 567 U.S., 2012; Law, 2012). According to J. Ginsburg, Congress indeed does have a rational basis for arriving at the conclusion that the uninsured citizens substantially affect interstate commerce. In her opinion, *“those without insurance consume (by crossing state lines as well) billions of dollars of health care goods that are produced, sold, and delivered largely by national and regional companies who routinely transact business across state lines”* (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 21; Law, 2012, p. 13), thereby significantly affecting interstate commerce and thus falling within the scope of commerce clause powers. Had it been down to the minority of the four justices, they would have thereby found that the ACA-imposed individual mandate represents a compelling enough standing to pass constitutional scrutiny with respect to the provisions of the commerce clause and the necessary and proper clause.

J. Ginsburg additionally noted that the market for health services is clearly unique in its nature and should thus not be superfluously equalized with commodities' markets as such. It is not only a rudimentary fact that everyone eventually needs medical attention (care) at some point during their existence *“but rather that doctors and hospitals are required to provide essential care, as a matter of law and social and professional norms”* (Law, 2012, p. 13; NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 23). She further contrasted the effective difference between the (market for) health care and (most of the) other markets by stating that *“[if one] wants a car or has a craving for broccoli, he/she will be obligated to pay at the counter before receiving the vehicle or nourishment. He/she will get no free ride or food, at the expense of another consumer forced to pay an inflated price. In requiring individuals to obtain insurance, Congress is therefore not mandating the purchase of a discrete, unwanted product. Rather, Congress is merely defining the terms on which individuals pay for an interstate good they inevitably consume: persons subject to the mandate must now pay for medical care in advance (instead of at point of service) and through insurance (instead of out of pocket). Establishing payment terms for good in or affecting interstate commerce is quintessential economic regulation well within Congress' domain”* (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., pp. 24-5).



In a sharp asymmetry to J. Ginsburg's opinion, C.J. Roberts, authoring the opinion of the Court along with the four conservative justices, identified the argument stating that the problem of the uninsured posts a substantial impact on interstate commerce, as irrelevant by way of espousing that the Constitution “*enumerates not federally soluble problems, but federally available powers. The Federal Government can address whatever problems it wants but can bring to their solution only those powers that the Constitution confers, among which is the power to regulate commerce*”...” Article I contains no whatever-it-takes-to-solve-a-national-problem power” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 26).

### **3.3.2 Invalidity Under The Necessary and Proper Clause**

The Court’s ruling comes across as even more striking when assessed in context of the necessary and proper clause, the latter being intertwined with the commerce clause via the so-called “substantial effects doctrine”<sup>10</sup> (Shapiro, 2013). Relying on the provisions of the necessary and proper clause, the government claimed that it is “*necessary for the functioning of a larger health care scheme to require people to buy health insurance*” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 21).

From the economic aspect, this assessment is likely to hold, since, quite clearly, the government cannot impose coverage for preexisting conditions and institute caps on prices and/or effectively introduce various other market distortions (if/when opting to do so) without simultaneously requiring comparatively healthier (and consequently less interested in health care insurance) cohort of the population to bear the burden of higher premiums than it otherwise would have. SCOTUS, however, ruled that even if the individual mandate is necessary for the effective enabling of Congress’s regulatory scheme, it is not proper (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., pp. 22-3). Finding justification for the individual mandate in the necessary and proper clause would consequently result in the institution of a substantial expansion of the federal authority, as the Congress would no more be limited to regulating (under the provisions of the commerce clause) only those who (“*by some pre-existing authority*” (Shapiro, 2013, p. 6)) bring themselves within the sphere of federal regulation (Shapiro, 2013), thus providing Congress with the possibility to widen its control beyond the constitutionally granted limits on its power and encompass within its regulatory authority those who would otherwise remain on the outskirts of it (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 24).

Shapiro (2013) duly points out that, with respect to the scope of commerce clause powers, SCOTUS essentially made explicit the contention which *Gonzales* (2005) opinion left out - that even though the substantial effects test reached beyond the scope of commercial activity alone and could therefore affect noncommercial economic activity such as growth and consumption as well, it could in no way affect inactivity (and/or one's effective

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<sup>10</sup> The substantial effects doctrine is the SCOTUS-defined “*articulation of the outermost bounds of the power of the Congress under the commerce clause*” (Tribe, 1988, p. 586) as put forward in *Lopez* (1995): “*We conclude, consistent with the great weight of our case law ... the proper test requires an analysis of whether the regulated activity ‘substantially affects’ interstate commerce*” (*Lopez*, 514 U.S., 1995, p. 599).

decisions to not engage in a commercial activity (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 18; Shapiro, 2013). And even though the argumentation of necessity might be proven, it nevertheless, according to C.J. Roberts and four justices for the majority, would not be proper, as markedly pointed out in their joint opinion: "*The Government was invited, at oral argument, to suggest what federal controls over private conduct (other than those explicitly prohibited by the Bill of Rights or other constitutional controls) could not be justified as necessary and proper for the carrying out of a general regulatory scheme*"... "*It was unable to name any*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 25). Ipso-facto, it is in no way proper to force individuals into engagement in an activity, since consequently no effective limits on federal power are guaranteed to remain (Shapiro, 2013).

### 3.3.3 Objections to SCOTUS-defined Scope of Federal Power Under The Commerce Clause

Several objections to SCOTUS reasoning with respect to the perception of the limits to Congressional power, as enumerated in the commerce clause, arise, among them the elementary lack of the existence of the need for judicially imposed limits on Congressional power, per-se. For example, even though there were effectively no such limits in place between the 1930s and the 1990s, the federal government, nonetheless, did not take over all state functions (Koppelman, 2011). *Lopez* (1995)<sup>11</sup> imposed a new restriction, though its contours to this date remain fairly uncertain, if not controversial (Koppelman, 2011). At the time, SCOTUS found that Congress was effectively attempting to regulate activity, which was noncommercial in nature (*Lopez*, 514 U.S., 1995), a point it reiterated in *Morrison* (2000)<sup>12</sup> by stating on several occasions in its opinion that Congress in fact is granted broad authority over matters of economic nature (*Morrison*, 529 U.S., 2000).

Reason to doubt the relevance and consequent applicability of the economic/noneconomic line persists, however. While it undoubtedly makes sense to claim that Congress is privy to any economic transaction regulation, the holding of SCOTUS suggests that this may constitute the "*litmus paper*" not only for what is in one way or the other (by relevant case-law) "*included in the commerce power of the federal authority, but also for what is not*" (Koppelman, 2011, p. 17). If such were the state of play, Congress would unreservedly be denied the authority to command and regulate matters such as the depletion and pollution of the natural habitats or the spread of deadly diseases across the borders of the respective states (Cooter & Siegel, 2010).

Furthermore, SCOTUS already has suggested on this basis that the federal authority may not command the constitutional powers necessary to impose federal regulation criteria on wetlands that lie geographically within a single state (*Solid Waste Agency v. United States Army Corps of Engineers*, 531 U.S. 159, 2001). Koppelman (2011) thus proposes a rule to

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<sup>11</sup> "Congress may regulate in the commercial sphere on the assumption that we have a single market and a unified purpose to build a stable national economy" (*Lopez*, 514 U.S., 1995, p. 574).

<sup>12</sup> "Where economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained" (*Morrison*, 529 U.S., 2000, p. 610).

implement the distinction, analogue to the line that the Framers of the Constitution drew - a line fundamentally unrelated to the currently most controversial and debated distinction between perceived activity and inactivity, albeit it might not support Congressional regulation of the economy. Namely, at Philadelphia in 1787, the Convention resolved that Congress could "*legislate in all cases...to which the States are separately incompetent, or in which the harmony of the United States may be interrupted by the exercise of individual legislation*" (Farrand, 1911, p. 21). The provision at hand was subsequently translated by the Committee of Detail into the enumeration of powers and stands as such to this day. Rakove (1996) contends that the telling fact that it went unchallenged upon its translation/ultimate formulation pointedly suggests that the Committee of Detail was doing little else but complying with the general expectations of the Convention. Balkin and Levinson (2010, p. 1800) argue that "*the purpose of the enumeration was not to displace the principle but to enact it.*"

He further illustrates that the word "*commerce*" at the time of the framing of the Constitution referred to "*all interactions between people,*" and so "*the commerce power authorizes Congress to regulate problems or activities that produce spillover effects between states or generate collective action problems that concern more than one state*" (Balkin & Levinson, 2010, p. 1806). If health care markets in any instrumental way inherently involve such effects and/or problems, then the commerce powers, as granted to the federal authorities by the Constitution, present a most compelling case in light of the fact that the chief resolution of the authors of the Constitution was to replace the fairly narrow and consequently not particularly rigidly binding Articles of Confederation with a central government that would in turn possess enough constitutional authority as to be in a position to address common issues (Koppelman, 2011).

According to Koppelman (2011), this line of reasoning by no means introduces a recipe for unlimited power, as a fairly broad consensus has been reached in the last few decades regarding federal power's exceeding of commerce clause provisions in some non-commercial matters of highly, if not purely, local nature, such as the federal ban on firearm possession near schools (Koppelman, 2011). But the national health care insurance market, however, is not even by far a purely local matter. The aforementioned approach clearly justifies Congressional authority over the economy, even in its local incidents, since USA indeed does boast a single unified economy.

### **3.3.4 Validity Under The Taxing Clause**

After invalidating the individual mandate in the ACA as unconstitutional under the commerce clause, C.J. Roberts found, however, that the mandate effectively constitutes a tax, and is as such within the taxing power of Congress by way of the Taxing and Spending Clause<sup>13</sup> (hereafter: taxing clause). Four liberal justices joined his opinion, with the four

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<sup>13</sup> The Taxing and Spending Clause is defined in the U.S. Constitution and reads: "*The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States*" (U.S. Const. art. I, § 8, cl. 1, 1789). It is the clause that grants the federal government the power of taxation.

conservative justices fiercely opposing it (Law, 2012). C.J. Roberts held that ACA de-facto states that *“if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes...[T]he mandate is not a legal command to buy insurance. Rather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income”* (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 34). Even though ACA referred to the payment as a *“penalty,”* C.J. Roberts found that the label was, however, not determinative, since it is enforced by and paid to the IRS, which is also authorized to withhold the payment from any refund due to the taxpayer, but there are no criminal or other sanctions for failure to comply, with the payment effectively capped at the level of the cheapest attainable health insurance premium. The failure to have coverage was therefore found to be merely a vehicle to enable taxation and thus did not constitute a breach of the law (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., pp. 35-40).

With respect to the argument that the mandate penalizes (or, effectively, taxes) *“inactivity,”* C.J. Roberts objected by stating that *“it is abundantly clear the Constitution does not guarantee that individuals may avoid taxation through inactivity. A capitation, after all, is a tax that everyone must pay simply for existing, and capitations are expressly contemplated by the Constitution. The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity. But from its creation, the Constitution has made no such promise with respect to taxes”* (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 35). Finally, the majority of justices highlighted the need for judicial restraint: *“Because the Constitution permits such a tax, it is not our role to forbid it, or to pass on its wisdom or fairness”* (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 43).

The four dissenters first vehemently protested by exclaiming that Congress should be held accountable for its naming of the payment a *“penalty,”* since the law has long drawn *“a clear line between a tax and a penalty”* *“...A tax is an enforced contribution to provide for the support of the government, a penalty is an exaction imposed as punishment for an unlawful act. To say that the Individual Mandate merely imposes a tax is not to interpret the statute but to rewrite it”* (NFIB, 567 U.S., 2012, Scalia, Kennedy, Thomas and Alito, JJ., dissenting, p. 18), which they perceived to be an unacceptable exercise of raw judicial authority, and thus concluding: *“In answering that question [whether the individual mandate is independently authorized by Congress's taxing power] we must, if 'fairly possible', Crowell v. Benson, 285 U. S. 22, 62 (1932), construe the provision to be a tax rather than a mandate-with-penalty, since that would render it constitutional rather than unconstitutional (ut res magis valeat quam pereat). But we cannot rewrite the statute to be what it is not. Although this Court will often strain to construe legislation so as to save it against constitutional attack, it must not and will not carry this to the point of perverting the purpose of a statute...or 'judicially rewriting it.' (Commodity Futures Trading Commission v. Schor, 478 U. S. 833, 1986, p. 841, quoting Aptheker v. Secretary of State, 378 U. S. 500, 1964, p. 515, in turn quoting Scales v. United States, 367 U. S. 203, 1961, p. 211). In this case, there is simply no way, without doing violence to the fair meaning of the*

words 'used', (*Grenada County Supervisors v. Brogden*, 112 U. S. 261, 1884, p. 269) to escape what Congress enacted: a mandate that individuals maintain minimum essential coverage, enforced by a penalty" (*NFIB*, 567 U.S., 2012, Scalia, Kennedy, Thomas and Alito, JJ., dissenting, p. 25).

### 3.3.5 Objections to The Individual Mandate Provision Reconstruction

Solely by admitting that the most “straightforward” and “natural” reading of the individual mandate is as a regulation with a penalty attached for noncompliance, C.J. Roberts did not yet attract harsh criticism (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 31; *NFIB*, 567 U.S., 2012, Scalia, Kennedy, Thomas and Alito, JJ., dissenting, pp. 26-8) but by going out of his way to effectively construe the individual mandate as a tax by way of obvious judicial activism and thus invoking constitutional avoidance canon, however, he succeeded in raising several noteworthy objections.

According to Shapiro (2013), C.J. Roberts applied in a wrongful manner the constitutional avoidance canon by stating that it is “fairly possible” to read the mandate as a tax and therefore the “duty” of SCOTUS to acknowledge it as such (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 31; Shapiro, 2013). Shapiro (2013) argues that this signals C.J. Roberts' going very much out of his way and “bending over backwards to save a piece of legislation” (Shapiro, 2013, p. 11). Also, there are noteworthy reservations apparent as to his solution not being the way to correctly apply the constitutional avoidance canon, as the latter only “stipulates that in the case of two equally reasonable ways of interpreting an ambiguous statute, one should use the interpretation that avoids a difficult constitutional question and consequently decide the case on statutory grounds” (Shapiro, 2013, p. 19; Rosenkranz, 2014). The individual mandate provision as the statute in question is hardly ambiguous, while Roberts explicitly stated that the better reading of the statute was as a regulation (*NFIB*, 567 U.S., 2012).

Secondly and in an overly bizarre manner, the majority opted to read the mandate as a tax for the almost obvious purpose of finding the key ACA provision constitutional after it had found that the very same provision was not a tax with respect to the constitutional jurisdiction of the Anti-Injunction Act (Shapiro, 2013). Moreover, the case of *Bailey v. Drexel Furniture Co.* (1933), which C.J. Roberts used as an example of how a tax becomes a penalty when Congress imposes fines on those failing to comply with a federally imposed set of regulations, essentially reflects and consequently supports just the opposite transformation than the one implemented by the majority in *NFIB* (2012) - a tax that becomes a penalty, and not the other way around (Shapiro, 2013; *Bailey v. Drexel Furniture Co.*, 259 U.S. 20, 1922; *NFIB*, 567 U.S., 2012).

SCOTUS opinion also simultaneously found that there exists no requirement of conscious or knowing violation of the law inside the individual mandate and that individuals are effectively presented with a “choice” whether to buy (or not to buy) health insurance (and consequently pay (or not pay) a fine (tax)) (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 39). However, this “choice” is in no way neutral or/and unconstrained, since it “stands in

*place of a command to do something accompanied by a punishment for failing to do just that thing*" (Shapiro, 2013, p. 13).

The argument of the majority that the penalty (tax) is set at a low enough amount as to enable the individual to make *"a reasonable financial decision,"* since it is not *"prohibitory, coercive, or punitive"* (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 38), comes across as somewhat feeble almost, since, in the instance of Congress ever opting to increase the tax in question to the amount that was to approach the overall premium cost of the cheapest attainable minimum-coverage health insurance plan at the time, the reasoning of the majority opinion would collapse and the provision would ipso-facto fail the test of constitutionality, as set in *NFIB* (2012) ruling. In effect, the aforementioned precludes Congress from forming such a program to incentivize individuals to buy health insurance, baffling the economic logic (Shapiro, 2013; *NFIB*, 567 U.S., 2012).

C.J. Roberts also pointed out the fact that the individual mandate-imposed penalty is collected in the same manner as are the taxes, notably, *"by the IRS"* (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 39). However, this contention is disputable in the context of constitutional relevance, since the nature of a federal program is by no means determined by the agency that (co)administers it (Rosenkranz, 2014). Shapiro (2013) points out the example of kindergarten, primary and secondary educational system in USA, which is state-administered and state-run. He contends that if a certain federal institution (for example, the army or postal service) were to be for any reason involved in the educational efforts on these respective educational levels in any way, that would, quite naturally, *"not make federal involvement in state-administered education constitutional"*, per-se.

Also, since the HHS administers part of the health care regulation as well, an obvious confusion with respect to determining the key to assessing the program's constitutionality would surely follow (Shapiro, 2013, p. 16). The contention in the opinion of the Court that the IRS cannot punish people or attach any other *"negative legal consequences"* for the non-payment of the individual mandate-imposed tax<sup>14</sup> (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 42) also lacks merit, since money is itself fungible (Shapiro, 2013, p. 17). In case of the individual opting for non-payment of taxes, that individual is under threat of federal criminal penalties. The only legal remedy for this obviously false contention in C.J. Roberts' opinion is, therefore, for the federal authority to do nothing in case of individual's non-compliance (non-payment of the "tax"), which defeats the inherent purpose of the tax as such.

There is also a view on majority's possible confounding of the tax credits on ownership or activity with the new "ACA tax" on inactivity. Namely, *"a credit, whether a deduction or exemption, is an incentive to relieve a generally applicable tax burden. There is, however, no generally applicable tax on health insurance from which purchasers are can be exempt"* (Shapiro, 2013, p. 14). According to Shapiro (2013, p. 15), *"there has also never been a*

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<sup>14</sup> Congress can use only its regulatory authority to punish people, not its taxing power (*NFIB*, 567 U. S., 2012; U.S. Constitution art. I, § 8, cl. 1, 1789).

*tax on inactivity or the failure to purchase something, so all of the examples Roberts gives to analogize his new Obamacare tax are inapposite: A tax on the purchase of gas is of course a tax on the purchase of a particular product. A tax on earning income is of course an income tax (which required an amendment to the Constitution to make lawful)"... "Congress has long induced purchases through tax credits, and under Roberts's logic, these provisions were hopelessly inefficient given that Congress could simply have taxed the non-ownership of electric cars or energy-inefficient windows. If the government truly had this direct way of achieving its goals, it would have used it long ago."*

### **3.3.6 ACA Medicaid Expansion Context**

Potentially the greatest impact on US constitutional doctrine as much as on the proposed overhaul of the US health care system came in the form of SCOTUS ruling on the ACA-mandated Medicaid expansion by the states. In this respect, the majority of seven justices, with justices Ginsburg and Sotomayor in dissent, found that Congress lacked the constitutional authority under the taxing and spending clause to mandate the states to join into the modified Medicaid program (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 45) under provisions as outlined in ACA (Law, 2012). Upon its introduction in 1965, Medicaid program was chiefly and overwhelmingly aimed towards poor people (Rice et al., 2013), whom it purported to enable the receiving of federally subsidized cash assistance in programs administered by the states, which, nonetheless, were required to meet federal standards (Dolgin & Dietrich, 2012). The initial choice concerning the entrance into the program was left to the respective states, all of which opted to join the program by 1982, with Arizona being the last to do so (Rice et al., 2013). Federal provisions required the states to cover specific cohorts of poor people as defined by the federal standards, in return receiving effective subsidies ranging from 50 percent and 83 percent of the cumulative Medicaid costs, the latter being subject to the economic standing of the respective state. Since the states, nevertheless, retained some aspects of discretion with respect to the definition of income eligibility, health care packages, and levels of provider premiums, diverse Medicaid programs have since been set up by the respective states (Law, 2012).

Arguably the most critical of elements of ACA was its aim to expand Medicaid coverage to virtually all poor people under the age of 65 by adding a universal new category of individuals eligible for Medicaid - those below the age of 65 who are not caretakers of dependent children or disabled, with real incomes effectively below or at 138 percent of the federal poverty level, were to be henceforth covered in a nondiscriminatory manner by the states under the umbrella of the newly expanded Medicaid program (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; Law, 2012, Rice et al., 2013). In return, the federal government opted to initially cover 100 percent of the marginal cost of these newly eligible individuals until 2018, and 90 percent thereafter (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; Law, 2012). So what ACA originally intended was for the federal government to induce

the states to expand their Medicaid programs by making available considerable funding<sup>15</sup> albeit with conditions attached - states would thus be obliged to increase the number of people covered by Medicaid and construct the mechanism to enable the imposition of federally mandated regulation, in essence radically transforming the administration of health care on their respective territories (Shapiro, 2013).

However, the crucial and (as it later turned out) constitutionally most troublesome provision came in the form of the requirement that states effectively spend more of their own money as well, regardless of the ratio the latter constitutes in relation to the overall federal funds allocated to respective states under ACA (Shapiro, 2013; *NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., pp. 51-4). Under the original ACA provisions, the states would be delegated the discretionary right to opt not to receive the allocated funding under the conditions attached by declining to enter the newly constructed Medicaid scheme, however, they would consequently be subject to the loss of the existing Medicaid funding thereupon (*NFIB*, 567 U.S., 2012; Operating of State Plans, U.S.C. § 1396c, Supp. II, 2008 (2006)). The 26 plaintiff states in *NFIB* (2012) thus argued that the new federal money represented the colloquial “*offer they could not refuse*” (Shapiro, 2013, p. 18; *NFIB*, 567 U.S., 2012). Furthermore, it was obvious that the states were in no position to anticipate a switch of such magnitudes with respect to the possible imposition of financial burdens upon conscious entry into the Medicaid program decades prior to ACA enactment (*NFIB*, 567 U.S., 2012; Shapiro, 2013).

According to Law (2012, pp. 18-9), the conditioning of federal subsidies to the states on compliance with federal statutes are not at all unusual, since Congress is allowed to assure the usage of federal funds in ways to achieve federally pioneered goals under the taxing and spending clause. Since the states are granted discretion with regard to the acceptance or rejection of federal funds (along with the conditions attached), SCOTUS has ruled conditions imposed to the states pending federal funding as repugnant to the Constitution (Law, 2012, p. 18; Shapiro, 2013). In *South Dakota v. Dole* (1987), which dealt with the federal requirement that the states raise their legal drinking age if they are to receive 5 percent of federal highway funds, SCOTUS sided with the federal government but also explained that “*the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion,’*” (*South Dakota v. Dole*, 483 U.S. 203, 1987, p. 211), thereby defining clear conditions placed on subsidies of federal nature as having to “*promote the ‘general welfare,’ ‘unambiguously’ inform the states what is demanded of them, be germane ‘to the federal interest in particular national projects or programs,’ and not ‘induce the States to engage in activities that would themselves be unconstitutional’*” (*South Dakota*, 483 U.S., 1987, pp. 207-8).

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<sup>15</sup> “...boatloads of money were offered...,” as formulated by J. Kagan (Mears, 2012, n. p.).



### 3.3.7 SCOTUS Medicaid Ruling

C.J. Roberts, writing for the majority of seven justices of the Court, identified the Medicaid-expanding provision of ACA as exceeding the authority of the Congress as defined in the taxing and spending clause, since it attached unacceptable conditions to its granting capabilities with respect to the states, and thus struck the provision down by pointedly stating: “[T]he financial ‘inducement’ Congress has chosen is much more than ‘relatively mild encouragement’—it is a gun to the head” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 49). Above all, it seemed that the effective peril to the existing funding of state-administered Medicaid program, contained in several of the ACA provisions, posed the constitutionally most troublesome matter, as the Court opined: “The threatened loss of over [ten] percent of a State’s overall budget ... is economic dragooning that leaves the States with no real option but to acquiesce” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 50).

SCOTUS thus clearly stated that while the states can and must to a reasonable degree anticipate and consequently accept modifications of existing federally funded programs (Law, 2012), Congress, however, cannot force them into a scheme, so radically different from the program they originally joined, as “The Medicaid expansion ... accomplishes a shift in kind, not merely degree” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 48). The Court clarified its stance even further by ruling that “[It] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 50). Majority’s final take on the ACA “incentive scheme” and the role of SCOTUS in assessing it was plainly put forward as: “The Court declines to define a standard differentiating between financial inducements and conditions, which are constitutionally permissible, and a penalty, or gun to the head, which is not. Wherever that line may be, this statute is surely beyond it” (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 57).

J. Ginsburg, joined by J. Sotomayor, filled a dissenting opinion in which she concluded that the expansion of Medicaid by attaching conditions to the states as defined by ACA is in fact constitutional by finding that Medicaid program has over the course of its existence been “revised and expanded many times over” (NFIB, 567 U. S., 2012, opinion of Ginsburg, J., p. 47; Law, 2012, p. 20) and that “if a state fails to comply with the recently proposed Medicaid requirements, Congress has not threatened to withhold funds earmarked for any other program,” (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 49), consequently finding that “[The] ACA does not describe operational aspects of the program for those newly eligible persons; for that information, one must read the existing Medicaid Act (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 51). She further protested that in rendering its ruling, SCOTUS has (intentionally) failed to explain how and when the Medicaid expansion as mandated by original ACA provisions “accomplishes a shift in kind, not merely degree,” (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 53) or to define “where persuasion gives way to coercion” (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 54).

### **3.3.8 Severity**

However, in this instance writing only for himself and J. Breyer and J. Kagan (but not for the four conservative justices), C.J. Roberts noted that "*[the] constitutional violation is fully remedied by precluding [Sebelius] from applying §1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out the expansion*" (NFIB, 567 U.S., 2012, opinion of Roberts, C.J., p. 59), thus leaving intact the remaining provisions of the ACA. J. Ginsburg and J. Sotomayor agreed in the point that the ACA-mandated Medicaid expansion, indeed can be severed from other provisions, regardless of the nature of its (un)constitutionality, effectively validating the remainder of the bill and thus forming a majority opinion by concluding for the Court that "*the government may not terminate 'old' Medicaid funds if a state refuses to offer expanded Medicaid coverage. But, if a state accepts the 100 percent federally funded expansion, it must comply with federal conditions on its use*" (NFIB, 567 U.S., 2012, opinion of Ginsburg, J., p. 60; Law, 2012, pp. 21-2). Justices Scalia, Kennedy, Thomas and Alito stated in a joint concurrence/dissent to the opinion of C.J. Roberts that they would have struck down the Medicaid expansion completely (Law, 2012). In spite of their co-forming the majority in imposing the limit on the constitutionality of federal authority to introduce conditions on the subsidies it has a discretionary right to grant, the dissenters, however, found that the unconstitutional nature of the Medicaid expansion, coupled by the invalidity of the penalty provision within the individual mandate provision, called for immediate striking down of the entire ACA (NFIB, 567 U.S., 2012, Scalia, Kennedy, Thomas and Alito, JJ., dissenting, p. 64; Shapiro, 2013).

## **4 BUDGET, HEALTH EXPENDITURES, INSURANCE COVERAGE AND INCOME DISTRIBUTION IMPLICATIONS**

ACA is the most comprehensive piece of health care legislation ever passed by Congress. It aims to radically, albeit gradually and over the course of a decade, transform some of the cornerstone aspects of the US health care system, resulting in an effective paradigm shift with respect to great many economic indicators both in the short and in the long run. Health care overspending being perhaps the clearest of US health system's features, ACA primary goal is thus, beside expanding health care coverage to those who were unable to obtain it prior to the bill enactment (or were effectively underinsured), the reforming of the system as a whole and its shifting towards greater cost efficiency with respect to both public and private expenditures, resulting in a gradual downturn of the national health care spending cost curve. Also, ACA-sparked implications with respect to the distribution of income, in spite of not representing an originally proclaimed objective of the reform, are, nevertheless, estimated to leave a considerably greater imprint on US income distribution than any previously enacted bill.

### **4.1 Budgetary and National Health Expenditure Effects**

CMS (2010) provides initial estimates of ACA provisions' effects with respect to their financial impact on the federal budget in the span of fiscal years 2010-2019 by diving them

in six chief categories (Table 3): (i) insurance coverage provisions, further encapsulating (a) health care insurance as defined by the individual mandate provision of ACA, (b) substantial expansion of Medicaid eligibility, and (c) additional funding of CHIP program, (ii) various Medicare provisions; (iii) various Medicaid and CHIP provisions otherwise not covered in (i), (iv) specialized provisions aimed at improving the trend in health care spending growth, (v) Community Living Assistance Services and Supports (hereafter: CLASS) program provisions, and, (vi) provisions mandating immediate health care insurance reforms (CMS, 2010; CBO, 2011). As demonstrated in Table 3, provisions mandating the expansion of health care insurance, favoring the broadening of Medicaid eligibility and providing for additional CHIP funding, are estimated to accumulate a total cost of US\$828 billion in the time span of fiscal years 2010-2019, whereas Medicare, Medicaid, provisions aimed at cost growth slow-down, CLASS, and immediate reform provisions are estimated to result in the overall net savings of US\$577 billion, leaving the net overall cost for the 2010-2019 period at US\$251 billion (CMS, 2010).

Table 3. Estimated total costs (denoted as +) and/or savings (denoted as -) in 2010-2019 period by selected categories of ACA provisions (in billions US\$)

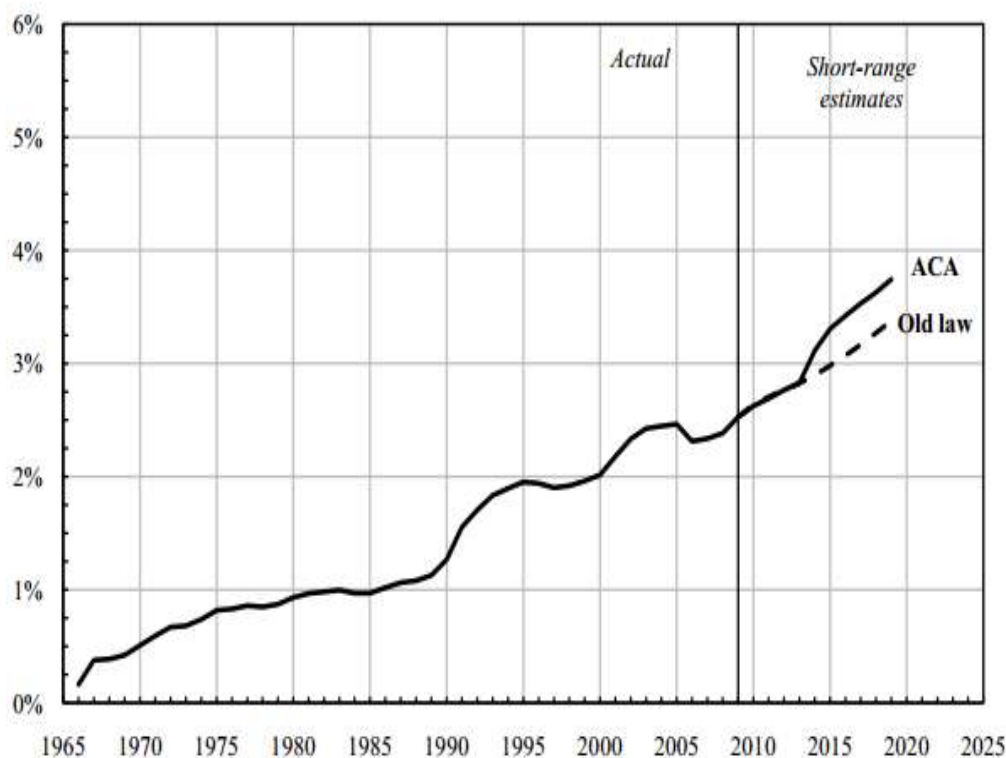
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total (2010-2019)
<b>Total</b>	<b>9.2</b>	<b>-0.7</b>	<b>-12.6</b>	<b>-22.3</b>	<b>16.8</b>	<b>57.9</b>	<b>63.1</b>	<b>54.2</b>	<b>47.2</b>	<b>38.5</b>	<b>251.3</b>
<b>Coverage</b>	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	<b>828.3</b>
<b>Medicare</b>	1.2	-4.7	-14.9	-26.3	-68.8	-60.3	-75.2	-92.1	-108.2	-125.7	<b>-575.0</b>
<b>Medicaid/CHIP</b>	-0.9	-0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	<b>28.2</b>
<b>Cost trend</b>	/	/	/	/	/	-0.1	-0.2	-0.4	-0.6	-0.9	<b>-2.2</b>
<b>CLASS</b>	/	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	<b>-37.7</b>
<b>Immediate reforms</b>	5.6	3.2	1.2	/	/	/	/	/	/	/	<b>10.0</b>

Note: / = provision not effective

Source: CMS, *Estimated Financial Impacts of the "Patient Protection and Affordable Care Act", as Amended, 2010, p. 2, Fig. 1.*

The most significant ACA provision (having commenced as of the beginning of 2014), measured on the scale of its impact with respect to both health expenditures and insurance coverage enrollment, is the expansion of Medicaid eligibility to all individuals under the age of 65 with effective incomes below 138 percent of FPL (Rice et al., 2013; CBO, 2014a; CBO, 2014b). This expansion alone is projected to add a total of US\$410 billion to the aggregate Medicaid expenditures during fiscal years 2010-2019 (a relative increase of approximately 8 percent), and further US\$28 billion for the additional funding of the CHIP program for 2014 and 2015 (CMS, 2010). Figure 13 illustrates past Medicaid and CHIP expenditures as percentage of GDP, along with their respective projections in case of ACA and in case of non-ACA scenario in the 2010-2019 period (CMS, 2011b).

Figure 13. Medicaid and CHIP expenditures as percentage of GDP before and after ACA implementation throughout 1966-2019 period, compared to non-ACA estimate

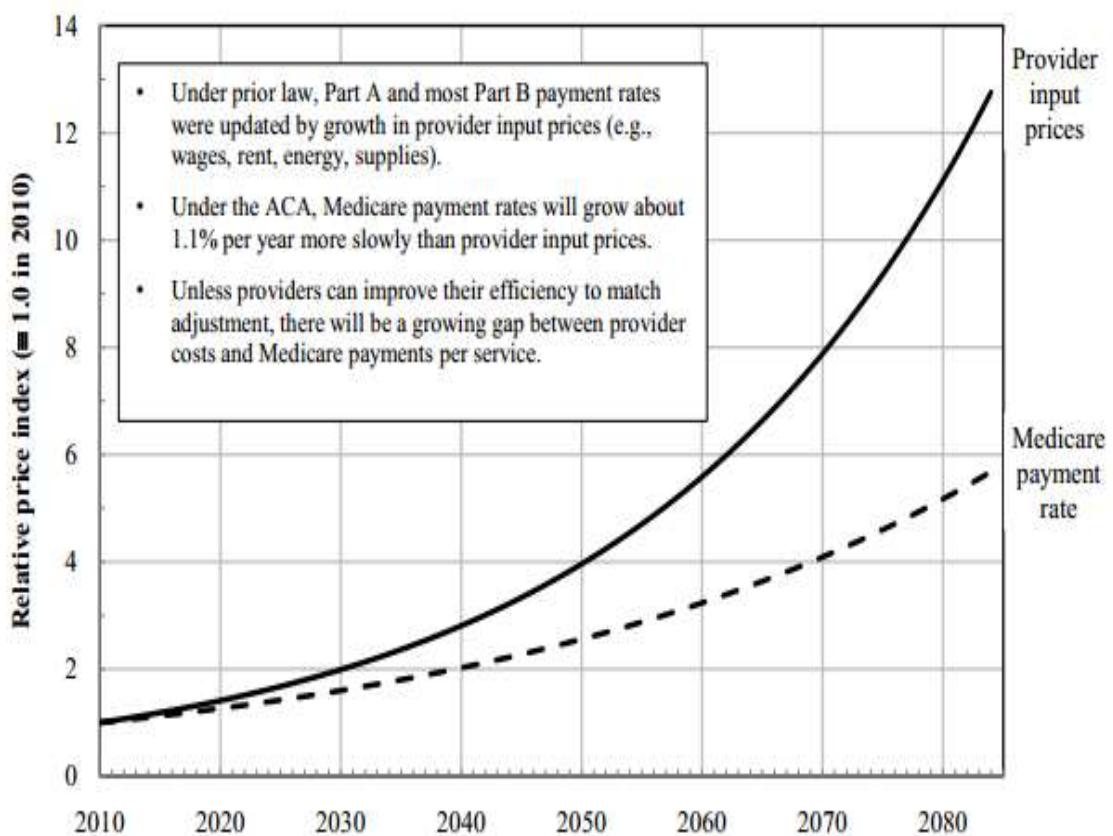


Source: CMS, *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, 2011b*, p.11, Fig. 5.

The majority of the remaining costs of the coverage provisions arise from (i) refundable tax credits and reduced cost-sharing requirements for individuals purchasing health insurance through health care exchanges (US\$507 billion), and (ii) credits for employers with less than 50 full-time employees to whom they choose to offer health care coverage (US\$31 billion) (CBO, 2012a). The increases in federal expenditures are estimated to be in part offset by the financial inflow of (i) penalties paid by the non-elderly non-poor individuals who will choose to remain uninsured, and (ii) employers who will opt not to offer health coverage to their employees. CMS (2010) thus estimates the combined total of both to amount to approximately US\$120 billion through fiscal year 2019, essentially reflecting a comparably mild penalizing policy with respect to the financial of the imposed financial burden (Thomas & Molk, 2013). More precisely, CMS (2010) forecasts that individual penalties should provide around US\$33 billion in revenue to the federal government in fiscal years 2014-2019, while with respect to firms that do not offer health insurance and are thus subject to the “play or pay” penalties, the latter are estimated to reach US\$87 billion in 2014-2019 fiscal years altogether. Also, sizable discounts imposed on providers by State Medicaid payment rules and significant discounts negotiated by private health insurance plans are expected to take place (CMS, 2011b). CBO (2010) forecasts the net effect of the due utilization increases and price reductions arising consequent to ACA-mandated insurance provisions to increase national health care expenditures by approximately 2.4 percent by 2019.

ACA is also estimated to greatly affect national health expenditures through its Medicare savings provisions. Impacts of the latter are estimated to reduce US total health costs by approximately 2.4 percent by 2019 (CBO, 2010), assuming that the productivity adjustments to Medicare payment updates are successfully sustained throughout the period in question (Chandra et al., 2013). With regards to the latter, Figure 14 denotes the future possible accumulated difference between the market prices health care providers are obliged to pay in order to obtain inputs needed to effectively provide health care services, and the corresponding Medicare payment rates as mandated by ACA (CMS, 2011b; Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006).

*Figure 14.* Cumulative increase in case of estimated provider input prices and in case of ACA-mandated Medicare payment rate in 2010-2019 period (in measure of relative price index, 1=2010)



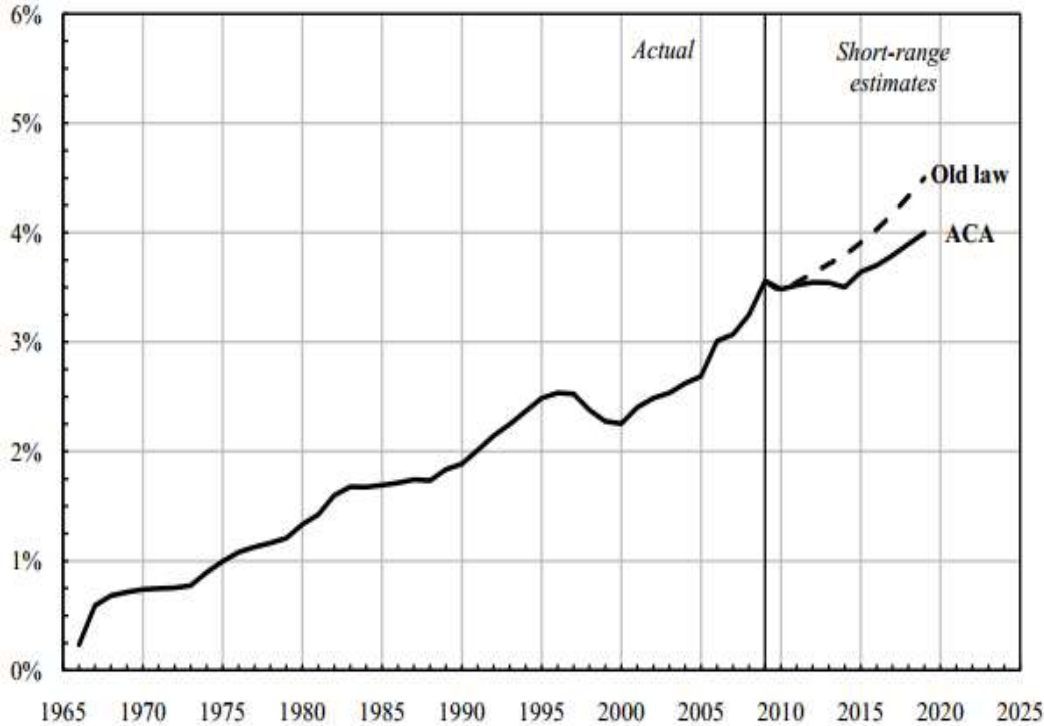
Source: CMS, *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, 2011b, p. 7, Fig. 4.*

This part of ACA legislation is, however, expected to trigger only a very limited impact on the utilization of health care services by Medicare beneficiaries, assuming that access is not hindered by possibly inadequate payment rates in the future (Kliff, 2013). As shown in Figure 14, Medicare savings are estimated to stack up rapidly, chiefly due to the compounding effect of the slower payment updates for most categories of providers (CMS, 2011b; Rice et al., 2013).

Figure 15 illustrates past Medicare expenditures as a percentage of GDP, together with estimated future amounts for fiscal years 2010-2019 both under the ACA-mandated

provisions and under assumption of the prior law staying in place, respectively (CMS, 2011b). Of the estimated net total Medicare savings of US\$575 billion over this period (CMS, 2010; CBO, 2010), US\$486 billion is directly attributable to the net reductions in Medicare expenditures (Thomas & Molk, 2013).

*Figure 15. Medicare expenditures as percentage of GDP before and after ACA implementation in 1965-2019 period, compared to non-ACA estimate*

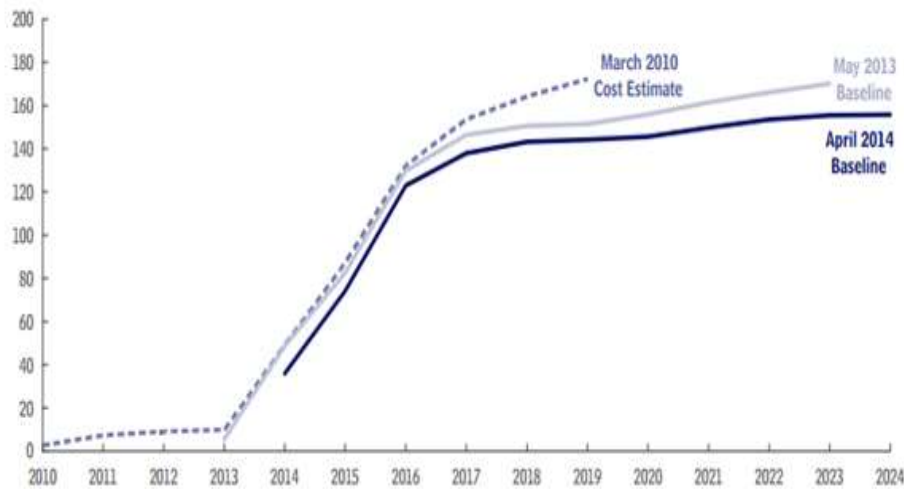


*Source: CMS, The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, 2011b, p. 6, Fig. 3.*

By 2019, the net reduction in Medicare expenditures is estimated to amount to approximately 0.5 percent of GDP, which represents an 11 percent decrease from the level projected prior to ACA set-up (CMS, 2011b; CBO, 2010).

Subsequent revisions of CBO forecasts of the net absolute effect on budgetary matters with respect to ACA-mandated health coverage provisions (Fig. 16), have since resulted in roughly the same overall estimate, with a slight downward revision even, chiefly due to the improving economic trends in years subsequent to ACA enactment, freshly obtained data and a slight overall decrease in health care costs projection both for the government and the private sector (CBO, 2014a)

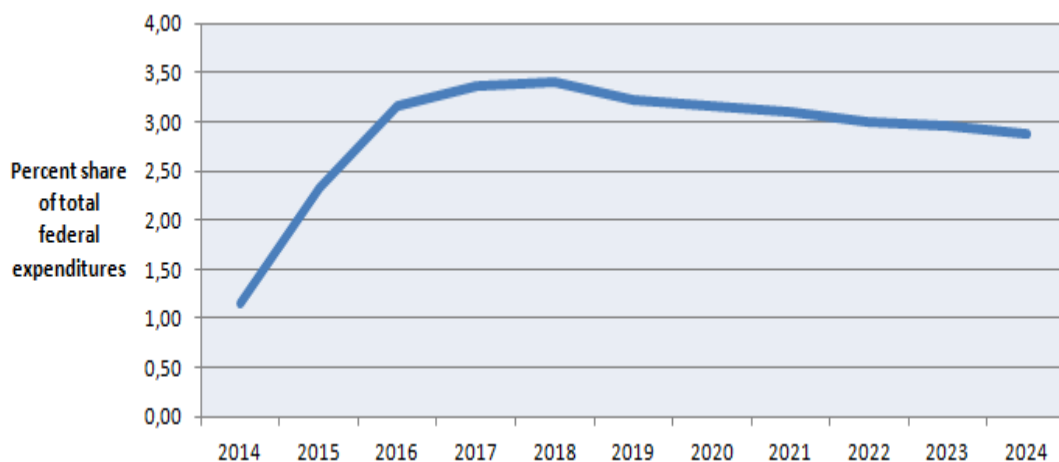
Figure 16. Comparison of CBO estimates of ACA-mandated health coverage provisions' absolute budgetary effects by year (in billions US\$)



Source: CBO, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, 2014a*, p. 21, Fig. 3.

With respect to the estimated net effect of all respective categories of ACA provisions in terms of the share of total federal expenditures, it is expected to initially increase at a steady pace until 2018 (Fig. 17) (comprising approximately 3.41 percent of total federal budget outlays (CBO, 2014b)) on the account of two key factors: (i) initial pledge of the government to until 2019 finance 100 percent of additional costs to arise by the inclusion of newly eligible individuals into the state-administered Medicaid program, and (ii) the comparably greater pace of entry into the newly-founded health care exchanges by individuals of whom great majority are expected be eligible for federal subsidies (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; CBO, 2014b).

Figure 17. Share of ACA-mandated provisions' net costs as percentage of overall federal expenditures in 2014-2024 period

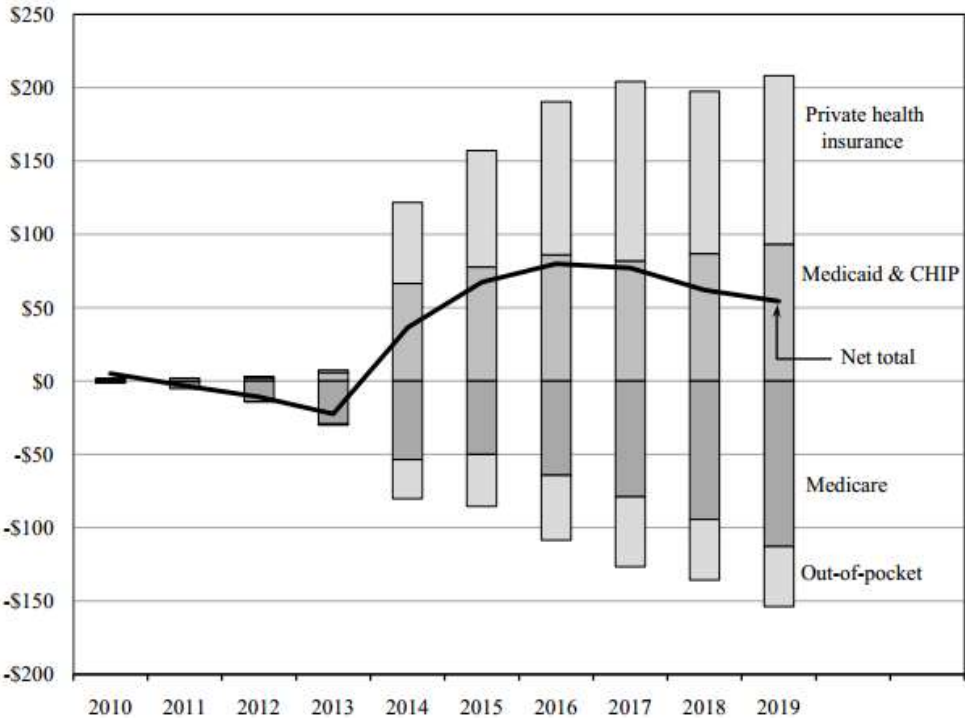


Source: CBO, *The Budget and Economic Outlook: 2014 to 2024, 2014b*, pp. 12, 106, Tables 1.2, B.1.

Upon partial cessation of federal subsidizing of the Medicaid broadening process but also due to forecasted decrease in health care exchange-related eligibility for public subsidies, respective share is estimated to stagnate, displaying a weak negative trend, settling at the value of below 2.9 percent of total federal outlays by 2024 (CBO, 2014b). In overall terms, estimated budgetary impacts demonstrate relative fiscal neutrality of ACA provisions.

Forecasted ACA effects with respect to absolute changes in US health care spending reflect several notable quid-pro-quo within the overall category, significantly altering private health insurance, Medicare, Medicaid, and individuals’ own out-of-pocket costs (CMS, 2011b), as illustrated in Figure 18. National health expenditures are estimated to experience an average increase of approximately US\$200 billion annually in the 2010-2019 period, chiefly due to the substantial health care insurance broadening as mandated by ACA (Aaron & Burtless, 2014).

Figure 18. Estimated increases (denoted as +) and/or decreases (denoted as -) of US total health spending as result of ACA implementation in 2010-2019 period, by selected categories (in billions US\$)



Source: CMS, *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, 2011b, p.12, Fig. 6.*

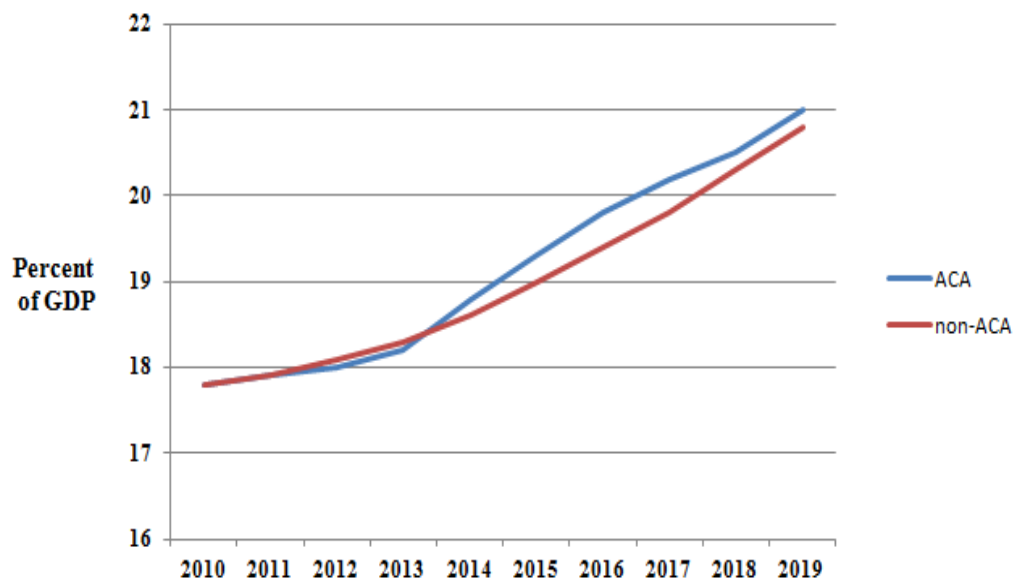
Since, by 2019, a considerable portion of the previously uninsured cohort is estimated to obtain comprehensive health care insurance either via health insurance exchanges employers or Medicaid (CBO, 2010), its mandated availability is thus expected to result in a substantial increase in the rate of health care service utilization, displaying a corresponding impact on the overall level of health care expenditures (Fig. 18) (CMS, 2011b; CBO, 2010).



As indicated in the Figure 18, out-of-pocket spending is also expected to erode significantly (an estimated net total decline of \$237 billion in 2010-2019 period (CMS, 2011b), reflecting the net impact of several ACA provisions, the ones with the greatest impact being (i) the mandated health insurance expansion via Medicaid or by way of signing-up for health insurance exchanges, (ii) the significant cost-sharing subsidies for individuals with low-to-middle-income who obtained health insurance via health care exchanges, and (iii) the maximum out-of-pocket limitations associated with the qualified health benefits (CMS, 2011b; Chandra et al., 2013). A number of other ACA provisions are also estimated to affect national health expenditures in the corresponding period, albeit with considerably smaller magnitude than the aforementioned (CBO, 2014a).

With respect to the non-ACA implementation scenario, the Act's enactment is estimated to cause a marginal net increase in US total health care spending of 0.9 percent or US\$311 billion in comparison to the former. On year-by-year basis, the relative increases are estimated to peak in 2016, when the coverage expansions are expected to be phased in fully, from which point on the former are expected to gradually decline, reaching 1.0 percent by 2019 (CMS, 2011b). ACA's relatively benign effects with respect to the possible marginal net budgetary burden imposed by its enactment (Fig. 17) are thereupon even further displayed in the wider context of US total health care expenditures, the share of which is estimated to reach 21.0 percent by 2019, with CMS (2011b) putting the respective share in the event of ACA discarding at roughly 20.8 percent in the corresponding year (Fig. 19), resulting in a mere 0.2 percentage point difference, attributable primarily to (i) the (initial) substantial expansion of coverage via health-care exchanges and/or Medicaid, and (ii) Medicare-related spending reductions.

*Figure 19. US national health expenditures as percentage of GDP before and after ACA implementation in 2010-2019 period, compared to non-ACA estimate*

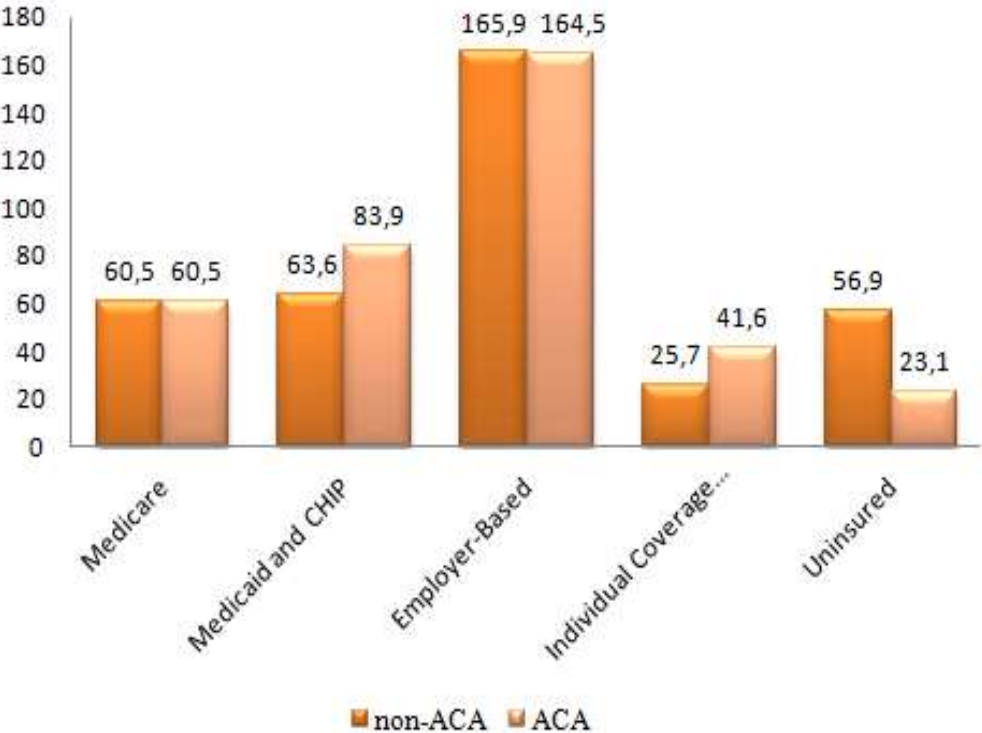


*Source: CMS, The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, 2011b, Att. 4-5, Tables 4-5.*

### 4.2 Insurance Coverage Net Effects

Figure 20 summarizes the estimated ACA-related impacts on US total health care coverage. The mandated coverage provisions and the creation of the ACA-mandated health care exchanges are estimated to result in significant shifts with respect to type of health insurance but will, nonetheless, facilitate a substantial overall reduction in the number of the uninsured (Fig. 20), as many of the individuals previously lacking health care coverage should in the near future be able to obtain insurance either through their employers, Medicaid, or the health care exchanges (CMS, 2010).

Figure 20. Estimated effect of ACA on total number of insured individuals by 2019, compared to non-ACA estimate, by type of health care insurance (in millions of individuals)



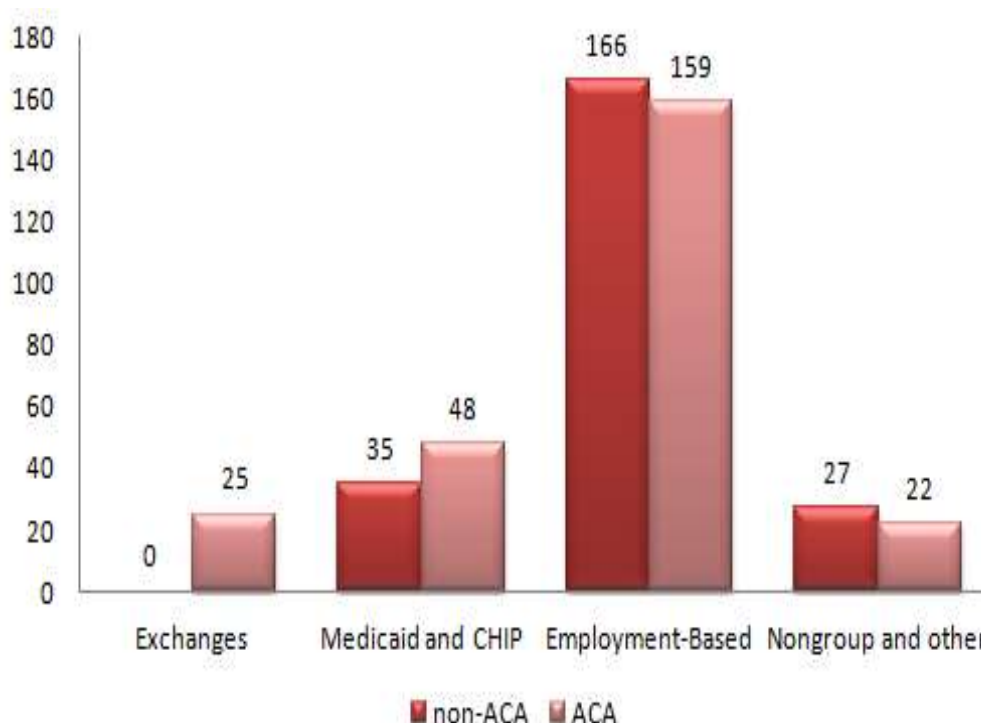
Source: CMS, *Estimated Financial Impacts of the "Patient Protection and Affordable Care Act", as Amended, 2010, p. 3, Fig. 2.*

By the end of 2019 fiscal year, the insurance coverage mandates, exacerbated by Medicaid expansion, are estimated to reduce the number of uninsured from 57 million, as projected under prior law, to an estimated 23 million under ACA (CBO, 2010). The additional 34 million individuals who are estimated to obtain health care coverage by 2019 reflect the net effect of several shifts: (i) an estimated 18 million individuals are expected to obtain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults with incomes effectively under 138 percent of FPL (additionally, roughly 2 million persons with employer-sponsored health care insurance are expected to enroll in Medicaid for supplemental coverage as well), (ii) a total of another 16 million persons are estimated to receive individual health care insurance through mandated health care exchanges, with majority qualifying for federal premium and cost-sharing subsidies, while (iii) the number

of individuals with employer-sponsored health care insurance is estimated to decrease overall by approximately 1.4 million, as denoted in Figure 20 (CMS, 2010).

A recent CBO estimate (2014a), employing a roughly similar distinction by type of insurance as CMS (2010) but instead focusing on individuals below the age of 65 exclusively, produced broadly the same results, again displaying on one hand the obvious ACA-conditioned marginal improvements with respect to the number of non-elderly insured individuals who are estimated to either (i) enter health care exchanges, and/or (ii) become newly eligible for Medicaid and CHIP, and a consequent sharp decrease of 26 million uninsured individuals on the other (Fig. 21) (CBO, 2014a).

*Figure 21. Estimated effect of ACA with respect to total number of insured non-elderly individuals by 2024, compared to non-ACA estimate, by type of health care insurance (in millions of non-elderly individuals)*



*Source: CBO, Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, 2014a, p. 5, Fig. 1.*

On January 1st, 2014, Medicaid expansion as mandated by ACA became effective. Those individuals who were not eligible for Medicaid expansion but could, nonetheless, obtain health care coverage via health care exchanges, were obliged to sign up for it by March 31st, 2014. Also, upon formal request, an extension through April 15th was possible (Levy, 2014). Consequently, as illustrated in Figure 22, the uninsured rate fell consistently throughout the first quarter of 2014, reaching 15.0 percent in March (within March alone, the rate dropped by one percentage point, from 15.5 percent in the first half of the month to 14.5 percent in the second half) (Levy, 2014), a fact attributable to the fast approaching deadline for the health exchange enrollment (by the ultimate April 15th deadline, eight

million people in total signed up to obtain health care insurance via health care exchanges (Gentilviso, 2014).

Figure 22. Percentage of uninsured individuals in USA by quarters



Source: Levy, Uninsured rate down nearly four percentage points since late 2013, 2014.

The uninsured rate for every major demographic group declined in the first quarter of 2014 as well (Table 4). For those residing in households with less than US\$36,000 annual income, it dropped by 3.2 percentage points to 27.5 percent, displaying the largest decline within any of the key subgroups (Levy, 2014). The corresponding rate with respect to race fell by the greatest margin in case of Blacks (by 3.3 percentage points to 17.6 percent), with Hispanics remaining the subgroup most vulnerable with respect to lack of health insurance, standing at an uninsured rate of 37.0 percent as of the first quarter of 2014, in spite of it dropping by 1.7 points in the corresponding quarter (Levy, 2014).

Table 4. Percentage of uninsured individuals in USA by selected quarters, by selected subgroups

	Q4 2013 (%)	Q1 2014 (%)	Net change(pct. pts)
<b>National adults</b>	17.1	15.6	-1.5
<b>18-25 years</b>	23.5	21.7	-1.8
<b>26-34 years</b>	28.2	26.4	-1.8
<b>35-63 years</b>	18.0	16.1	-1.9
<b>65+ years</b>	2.0	1.9	-0.1
<b>White</b>	11.9	10.7	-1.2
<b>Black</b>	20.9	17.6	-3.3
<b>Hispanic</b>	38.7	37.0	-1.7
<b>Less than US\$36,000 annual household income</b>	30.7	27.5	-3.2
<b>US\$36,000 to US\$89,999 annual household income</b>	11.7	10.7	-1.0
<b>US\$90,000+ annual household income</b>	5.8	4.7	-1.1

Source: Levy, Uninsured rate down nearly four percentage points since late 2013, 2014.

### 4.3 Coverage Effects By Income and Age Groups

Aaron and Burtless (2014) estimate the net changes in total health care coverage enrollments by 2016 by vehicle of insurance obtained with respect to different parts of the money income distribution in quintiles as shown in Table 5 (Aaron & Burtless, 2014; U.S. Census Bureau, 2012). The upper panel of Table 5 demonstrates the estimated net absolute changes in total health care insurance enrollment for each of the respective quintiles of the pre-ACA income distribution as affected by ACA enactment by 2016, whereas the bottom panel shows in an analogue manner the same changes as percentages of the total population in respective quintiles in the corresponding period (Aaron & Burtless, 2014).

According to Aaron and Burtless (2014), individual health care coverage is estimated to increase by approximately 26 million in total by 2016, mainly due to the mandated expansion of Medicaid coverage and the enrollment in ACA-established health care exchanges. However, as Table 5 clearly denotes, net enrollments in (i) employer-based insurance and (ii) non-group insurance plans are estimated to shrink modestly. Even though some members of the employed cohort along with dependents are expected to enter employer-sponsored schemes by 2016, all quintiles, with the sole exception of the second, are estimated to experience shifts from employer-based health care insurance to the more affordable health care exchange-based insurance coverage or even towards free insurance available via Medicaid program (Table 5) (Aaron & Burtless, 2014; Gabel, Lore, McDevitt, Pickreign, Whitmore, Slover, & Levy-Forsythe, 2012).

Table 5. Estimated total (in millions of individuals) and percentage change (as share of total quintile population) in US total health insurance coverage as result of ACA enactment by 2016, by insurance source and position in pre-ACA income distribution

Quintile	Employer coverage	Medicaid	Unsubsidized	Sunsidized	Other coverage	Uninsured
<i>Millions of individuals</i>						
Bottom	-2.8	9.2	0.2	3.1	-0.7	-9.1
2nd	0.3	0.4	0.5	7.9	-0.2	-8.8
3rd	0.7	0.0	0.5	3.0	-0.1	-3.2
4th	-1.1	0.0	3.5	0.3	0.0	-2.7
Top	-2.1	0.0	4.1	0.0	0.0	-1.0
<b>All</b>	<b>-5.9</b>	<b>9.6</b>	<b>8.8</b>	<b>14.2</b>	<b>-1.0</b>	<b>-25.7</b>
<i>Percent of individuals in quintile</i>						
Bottom	-4.4	14.5	0.3	4.9	-1.0	-14.3
2nd	0.5	0.6	0.7	12.3	-0.4	-13.8
3rd	-0.4	0.0	0.8	4.7	-0.1	-5.0
4th	-1.7	0.0	5.5	0.4	0.0	-4.2
Top	-3.3	0.0	6.5	0.0	0.0	-3.1
<b>All</b>	<b>-1.9</b>	<b>3.0</b>	<b>4.1</b>	<b>4.5</b>	<b>-0.3</b>	<b>-8.1</b>

Source: Aaron and Burtless, *Potential Effects Of The Affordable Care Act On Income Inequality*, 2014, p. 35, Table 2.

Comparatively the largest projected increase in overall health care coverage occurs in the bottom quintile, in no small part due to the aforementioned ACA-mandated expansion of Medicaid eligibility, while in the second quintile it is the increase in the health care exchange program enrollment that bears the grunt of the health care coverage increase. Also, with regard to individuals in the bottom three quintiles enrolling through health care exchanges, great majority of them is estimated to become eligible for public subsidies, resulting in a probable hefty increase with respect to health care coverage in all of the three respective quintiles (Table 5) (Aaron & Burtless, 2014; U.S. Census Bureau, 2012).

ACA-imposed insurance extensions are estimated to primarily affect the non-elderly, since the pre-ACA combination of publicly administered Medicare and Medicaid programs already covered great majority of the above 65 cohort (Chandra et al., 2013). Consequently, ACA provisions mandate certain cuts with respect to the growth of Medicare spending in order to obtain financial resources necessary for some of the expansions in insurance coverage of younger people and those of prime age (Mulligan, 2013; Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; Aaron & Burtless, 2014).

Tables 6 and 7 further transcend relevant estimations with respect to the ACA-imposed changes in health care coverage by 2016 by insurance source and pre-ACA money income quintiles for the under 25 cohort and the 25-64 cohort, respectively (Aaron & Burtless, 2014).

Table 6. Total percentage and estimated percentage change (as share of total quintile population) in health care coverage for the under 25 cohort as result of ACA enactment by 2016, by insurance source and position in pre-ACA income distribution

Quintile	Employer coverage	Medicaid	Unsubsidized	Subsidized	Other coverage	Uninsured
<i>Percent of individuals under 25 with coverage prior to ACA enactment</i>						
Bottom	12.6	54.0	/	/	9.0	23.4
2nd	37.5	27.8	/	/	10.5	24.2
3rd	61.3	9.0	/	/	11.1	18.6
4th	74.8	3.3	/	/	9.2	12.7
Top	77.3	2.0	/	/	12.1	8.6
<b>All</b>	<b>48.1</b>	<b>22.7</b>	<b>/</b>	<b>/</b>	<b>10.2</b>	<b>18.9</b>
<i>Change in percent of individuals under 25 with coverage post-ACA</i>						
Bottom	-3.6	13.0	0.5	3.7	-1.4	-12.3
2nd	3.4	0.8	0.6	10.9	-0.5	-15.2
3rd	2.5	0.0	0.5	4.4	-0.2	-7.2
4th	2.3	0.0	4.5	0.7	-0.2	-7.2
Top	-0.4	0.0	5.5	0.0	-0.1	-5.0
<b>All</b>	<b>0.7</b>	<b>3.5</b>	<b>1.9</b>	<b>4.4</b>	<b>-0.6</b>	<b>-10.0</b>

Note: / = option non-existent

Source: Aaron and Burtless, *Potential Effects Of The Affordable Care Act On Income Inequality*, 2014, p. 36, Table 3.

There is a larger estimated percentage decline in the level of non-coverage apparent among low-income prime age population as compared to the below 25 low-income population (insurance non-coverage rate is forecasted to fall by approximately 23 percent among the 25-64 cohort in the bottom money income quintile (Table 7), compared to just 12 percent in the under 25 cohort in the corresponding quintile (Table 6)).

Table 7. Total percentage and estimated percentage change (as share of total quintile population) in health care coverage for the 25-64 cohort as result of ACA enactment by 2016, by insurance source and position in pre-ACA income distribution

Quintile	Employer coverage	Medicaid	Unsubsidized	Sunsidized	Other coverage	Uninsured
<i>Percent of individuals aged 25-64 with coverage prior to ACA enactment</i>						
Bottom	19.2	21.1	/	/	15.5	44.1
2nd	47.2	6.5	/	/	11.2	34.7
3rd	69.1	2.1	/	/	8.9	19.8
4th	80.3	0.6	/	/	7.3	11.8
Top	83.7	0.4	/	/	8.8	7.2
<b>All</b>	<b>64.1</b>	<b>4.9</b>	<b>/</b>	<b>/</b>	<b>9.9</b>	<b>21.1</b>
<i>Change in percent of individuals aged 25-64 with coverage post-ACA</i>						
Bottom	-7.5	23.1	0.4	8.6	-1.2	-23.4
2nd	-1.6	0.6	1.2	18.6	-0.4	-18.4
3rd	-2.4	0.0	1.1	6.0	0.0	-4.7
4th	-4.0	0.0	7.2	0.4	0.0	-3.7
Top	-5.0	0.0	8.1	0.0	0.0	-3.1
<b>All</b>	<b>-4.0</b>	<b>3.6</b>	<b>4.1</b>	<b>5.8</b>	<b>-0.3</b>	<b>-9.3</b>

Note: / = option non-existent

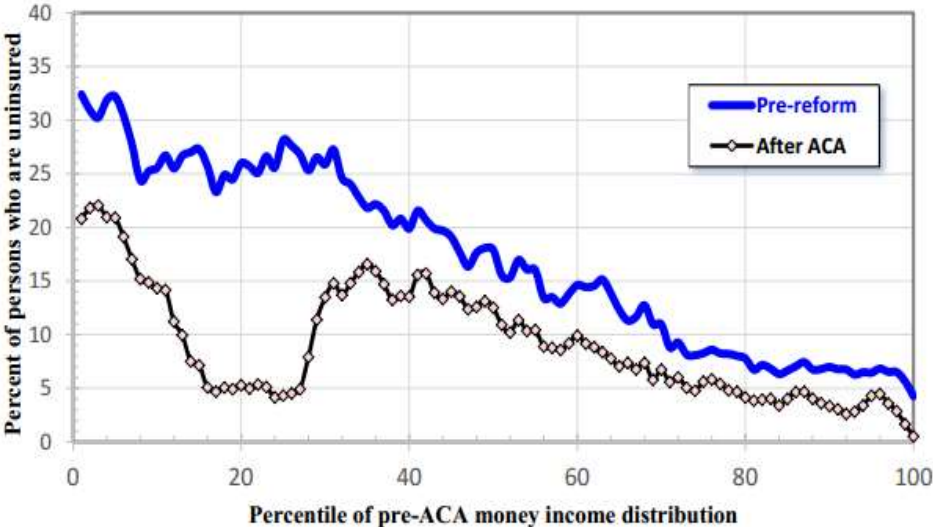
Source: Aaron and Burtless, *Potential Effects Of The Affordable Care Act On Income Inequality*, 2014, p. 36, Table 3.

The aforementioned feature is mainly ascribable to the ACA-mandated Medicaid expansion. In the second and third quintiles, however, estimated decreases are attributable to the future enrollment in subsidized health care exchanges with respect to both cohorts (CMS, 2010, 2011b).

Figure 23 further contends that as incomes increase, people are generally less likely to lack health coverage. However, even though health care coverage is expected to increase throughout the income distribution by 2016 as a consequence of ACA enactment, the comparatively sharpest decrease is estimated to occur between the 15th and the 30th percentiles with respect to pre-ACA income distribution, with approximately 20 percent of the population in the respective income range estimated to obtain health care insurance anew (Fig. 23) (CBO, 2014b). With regard to the evidently smaller increase in the percentage of newly obtained health care coverage plans below the 15th percentile of pre-ACA income distribution, the reason obviously rests up to a formidable degree in the part of the SCOTUS *NFIB* (2012) opinion addressing the unconstitutionality of the ACA provision mandating ineligibility for further respective funding with respect to the states in case of latter's refusal to facilitate expansion of Medicaid (*NFIB*, 567 U.S., 2012). Since

the expansion in health care coverage for the bottom third of the income distribution is estimated to arise almost entirely from either the broadened Medicaid eligibility or from the subsidized health care insurance obtained via health care exchanges, the states that choose to decline Medicaid expansion will consequently be left only with the offer of refundable tax credits for health care exchange-provided insurance policies to individuals with effective incomes above 100 percent of FPL (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; Kaiser Family Foundation, 2011).

Figure 23. Estimated percentage of uninsured US population as result of ACA enactment by 2016, compared to non-ACA estimate, by position in pre-ACA income distribution



Source: CBO, *The Budget and Economic Outlook: 2014 to 2024*, 2014b, p. 145, Table F-2.

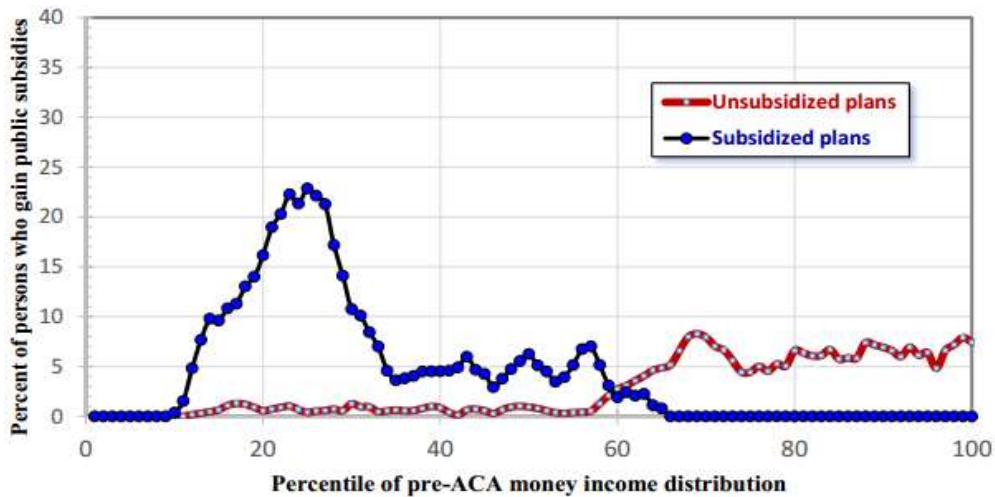
The potential refusal of respective states to expand coverage as dictated by ACA thereby translates into a situation where some (of the non-elderly poor) individuals who would have otherwise been eligible for Medicaid coverage will thus become eligible for health care exchange subsidies only (Tanner, 2012; Kaiser Family Foundation, 2011). The broadening of health coverage is therefore expected to reach a much lesser degree below the 15th percentile than would have been the case had SCOTUS found the ACA-mandated Medicaid expansion constitutional (Aaron & Burtless, 2014; Tanner, 2012).

Estimates of the percentage of individuals who are expected to obtain health care coverage by way of health care exchanges by 2016 with respect to their percentile in the pre-ACA income distribution, be it through subsidized (receiving refundable tax credits) or unsubsidized coverage plans, public or private, are shown in Figure 24 (CBO, 2014b; Aaron & Burtless, 2014). Owing to the expanded Medicaid eligibility, no member of the bottom tenth cohort of the pre-ACA income distribution is estimated to opt for signing up to the health care exchange insurance plan (Fig. 24) (Medicaid comes at nil price, whereas health care exchanges only offer enrollees refundable tax credits provided their effective incomes are above 100 percent of FPL, overall presenting a too demanding of a financial obstacle for the non-eligible poor). Also, those with effective incomes below 100 percent of FPL are extremely unlikely to find themselves in a position where they rationally opt to



obtain private health care insurance, since they face no financial penalty (tax) if they choose to remain uninsured (Mulligan, 2013).

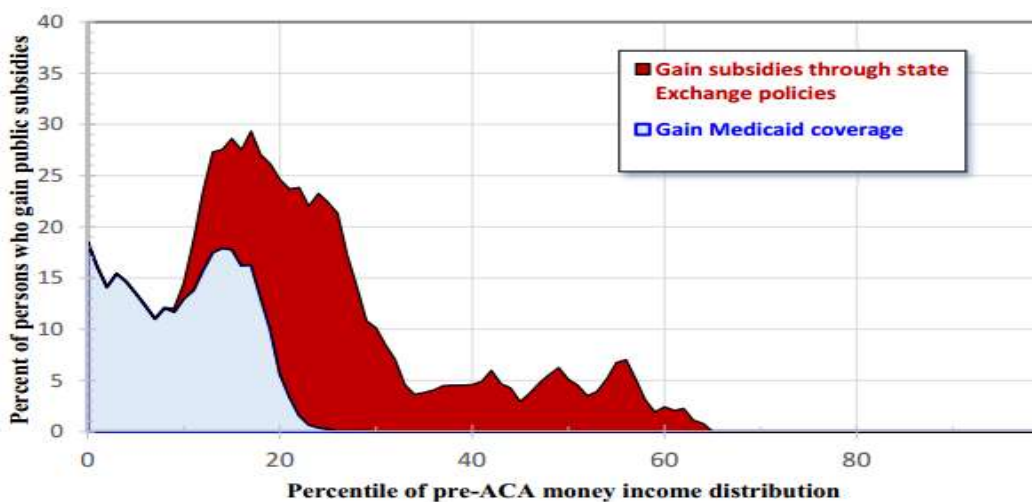
*Figure 24.* Estimated percentage of individuals to gain publicly subsidized and unsubsidized health care exchange-mandated plans as result of ACA enactment by 2016, by position in pre-ACA income distribution



*CBO, The Budget and Economic Outlook: 2014 to 2024, 2014b, p. 108, Table B-2.*

Figure 25 additionally strengthens the above conclusion by illustrating the percentage of individuals estimated to obtain some sort of publicly subsidized health care insurance with respect to their pre-ACA income distribution. As visible, Medicaid expansion facilitates all of the additionally obtained health coverage in the lowest percentiles, whereas, roughly above the 15th percentile, refundable tax credits via health care exchanges take over as the primary vehicle of the newly obtained health care coverage delivery (HHS, 2012; CBO, 2014b).

*Figure 25.* Estimated percentage of individuals to gain effective public subsidies for health care insurance as result of ACA enactment by 2016, by position in pre-ACA income distribution



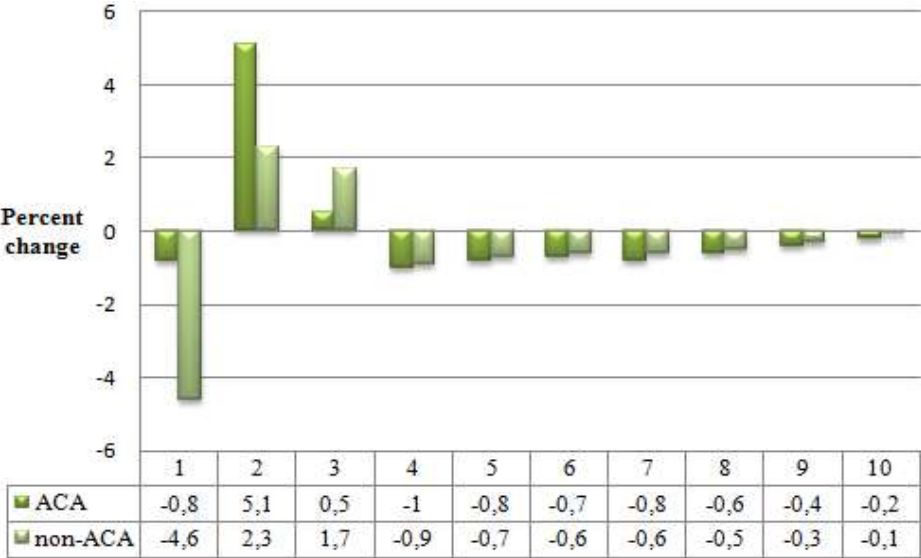
*Source: CBO, The Budget and Economic Outlook: 2014 to 2024, 2014b, p. 106, Table B-1.*

Also worth noting is the fact that approximately 5 percent of individuals with incomes in the proximity of the median income are expected to buy health care insurance policies via health care exchanges with the help of ACA-mandated federal tax credits, whereas above the 60th percentile, however, virtually no public subsidies are estimated to be made available for those opting to purchase coverage through health care exchanges (Fig. 25) (CBO, 2014b; Mulligan, 2013).

**4.4 Income Distribution Effects**

The net effect of ACA with respect to health care coverage expansion in turn further affects the distribution of income, although the severity of the latter contention much depends on the definition of income as such (Tanner, 2012). Figure 26 demonstrates the estimated income impacts as result of ACA enactment as well as the estimated income changes in the non-ACA scenario by 2016, respectively, in case of individuals money income being increased by (i) the cash value of employee health plans (financed by employer contributions), (ii) cash value of food stamps, and (iii) the fungible value<sup>16</sup> of public insurance (U.S. Census Bureau, 2012).

Figure 26. Estimated percentage increases (denoted as +) and/or decreases (denoted as -) in "money income + fungible monetary value of insurance" income as result of ACA enactment by 2016, compared to non-ACA estimate, by position in pre-ACA income distribution



Source: Aaron and Burtless, *Potential Effects Of The Affordable Care Act On Income Inequality*, 2014, p. 38, Charts 1a, 1b .

Incomes of the bottom tenth of the population are expected to decrease, partially due to the underlying reason that very little of the fungible value of health insurance counts as income

<sup>16</sup> A method of assigning different respective values to the public health care insurance received by income distribution cohorts. For example, low-income households may choose not to spend the entire nominal cash value of the insurance package on that particular insurance plan. Health insurance is thus assigned a positive value only if the household's effective income is greater than its basic budget for food and housing as defined by CBO (U.S. Census Bureau, 2012).

to individuals with such low incomes, since they are unable to afford even basic food and housing (CBO, 2014a; Tanner, 2012). Also, majority of the individuals in the bottom tenth of the respective pre-ACA income distribution that had had employer-sponsored health insurance prior to ACA enactment are estimated to most likely switch over to Medicaid insurance and suffer consequent income losses<sup>17</sup> (Burkhauser, Larrimore, & Simon, 2010).

Conversely, the estimated gains in the bottom second tenth reflect the respective individuals' shift from the employer-based health insurance to the health care exchange-based subsidized health coverage. Employers are thus expected to experience lower insurance costs, in turn enabling them to pay higher wages to their employees (Mulligan, 2013). Also, it is estimated that employees with low earnings who will opt to switch away from the employer-based insurance will not consequently trigger ACA-mandated penalties with respect to their employers, either because they are employed in businesses employing less than 50 employees altogether, or because they are not fully employed to start with (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; Mulligan, 2013; Chandra et al., 2013). At the top of the pre-ACA income distribution, a small proportion of the well-off cohort is also estimated to find unsubsidized health insurance through health care exchanges more affordable than the high-cost employer-base health coverage (Fig. 26) (Mulligan, 2013). Consequent employers' savings are thus estimated to translate into an almost proportionate increase in high earners' money wages, resulting in the most modest of losses (Aaron & Burtless, 2014).

Additionally, ACA-mandated Medicare changes are to be held accountable for much of the estimated income decline in the first seven deciles of the pre-ACA income distribution, as the Act introduced the elimination of excess subsidies in the Medicare Advantage plans (Dews, 2014; Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006). Even though enrollment in Medicare Advantage mechanism is distributed throughout the income distribution, older individuals, however, manifest on average somewhat lower incomes than do the younger, even when the fungible value of public insurance is included (Aaron & Burtless, 2014; Chandra et al., 2013). Older Medicare Advantage enrollees are thus not estimated to experience any income loss of the fungible value owing to the fact that their cash incomes alone were too low in the first place to make them eligible for Medicare subsidies. Conversely, those with comparably higher incomes are estimated to experience both subsidy cuts as well as ACA-imposed higher Part B and Part D premiums, resulting in an overall negative net change of Medicare health coverage value (Tanner, 2012; Dews, 2014).

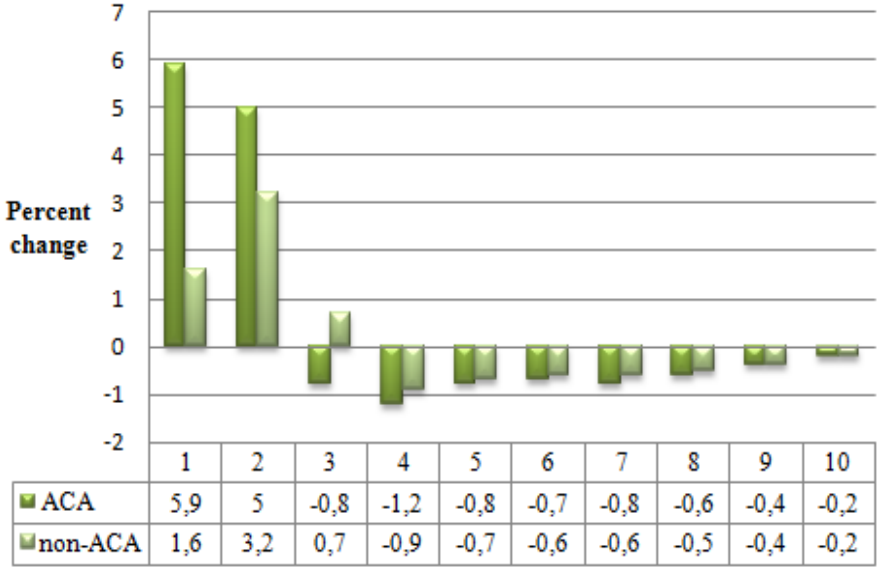
However, if the full monetary value of government contributions to public health coverage plan is counted into individual's income (effectively including the full imposed cost to the government for providing health benefits) (Fig. 27), Aaron & Burtless (2014) estimate that those in the bottom tenth of the income distribution - in sharp contrast to the result in case of income criteria including the fungible value of public coverage only - should experience

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<sup>17</sup> Fungible income calculations count all of the cost of employer-financed health insurance but only the fungible portion of government health benefits (U.S. Census Bureau, 2012).

an income gain of 5.9 percent by 2016 as a consequence of ACA implementation (Aaron & Burtless, 2014; U.S. Census Bureau; 2012). Also, individuals constituting the marginal addition to the Medicaid cohort post-ACA are likely to prove considerably less expensive on average in terms of coverage than is the case with the current Medicaid cohort, owing to the fact that low-income individuals with costly acute or chronic conditions are likely to be already receiving benefits, whereas majority of the newly insured are estimated to be neither aged nor disabled (Kaiser Family Foundation, 2011; Piketty & Saez, 2001).

Figure 27. Estimated percentage increases (denoted as +) and/or decreases (denoted as -) in "money income + total monetary value of insurance" income as result of ACA enactment by 2016, compared to non-ACA estimate, by position in pre-ACA income distribution



Source: Aaron and Burtless, *Potential Effects Of The Affordable Care Act On Income Inequality*, 2014, p. 42, Chart 6a.

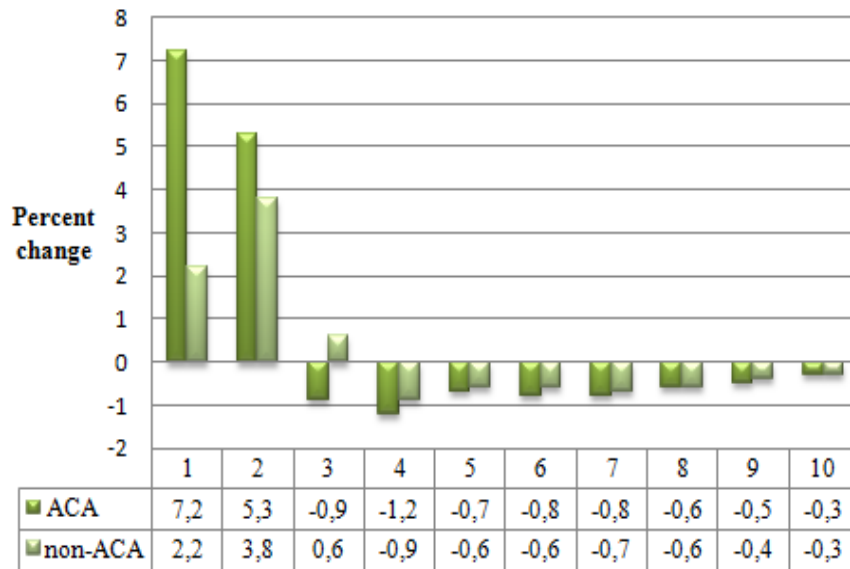
For the individuals in the top six tenths of the income distribution, there is, however, effectively no impact in case of income calculation modification since the value of the fungible part of their public coverage is, due to their relatively higher income positioning, identical to its total value (Aaron & Burtless, 2014; Kaiser Family Foundation, 2011).

Lastly, if the individual's share of Social Security, Medicare payroll taxes and new Medicare tax on high-income investors' income<sup>18</sup> are combined and taken into account upon determining respective income, the net income losses of those in high-income cohorts increase by a very small margin (Fig. 28), whereas those lodged in the bottom two tenths of the pre-ACA distribution experience further gains as compared to Figure 25. The former

<sup>18</sup> The most notable of ACA-mandated tax increases affect individuals with annual earnings in the excess of US\$200,000 and married couples with annual earnings in the excess of US\$250,000 by addition of the 0.9 percentage point payroll tax on earnings and the 3.8 percent tax on most investment income applicable above the ACA-imposed thresholds (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006; Kaiser Family Foundation, 2011).

is due to the lowering of net incomes of individuals in every portion of the income distribution by accounting for the Social Security and Medicare payroll tax and thus facilitating a larger respective percentage increase in case of absolutely equal additional ACA-mandated health benefits than is the case in Figure 27 (Aaron & Burtless, 2014).

Figure 28. Estimated percentage increases (denoted as +) and/or decreases (denoted as -) in "money income + total monetary value of insurance - payroll and investment tax" income as result of ACA enactment by 2016, compared to non-ACA estimate, by position in pre-ACA income distribution



Source: Aaron and Burtless, *Potential Effects Of The Affordable Care Act On Income Inequality*, 2014, p. 42, Chart 6b.

## CONCLUSION

US health care system represents a uniquely tailored paradigm where all levels of government, profit-oriented business entities, and various other stakeholders cohabitate in an overly bizarre manner. Due result exhibits itself in a form of a system, fraught with dissipative pressures but displaying huge inequalities with respect to access to quality health care. Although arguments favoring the features of the current US health system were/are few and far between, federal government's predominantly quiescent state with respect to reforming efforts has over the last several decades led to the extent of the ineffectiveness and disparities present today (Tanner, 2012).

Until recently, the most notable of such efforts was the introduction of Medicare and Medicaid programs half a century ago, which took over the care for the elderly and the poor, in turn ceding to the private sector the remainder of the cake (Rice et al., 2013). The 1980s, however, had left a poignant remainder of the policy of deregulation, tax cuts, and free market economics as income inequality greatly increased and has been on the steady rise ever since (CBO, 2012b). This process ultimately led to the creation of the working-poor class, consisting of the non-elderly individuals without employer-sponsored coverage who were not eligible for government assistance through the Medicaid program but did not

possess the financial ability to obtain health coverage on their own. Additionally, there are apparent differences in the access to quality health care aspect with respect to a vast array of attributes, such as geographical location, race, migration status, and age. In overall terms, US state of national health has for decades been lingering in an abysmal sort of purgatory when compared to the other highly-developed economies (OECD, 2013a; OECD, 2013b). It does not in such instance come across as a surprise that different cohorts of US citizens would most likely grade the quality of their health system quite differently (Swartz, 2006).

Even though the Medicare and the Medicaid programs took the edge off by attending to the elderly and the poor, by 2009, however, over 50 million uninsured individuals remained, with the figure rising steeply (U.S. Census Bureau, 2010). Those of the non-elderly who were caught up in the limbo between the relatively expensive employer-based coverage (or the financially even more unreachable out-of-pocket insurance coverage) and the Medicaid eligibility were intended as the prime benefactors of ACA, as it purported to raise Medicaid eligibility to the level of 138 percent of FPL (Rice et. al, 2013), while simultaneously providing the previously uninsured individuals with a (possible) secondary option - the chance to obtain (by considerable federal subsidization) coverage through the newly established health care exchanges. However, since Medicaid is in small part state-financed but exclusively state-run, the federal government opted to provide the states with the "*offer they could not refuse*," (Shapiro, 2013, p. 18) by offering full subsidization of the due net increases in cost until 2018, at which time it would decrease to 90 percent of net increase subsidization (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006). If states refused, they were threatened to lose existing federal funding (*NFIB*, 567 U.S., 2012). Also, in order to decrease the effects of cost shifting and the consequent increases in insurance premiums, the federal government opted to compel people to buy health coverage or pay a penalty by way of introducing the individual health coverage requirement mandate (Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 et seq., 2006).

Both of the two key provisions stood heavily contested in the courts as opponents believed them to represent a clear overstepping of federal powers as designated in the commerce clause, and the taxing and spending clause. Especially the former's intent, scope and consequent effectiveness with respect to the question of federal interstate commerce regulation has been throughout history heavily debated as differing judicial doctrines curbed or expanded its effects at different points in time (Williams, 2005). SCOTUS ultimately ruled that the federal mandating of people into buying a certain market product is unconstitutional as it effectively penalizes the rejection to do so (*NFIB*, 567 U.S., 2012). The Court did, however, also find that the penalty in question inherently delivers the same effects as does a tax, consequently ruling the penalty to be constitutional under the taxing and spending clause. Shapiro (2013) goes as far as to claim that C.J. Roberts formulated the latter contention in his opinion in order to keep ACA alive (de-facto for political reasons), since the severing of the individual mandate provision as such would result in effectively decapitating the Act. With respect to the Medicaid expansion ruling, SCOTUS

found that while it indeed did lay within the scope of Congress' taxing and spending powers, it could not be followed through by financially coercing the already participating states into giving in to the federal demands, or, in the words in C.J. Roberts, the financial inducements by the Congress represented "*a gun to the head*" (*NFIB*, 567 U.S., 2012, opinion of Roberts, C.J., p. 49).

The epilogue of the Court's decision is mixed with respect to both economic and constitutional categories. While the federal government did emerge successful at effectively mandating people to obtain health coverage, it was, nevertheless, denied the right to compel them to do so within its constitutionally granted commercial powers, thus not succeeding in the quest for expansion of its powers in the realm of interstate commercial activities' regulation (*NFIB*, 567 U.S., 2012). Also, the government was found to possess the right to pass any taxing legislation it deemed appropriate but could not coerce the states into taking part under arbitrarily pre-imposed conditions (Shapiro, 2013). The Court, however, expressly declined to define the line between inducement and coercion (*NFIB*, 567 U.S., 2012), leaving the arena open for further (judicial) interpretation.

From an economic perspective, various points arise. Up-to-date forecasts show that ACA is, with respect to both national health expenditures and public health expenditures, a relatively neutral provision, as it is not estimated to gravely infringe upon the respective cost curves (CMS, 2011b; CBO, 2014b). Although it does not seem to in any way solve the worrisome problem of the growth of US total health expenditures or inhibit public spending in that regard, it does, however, expand health care coverage at a consequently relatively low price (Gabel et al., 2012).

Health coverage-related implications seem less downright. Although coverage is estimated to increase by an overall of 34 million plans by 2019 (CBO, 2010), the question of weights with respect to the type of coverage facilitating this poignant increase, remains. States which will choose to remain in the old Medicaid scheme, effectively rejecting the program expansion, are estimated to experience lower increases in health care coverage (Tanner, 2012), as the only effective change for the respective states' citizens who are uninsured and remain ineligible for Medicaid enrollment will come in the form of federal subsidies for health care exchange enrollment. However, these subsidies are only available to those with effective incomes of at least 100 percent of FPL. Consequently, some of the previously uninsured individuals might now find themselves in a position where they can receive subsidized health care plans. Those who don't, however, are highly unlikely to buy out-of-pocket health insurance on their own, opting instead to remain uninsured (Rice et al., 2013).

With respect to income distribution, the precluding condition for any relevant analysis rests in the definition of income as such. If only fungible part of the health insurance is included in the income calculation, incomes of the poorest cohort are expected to decrease, partially due to the underlying reason that very little of the fungible value of health insurance counts as income to low-income individuals (Aaron & Burtless, 2014), and in part because those

who have previously been fortunate enough to have had employer-sponsored health insurance are estimated to most likely switch over to the cheaper Medicaid insurance plans and thus suffer consequent income losses (Burkhauser et al., 2010; Tanner, 2012; CBO, 2014b). Other respective cohorts are estimated to experience either minor net gains or no significant effects at all. Conversely, if the total value of health care insurance is included in the income calculation, the bottom income cohort stands to gain most of all, with estimated net increases in income decreasing almost uniformly throughout the distribution, where those with comparatively higher incomes are estimated to experience only negligible net changes. A fairly analogue situation is estimated to take place, if Social Security and payroll taxes are also accounted for (Aaron & Burtless, 2014).

All in all, the future workings of US health care system remain highly uncertain. The sheer complexity of its framework, coupled by its consequent inertia and paradigmatic rigidity espouse little hope for significant reforms in the near future. Also, the highly federal nature of the system's financing, administration and reform calls for the meeting of the pre-existing condition in the form of concerted efforts of all stakeholders if any landmark reform paths are to be embarked upon. At this time, alas, such is not the case, as the experience of the ACA clearly demonstrates.

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