AU – JLS Varnum Independent Study
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Why American Needs the Affordable Care Act and Why It Is Constitutional

Introduction

On March 30, 2010, President Obama signed health care reform legislation: "The Patient Protection and Affordable Care Act." Pub. L. No. 111-148, 124 Stat. 119 (2010), which was further amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010) (the Affordable Care Act, the "ACA"). The ACA is a sweeping piece of legislation that, at its core, attempts to change the economically unsustainable way we provide, deliver, and insure healthcare in America. Currently healthcare costs represent one out of every six American dollars.[i] The Congressional Budget Office predicts that by 2025, Healthcare spending will consume one fourth of the GDP and ten years later, it will consume one third of the GDP.[ii] Congressional committees have heard testimony on the health care crisis of America long before the 2008 elections, in which all three major presidential candidates promised health reform and the vast majority of congressional candidates from both parties enacted reforms. The United States Congress has enacted, through a fully open and fair democratic process that no one challenges, by a majority of the American people's representatives, a sweeping federal law intended to cover and deliver healthcare in a more economically efficient way to more people, and at lower cost, than we currently do today, which will allow this nation to curb the unsustainable costs of America's healthcare system. The law in its scope and intent is comparable to the Medicare legislation

enacted in 1964 whose constitutionality is not questioned,[1] and on whose benefits the vast majority of the American people rely. Currently 7 out of every 10 United States adults believe our health care system needs drastic fundamental change,[iii] and throughout the history of health reform, reforms much greater than the current legislation have been at the cusp of enactment, only to see extraneous events erode them.[2]

Americans need health reform for three reasons – unsustainable costs, inadequate quality, and insufficient access to care. Currently, 40 percent of our population has at least one chronic condition,[iv] and that population alone accounts for 75 percent of our overall health expenditures.[v] One out of every three Americans obtains an additional ailment through medical treatment error when entering a hospital, driving up costs.[vi] By 2009, more than 50 million Americans lacked health insurance,[vii] an act that kills 45,000 Americans per year.[viii] These

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[1] Medicare is a single-payer public system that does not rely on an individual responsibility requirement in the same way that the ACA does and thus is not completely analogous.

[2] President Truman's attempts at reform in the 1940s were delayed due to WWII. Anti-communist sentiment and the Korean War overshadowed much-needed reform until a growing elderly and poor community along with private plans setting unaffordable premiums forced change. The Kerr-Mills Act of 1960 provided the opportunity for states to use federal grants to cover the elderly poor, but states failed in participating or budgeting sufficiently, ultimately forcing the most substantial United States' health reforms through the passage of the Social Security Amendments of 1965 that cemented Medicare and Medicaid. Still, Congress saw the need for more substantial reform due to the costs and access to health care a mere six years later and from 1971-1974 bi-partisan support through President Nixon and Senator Ted Kennedy produced various proposals, both of which included universal coverage. When Watergate destroyed Nixon's reputation and with the growing inflation crisis demanding economic action, the 'need' for health reform again diminished. Finally, in the past 30 years, minor reforms, such as the passage of HIPPA in 1986, CHIP in 1997 and Medicare Part D in 2003 were overshadowed by the gigantic failure of reform from the Clinton administration.

tribulations, and many more like them, established a central need for Congress to enact a comprehensive health reform bill in order to promote the general welfare of its people.

This legislation regulates the most comprehensive economic activity in America – the business of healthcare. Congress obviously has the ability to regulate such a business that cost 2.5 trillion dollars in 2009.[ix] This business' financial implications on the country are radical. If the country continues to spend at the current rate, the only way to account for the exponential growth will be to cut other markets substantially. The growth rate for healthcare compared to GDP has been on average 2.4 percentage points higher. By itself, this individual growth rate will ensure our deficit continues to grow at unsustainable levels, and thus, has the ability to bankrupt America.

In order to regulate the health insurance market in an attempt to lower the costs of care, provide quality, and promote the general welfare of the nation, Congress enacted an individual responsibility requirement so that every individual would maintain minimum essential health insurance coverage. This provision creates an economic incentive in the form of a 750 dollar per year increase in financial income tax liability for those who do not comply. This responsibility requirement is interlinked with a variety of reforms that are needed in order to avoid certain economic calamity. Furthermore, the centrality of the health insurance business in relation to how the actual business of healthcare runs as a whole brings the individual responsibility requirement to the forefront of the constitutionality of the ACA.

Consequently, this paper contends that one single provision, which is essential to reshaping the healthcare business in America – a business that demands one-sixth of America's money – by requiring individuals to enter into a marketplace that Congress can regulate is a rule within Congress' constitutional power. Furthermore, due to the interwoven necessary regulations Congress created within the ACA, this legislation secures the economic stability of the country.

Why Health Reform is Needed

There are three reasons why we need health care reform: the costs of the current system are significantly unsustainable[x] due to a variety of reasons[3]; 50 million people are uninsured or do not have the ability to pay for health care, so when those people receive care they shift the cost of care onto taxpayers and those paying insurance premiums;[xi] and the quality of care actually received is inadequate. Policymakers heard significant amounts of studies chronicling the inadequacies of our health care system along with what actions should be taken to overcome the problems of unsustainable cost, inefficient quality, and under

[3] these reasons include the fact that the fee-structure provided by the current system rewards physicians for any care given regardless of the quality of that care; defensive medicine, while being sought by physicians to discourage medical malpractice, also provides economic benefits to physicians; and the concept of early preventative care is not politically financially ideal for private insurance payers as once their consumers become 65, their consumers' costs increase to long-term care numbers, but consumers leave private payers for payment through Medicare.

utilization of access when creating the bill.[xii] Those studies include describing the need to practice preventative medicine, secure an increase in primary care doctors, decrease costs for patients with chronic care and long-term care, reduce childhood obesity, lower the number of medical errors and the amount of over-utilization of medicine and engage in practices that pay for performance rather than traditional fee-for-service methods. This section of the paper describes the unsustainable costs, quality and access problems of our health care system, the reasons for those unsustainable costs, quality and access problems and how the ACA curbs these issues through policy changes.

Without the ACA, health care costs will spiral out of control. On average, health care costs have grown faster than the Gross Domestic Product (GDP) by 2.4 percentage points per year since 1970.[xiii] The annual growth in health care costs was measured at 6.3 percent in 2009. The ACA curbed this growth to 5.7 percent.[xiv] National Health Expenditures were at 2.5 trillion dollars as of 2009, which is equivalent to $8,086 per person or approximately 17.6 percent of GDP.[xv] By 2019, National Health Expenditures were expected to reach 19.3 percent without the ACA.[xvi] The ACA lowers the costs of the current health care system, reducing the federal deficit by an estimated 143 billion dollars between 2010-2019; repealing the bill would cause an estimated increase in the federal deficit of 210 billion dollars between 2012-2021[xvii]. A

Commonwealth Fund[4] report estimated that the ACA would go much further than that, lowering the federal deficit by 400 billion dollars.[xviii]

In comparison to countries within the Organisation for Economic Co-Operation and Development (OECD)[5] who spend above-average per-capita national income on health care, the United States is by far the worst performer. According to data from 2006, health spending in the United States was $6,567 per capita, a staggering 52 percent more than the next highest country (Switzerland).[xix] This number was also roughly 90 percent greater than the majority of countries the United States consider global competitors.[xx] Relative to GDP, the United States was spending four percentage points more than any European country in the OECD.[xxi] Unfortunately this spending was not found to produce substantially better health grades than other developed countries.[xxii] This has held true throughout the growth of costs in the United States.[xxiii]

Curbing the growth of costs was a main need of reform,[6] and it continues to be the main focus of the congressional budget debate. Through a variety of measures, the ACA curbed the

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[4] A private organization dedicated to creating a high performing health system. The Commonwealth Fund routinely publishes materials on improving quality care, lowering costs, and providing effective care. Independent researchers from the Commonwealth Fund often publish on various high-performing aspects of our current system, for example, health providers such as Geisinger Health System, Intermountain Health, and the Mayo Clinic that were among those providing testimony to Congress.

[5] This organization contains the majority of European countries, Australia, Japan, and other Westernized nations that the United States in generally comparative to.

[6] Curbing the costs could also be debated as *the* main need of health reform, although many would argue that access to healthcare through insurance was the main need. This debate is

growth of health expenditures to 5.7 percent (from 6.3 percent).[xxiv] These measures impact Medicare spending, premiums for private insurance and administrative costs. The growth of Medicare spending prior to the ACA was 6.8 percent. The CBO estimates that the ACA lowers that growth to 5.5 percent,[xxv] while the Commonwealth Fund estimates the ACA suppresses growth to 4.9 percent.[xxvi] Projections show that by 2019 the estimated annual premium will be 2,000 dollars cheaper due to the ACA.[xxvii] Administrative costs are expected to decrease by a marginal 27 billion dollars,[xxviii] but the Commonwealth Fund believes that due to the reduced costs for insurer's administration overhead due to the creation of state insurance exchanges, a more realistic figure is 211 billion dollars.[xxix]

The provisions within the ACA that reduced costs were also needed for two other reasons: to 1) grant affordable access to millions of uninsured or underinsured citizens and 2) provide quality care to create a healthier United States in the future, both of which will further curb costs. While some aspects of the ACA may indeed not individually affect one another (for instance, providing incentives for independent health providers to create large integrated delivery systems in an attempt to bundle acute episodes of care does not depend on the creation of state health insurance exchanges), the majority of the areas of the ACA dealing with access, costs, and quality are unequivocally linked (for example, not allowing insurers to deny policies based upon pre-existing conditions will increase costs unless a greater number of healthy people balance out the risk pool). Therefore, it is important to examine reasons why

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unnecessary as the lack of access to insurance raises costs in a variety of ways, as will be presented in this section of the paper.

costs are so high in order to understand how the provisions within the ACA will only lead to lower costs, greater access, and better quality if they are in conjunction with one another.

Factors of Costs: Addressing Patients with Chronic Conditions

Costs have escalated for a variety of factors. Perhaps no other factor epitomizes the need to connect access, quality, and costs then the amount of money spent on individuals with chronic conditions. More than 40 percent of the U.S. population lives with at least one chronic condition.[xxx] That population percentage accounts for 75 percent of all health care spending in the United States.[xxxi] These patients need constant care, and for the United States that translates to extreme costs. A little less than one fourth of all health care spending is for the top 1 percent of our population, and the top 5 percent of our population accounts for half our spending.[xxxii]

Some of these costs stem from lack of access. Roughly 12 percent of nonelderly adults with chronic conditions are uninsured; these people delay or forego treatment at twice the rate of privately insured nonelderly adults,[xxxiii] becoming sicker and costing the system more money once they receive care.[7] Uninsured chronic condition patients are four times more likely to not have access to care than those with private insurance or Medicaid.[xxxiv]

[7] This could occur in a number of instances, including when these patients finally go to the hospital for emergency or even everyday service and/or once they become eligible for Medicare at age 65.

Access to care for all chronic condition patients regardless of insurance carrier[8] decreased due to the sheer escalation of costs for services between 1997 and 2006.[xxxv] Financially, out of pocket health expenditures grew to consume more than 10 percent of family incomes for over 45 million people in 2004.[xxxvi] Persons with a single chronic condition will see their annual out-of-pocket health spending increase by more than 70 percent, and two chronic conditions increase that number to 75 percent.[xxxvii] As the definition of chronic condition implies, this annual percentage will be a constant family burden year after year.

Research shows lowering preventable complications, co-morbidities, and avoidable hospitalizations will significantly reduce direct and indirect expenses for patients with one or more chronic conditions.[xxxviii] Due to the costs of caring for chronic conditions, both preventing chronic conditions and granting affordable insurance to pay for services is vitally important. Granting access to chronic condition patients without insurance significantly lowers their financial burden and produces healthier results for these citizens overall.[xxxix]

The ACA forces insurance companies to insure adults with pre-existing conditions and therefore will enable uninsured chronic care patients the ability to receive quality care at

[8] The study focused on patients with Medicaid (including any adults with coverage through the State Children's Health Insurance Program (SCHIP)), private insurance of any kind, and no insurance.

significantly lower out-of-pocket expenditures.[9] Furthermore, the ACA encourages prevention of chronic conditions through increasing primary care services, especially to underserved areas.

An Example of ACA Solutions: Primary Care Services

Preventive services begin with primary care. Evidence shows that an increase in the number of primary care physicians is associated with decreasing mortality figures, smoking rates, obesity, cancer detection, and other positive measures by practicing preventative care.[xl] Geographic areas with greater primary care supply are associated with lower hospitalization rates for conditions[10] that should be discovered or prevented due to primary care services.[xli] Rates of hospital admission decrease significantly for children where primary care physicians are more involved both before and after hospitalization.[xlii] Individuals utilizing their primary care provider over time for a majority of their health care needs have better satisfaction, lower hospitalization rates, and fewer emergency rooms than those who do not utilize a primary care provider.[xliii]

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[9] This occurs as the insurance company will pay for the majority of the costs with those individuals only paying the premiums and co-pays. This provision will only actually reduce costs if healthier individuals enter into the same risk pool as the uninsured chronic care patients, thereby increasing the number of individuals and premiums paid in total to that particular insurance market and thus lowering the percentage each individual will pay to that market. This paper explains this more in depth later in the paper.

[10] These conditions include chronic conditions such as diabetes, congestive heart failure, and hypertension.

The primary care workforce accounts for about a third of the physician workforce, yet over the past ten years, medical students have shown a vast decrease in interest in primary care.[xliv] During that time, the percentage of positions filled by medical graduates in family practice has decreased by around 20 percent. Also, only 247 residency positions were awarded to those students entering primary care internal medicine in 2009 as opposed to 575 in 1999 (a 43% decrease).[xlv] Many studies attribute the shortage of primary care providers to the astronomical cost of medical tuition and the burden of repaying medical school loans, in comparison to the relatively lower revenues from primary care practice in contrast to other specialties. Students entering specialties instead of primary care earn $3.5 million more over a 35-to-40-year career.[xlvi]

There has been success in steering students and medical residents toward primary care through programs such as the National Health Service Corps (NHSC), a program that provides scholarships and loans repayment to students who dedicate two years of service to urban and rural communities identified as experiencing shortages of primary care physicians. Those granted loan-repayment by the NHSC are about seven times more likely to go into primary care, while those steering clear of debt are close to four-and-a-half times more likely.[xlvii] The NHSC has been bolstered by over 300 million dollars from the American Recovery and Reinvestment Act and the ACA appropriated more than 1.5 billion dollars over the next 5 years to the program.[xlviii]

The ACA also provides primary care services through the use of Community Health Centers.[11] Community Health Centers provide primary care services to over 20 million people who are considered to be in underserved and medically deprived localities.[xlix] In 2008, community health centers had total revenues of 10.8 billion dollars.[l] The ACA doubles that, providing mandatory funding of 11 billion dollars between 2011 and 2015.[li] This funding is absolutely necessary to ensure consistent care and availability of services through these health centers. The ACA expands Medicaid coverage to those individuals below 133 percent of the federal poverty line,[lii] even though 71 percent of community health center patients already were those at or under the federal poverty line.[liii] Also, the uninsured population relies heavily on community health centers heavily as their method of primary care. Thirty-eight percent of the uninsured population depended on community health centers as their primary care service in 2009, but due to the ACA, that number is expected to decrease to 22 percent by 2019.[liv]

These statutory provisions strengthening the economic business of providing primary care services to Americans through the primary care workforce will bring costs down through increased preventative services while providing access and quality of care to millions of Americans. The ACA may not go far enough in upgrading their primary care workforce, as the NHSC was the only program to receive committed funds. While this, coupled with the newly available funds community health centers have, will surely attract primary care physicians to underserved populations, granting care to those populations represents the only new incentive

[11] This term is analogous with Federally Qualified Health Centers.

for students to enter the primary care workforce. It is important to continue to build primary care and preventive services to the entire population, as quality is directly related to primary care, further increasing the value of a strong primary care workforce.

Factors of Costs: Inadequate Quality and Medical Errors

Quality care, regardless of cost, varies widely throughout the United States. This is important as higher spending is associated with lower quality of care.[lv] States that were found to spend over $1,000 per Medicare beneficiary dropped almost ten positions in quality of care given, including decreased utilization of beta-blockers after heart attacks and mammography rates for older women.[lvi] Hawaii spent 4,530 dollars per beneficiary in 2003 while New Jersey spent 8,080 dollars per beneficiary, yet there was no relationship between these figures and achieving higher mortality rates or higher quality of care between Medicare beneficiaries.[lvii] Costs ranged from 23,314 dollars in the best ten percent of hospital regional referrals, to 29,047 dollars in the worst ten percent, yet once again there was no correlation between the excess cost and mortality rates.[lviii] If each state performed at the level of the top performing state, costs would be significantly lower and over 100,000 lives could be saved.[lix]

Lives lost, as well as further complications arising due to medical errors, have been greatly documented over the past ten years. An infamous 1999 report published by the Institute of Medicine reported that between 44,000 and 98,000 people die each year from

medical errors, a number greater than those that die each year as a result of breast cancer and even motor vehicle accidents.[lx] An April 2011 report found that every third person receiving care in a hospital experiences some sort of adverse effect.[lxi12] While not every one of these adverse effects are life-threatening or even result in serious injuries, they can easily lead to further care being given, thereby increasing costs of the hospital, payer, and a patient's co-payments.[lxii]

To answer the problem of quality, the ACA made reforms based upon research that started with the 1999 Institute of Medicine report. At that time, health policy researchers proposed a need for providers to better communicate amongst each other when providing care for the same individual patient, a focus that would become part of what is known as patient-centered care.[lxiii] A second, well-received report from the Institute of Medicine in 2001 elaborated on this concept, describing quality as promoting six individual areas – safe, effective, timely, efficient, equitable and patient centered care – that could improve the health of the citizens of the United States.[lxiv] As these measurements of quality became standardized, the patient-centered model of care became a proposed solution in health policy. The advent of electronic medical records has allowed physicians and nurses to communicate the needs of patients, particularly those with chronic conditions. The ACA took these studies and created delivery system reforms to promote quality by offering incentives for providers to create

[12] This report defined adverse effect as, "injuries caused by medical management, not the underlying disease."

necessary delivery reforms in a variety of collaborative efforts, including patient-centered medical homes[13] and Accountable Care Organizations.

ACA Solutions through delivery reform: The Medicare Shared Savings Program and Accountable Care Organizations.

The ACA establishes the Medicare Shared Savings Program (MSSP) in section 3022, which provides financial incentives for health providers to work together through accountable care organizations.[lxv] An accountable care organization (ACO) is a legal entity comprised of Medicare-enrolled providers that collaborate to improve quality and efficiency.[lxvi14] An ACO must include a sufficient number of primary care physicians that can maintain a minimum of

[13] Generally, a patient-centered medical home provides 24/7 access to care for patients through an electronic database, connects care given to patients from their multiple providers, and lowers costs by reducing visits to primary and secondary care sources.

[14] In April 2011, CMS published a 429-page list of regulations on the Medicare Shared Savings Program, which includes Accountable Care Organizations. The complete regulations are available here: http://edocket.access.gpo.gov/2011/pdf/2011-7880.pdf. Many lawyers, consultants, health policy experts and healthcare providers immediately published articles dissecting these regulations. This section will rely on the ACO Cheat Sheet published by Spencer Healthcare Strategists, a healthcare consulting firm in Kansas City, Kansas. The ACO Cheat Sheet is available here: http://www.shstrategists.com/uploads/file/--FINAL%2004_19_11%20ACO%20Cheat%20Sheet.pdf. (The author currently works for Spencer and helped prepare the ACO Cheat Sheet).

5,000 Medicare beneficiaries.[lxvii] Any other Medicare-enrolled provider can join an ACO.[lxviii] While ACOs are subject to applicable state law, they are not contained to one individual state.[15]

Accountable care organizations receive financial incentives by receiving a performance score that is determined by meeting specific reporting and performance standards that are based on quality measures.[lxix] The ACO's performance score determines the percentage of savings the ACO will receive, but if the score is below a certain level, the ACO will not be able to collect the savings.[lxx] For some types of ACOs, low performance scores can lead to an overall increase in health expenditures per a CMS-created benchmark, resulting in the ACO paying a penalty to CMS.[lxxi16] The quality measures that make up the performance score are split into three domains – patient/caregiver experience, care coordination, and patient safety – that each improve the quality of care given to patients.[lxxii]

For example, one of the patient safety measures requires ACOs to report on hospital acquired conditions, a synonymous term of adverse effects or medical errors.[lxxiii] If ACOs report "x" number of hospital acquired conditions, it lowers their overall score and thus could lead to a loss.[lxxiv] In this way, ACOs provide the incentive for physicians to combat hospital acquired conditions while improving quality as a whole as savings gained from proven quality standards

[15] Section II.B of the regulations discusses the eligibility of ACO participants. These participants can include hospitals, health systems, critical access hospitals, federally qualified health centers, and rural health clinics, all of which can cross inter-state lines.

[16] There are two tracks of ACOs and this provision only applies to track 2 ACOs. All ACOs have to become track 2 ACOs by their third year of being an ACO. In any case, ACOs are subject to shared savings they can disperse to physicians for providing quality care or shared losses they could potentially pay a penalty for due to inadequate quality given to the patient.

will lead to higher payments for physicians. Similarly, this decrease of medical errors will result in lower healthcare expenditures in these ACOs. In fact, ACOs are estimated to save over 500 million dollars over three years.[lxxv]

The accountable care organization is just one of many delivery system reforms established by the ACA to create a health system that actually performs the way it is supposed to – providing better health. ACOs encourage collaboration among providers and insurers. Most of these organizations will stay within one state, but a significant amount ACOs will cross state boundaries and lower costs while at the same time working with multiple insurance payers.[17] This formation of legal entities to integrate and collaborate in care-giving is an example of how the ACA is affecting interstate commerce when providing solutions in order to lower costs and provide higher quality health care services. One large area, stimulating access to health care, further establishes the ACA's need to affect interstate commerce.

Factors of Cost: Access to Health Insurance

In 2009, Harvard researchers determined that nearly one person in the United States dies every 12 minutes, or a total of 45,000 people each year, because they lack health insurance

[17] Examples of these systems are Intermountain Healthcare in Utah and Idaho, Mercy Health System in Wisconsin and Illinois, and St. Luke's Health System in Kansas and Missouri.

and cannot receive good care.[18][lxxvi] This number updated previous research, including a 2004 study that estimated that 20,000 people died due to a lack of health insurance.[lxxvii] While economic studies have not measured the direct amount of costs associated with mortality figures from the data collected in the Harvard study, the Institute of Medicine did estimate the costs associated with the lack of health insurance for the 2004 study as between 65 billion and 130 billion each year.[lxxviii]

Prior to enactment of the ACA, 50 million people did not have health insurance.[lxxix] More than one in five individuals under 65 did not have health insurance in 2009, and between 2007 and 2009, 5 million individuals lost health insurance.[lxxx] Over half of the uninsured have no regular source of care, thus foregoing treatments due to costs, which leads to more serious health problems that require hospitalizations for conditions that are considered preventable.[lxxxi] These costs are subsidized by those in the insurance market. Americans with health insurance currently pay 1,100 dollars per year compensating the care of the uninsured.[lxxxii] Effectively, uninsured Americans drive costs up for the entire health care system and for every individual American that does have health insurance.

ACA Solutions: State-based Exchanges, Insurance Regulations, and the Individual Responsibility Requirement

[18] The Harvard researchers claim to have used updated research methods from the previous studies that determined mortality rates based upon a lack of health insurance.

In the attempt to create access for consumers, the ACA established state-based health insurance exchanges that grant consumers the ability to compare and choose from among a variety of state health plans while establishing common rules for how insurance is offered and sold. Each state will be able to set-up a marketplace for individuals seeking insurance, another marketplace for small businesses of up to 100 employees (states can seek an option until 2016 to lower this number to 50 employees), and the ability to join a regional, multi-state exchange, if the state so chooses.[lxxxiii] States also have the option to combine these exchanges into one marketplace, may allow large businesses of more than 100 employees to join the exchanges beginning 2017, and can opt out of creating an exchange all together, at which point the Federal government will then assume the role.[lxxxiv] These state-based health insurance exchanges also adhere to the 1945 McCarren-Ferguson Act, which declared that the business of insurance should be regulated by the states.[19]

The exchanges are expected to contribute vast savings to consumers and the system as a whole. Twenty-nine million people are expected to purchase insurance through the exchanges, whether independently or through small businesses.[lxxxv] The exchanges are also

[19] The McCarren-Ferguson Act only maintains that insurance should be regulated by the states. It does not contend that Congress cannot regulate insurance as a whole. This bright line solution to a potential Federalism problem grants states the ability to regulate the insurance market even though Congress can enact specific rules on *how* states regulate the insurance market. Therefore, the ability to contain insurance regulation to the states through the state-based health insurance discouraged any Federalism constitutional claims.

designed to cut administrative costs from insurers. Part of the reason the exchanges offer these exchanges to individuals and small businesses rather than large businesses at the beginning stages is due to the percentage of insurance premiums devoted to administrative costs in each of the respective markets. It is estimated that insurance premiums account only for 5 percent of large businesses administrative costs, yet this number is approximately 30 percent for individual markets.[lxxxvi] Grouping individual and small business together into larger entities will lower this number down to an estimate-able 10 percent, reducing costs by 211 billion dollars.[lxxxvii]

Exchanges are also in charge of monitoring health plans' adherence to new rules. The exchanges will have the authority to reject a health plan if its premiums are too expensive. The ACA also mandates that insurance premiums must pay for 80 to 85 percent on the direct care of the consumer.[lxxxviii] This way, administrative costs cannot account for more than 15-20 percent of patients' premiums. The enforcement of these regulations on health plans by the exchanges provides states further ability to regulate insurance as well as curbs the costs of health expenditures in general.

Other newly enforced guidelines include the limited ability for insurers to medically underwrite and a prohibition against their denying coverage for those with pre-existing conditions. Medical underwriting, when an insurance company denies or increases premiums based upon a person's unique characteristics, cannot include health status and is limited to areas such as age and whether or not you smoke.[lxxxix] The ACA prohibits insurance companies

from denying coverage based upon pre-existing conditions, allowing the sicker people who were generally denied coverage the ability to now apply and receive coverage. This increases the risk of the insured pool, which will increase the costs of premiums unless the risk is spread out over a healthy population. The ACA also offers subsidies in the form of tax credits for those between 133% and 400% of the Federal poverty level to obtain insurance through the state exchanges.[20][xc] All these provisions together enable a sick, poor, ill population to enter a health insurance risk pool that has capped insurance premium rates. Essentially these guidelines only succeed if the risk pool can be spread to a large enough population that it significantly lowers the overall risk.

In order to reduce the rise in risk for these insurance markets, healthy persons need to consistently be in the same marketplace. As mentioned, Americans with health insurance currently pay 1,100 dollars compensating the care of the uninsured.[xci] The only way that number can decrease is if healthy uninsured residents enter the marketplace, spreading the risk to healthy individuals. The ACA established that every resident has the individual responsibility of obtaining health insurance. This will provide insurance companies a risk spread out across enough people to provide decreased premiums while still making the profits they need to afford care. Due to all the other significant areas of health insurance that are being reformed in order to lower costs, provide access, and give quality care, the Affordable Care Act needs the individual responsibility requirement to succeed.

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[20] Those below 133% of the Federal poverty level are eligible for Medicaid.

What does this all mean? Linking Costs, Quality and Access reforms

Overall, the problems of our health care system – unsustainable costs, inadequate quality, and insufficient access – are interlinked, as are the solutions the ACA creates to fix them. In an attempt to lower costs, the ACA improved a primary care workforce by funding a national organization, the NHSC, in order to better treat patients with chronic conditions. The NHSC provides care to underserved areas across state-boundaries, thus affecting interstate commerce. The incentives provided to students to practice primary care will allow students to practice care anywhere the NHSC does, which also affects interstate commerce.

The ACA created ACOs that are comprised of primary care physicians providing quality services that will decrease medical errors and thus, costs. ACOs are organizations that will cross state boundaries in an attempt to provide quality and efficient health services. The ability for these interstate organizations to lower costs affects interstate commerce.

State-based exchanges will provide the ability for almost 30 million people to obtain health insurance, lowering costs, and increasing quality of care. This model adheres to the standard practice of states regulating insurance in general.

The limits placed on medical underwriting and the complete discontinuance of denying insurance based on pre-existing conditions will significantly increase the ability for uninsured Americans to obtain insurance. Increasing insurance for the uninsured will lead to substantially

fewer deaths due to a lack of insurance, reduce the amount of money lost as a result of those deaths, and lower the 1,100 dollars of premiums that are shifted onto insured Americans to cover uninsured Americans. This will only succeed if the insurance pool is spread out across a healthy risk population. The ACA therefore, enacted an individual responsibility requirement in order to have healthy persons enter a market, which will substantially affect interstate commerce across America by reducing costs to all Americans.

II

Enacting the Affordable Care Act: Foundation of the Commerce Clause Precedent

With any piece of legislation, Congress needs to present the authority granted to them by the Constitution on which they can create new law. Two possible powers were available: the tax and spend power[21] and the Commerce Clause power[22]. The failure of having health insurance creates an economic incentive to obtain health insurance in the form of a 750 dollar per year increase in financial income tax liability for those who do not comply. This increase in

[21] Article 1 Section 8 of the Constitution states: "The Congress shall have the Power To lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States."

[22] Article 1 Section 8 of the Constitution states: "The Congress shall have the Power To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."

tax liability only occurs if the citizen has taxable income and does not already have health insurance coverage through Medicare, Medicaid, or the military.

Secondly available to Congress is use of the Commerce Clause power. Congress expressly stated their intention to use their Commerce Clause power in enacting the individual responsibility requirement provision.[23] Congress has the ability to regulate commerce in order to provide for the general welfare of the United States. The health of their citizens is part of the general welfare of the country. As described, the health insurance market clearly affects the overall health of the country's citizens, as poor quality of care and lack of insurance lead to deaths. Furthermore, Congress relied on legal Commerce Clause precedent to create rules for the insurance market.

In *United States v. South-Eastern Underwriters*,[xcii] in 1944, the Supreme Court held that Congress had Commerce Clause power to regulate the insurance business as "the modern insurance business is commerce, and, when it is conducted across state lines, it is interstate commerce."[xciii] The business of insurance often could execute its practice solely intrastate, yet because the insurance business "substantially affects" interstate commerce, it can be regulated by Congress.[xciv] Therefore, the Court established that Congress has the power to regulate the business of insurance. If Congress has the power to regulate the business of insurance, it logically has the power to regulate a singular type of insurance – in this case health insurance.

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[23] ACA: Title I, Subtitle F, section 1501 states: "the individual responsibility requirement provided for in this section…is commercial and economic in nature, and substantially affects interstate commerce…"[23]

Defining the Limits to the Commerce Clause Power

In 1938, Congress passed the Agricultural Adjustment Act, which, in relation to wheat, controlled the interstate and foreign movement of wheat.[xcv] The act limited the amount of wheat to a certain acreage per farmer and any amount grown over that would need to be given to the Secretary of Agriculture or the farmer would be fined.[xcvi] In *Wickard v Filburn*, small Ohio farmer Filburn grew more than his acreage and the excess was kept for his and his family's consumption; he refused to pay fines or turn in his excess wheat, as he believed Congress did not have power under the Commerce Clause to regulate instate local commerce.[xcvii] The Court held in an 8-0 decision that

> "even if an appellee's activity be local, and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce, and this irrespective of whether such effect is what might at some earlier time have been defined as 'direct' or 'indirect.'"[xcviii]

As *Wickard* has not been overruled nor tinkered with, this "substantial effect" holding remains as precedent. Therefore, an activity does not need to be regarded as commerce, and it may be reached if it exerts a substantial economic effect on interstate commerce.

The *Wickard* Court also stated that simple nomenclature such as 'indirect' and 'production' had no effect on their decision. Thus, direct and indirect activity is the same in the Court's view. Filburn's activity was simply production of wheat, and as that was within the wheat market, it was within Congress' power to regulate. From this holding, one concludes that any activity, whether or not it was regarded as commerce, i.e. un-commercial activity, is indeed within Congress' power, if it substantially affects the interstate commerce of a specific market.

The ACA's individual responsibility requirement substantially resembles the marketing quotas established by the Agricultural Adjustment Act. The Agricultural Adjustment Act includes a definition of the "wheat market" and its derivates as "feeding in any form to poultry or livestock which, or the products of which, are sold, bartered, or exchanged, or to be so disposed of."[xcix] The Court concluded from this that "(h)ence, marketing quotas not only embrace all that may be sold without penalty, but also what may be consumed on the premises."[c] Thus, the subject of *Wickard*, Filburn, could not utilize this excess wheat in any way – to feed his poultry or his family – because it would affect commerce. This implies that if you are eating your own wheat or giving your wheat to livestock, or doing anything else with your wheat for your purposes, you are substantially adversely affecting the market for wheat because you are not spending money in the market. This goes as far as saying that spending money in the market is necessary in order to keep market prices to a price determined by Congress.

The facts of *Wickard* are directly on point with the legislative scheme of the Affordable Care Act. When persons purchase health insurance they affect the premiums of that insurance company. When persons do not purchase insurance, they create an economic increase in prices of 1,100 dollars a year to other Americans.[ci] If a healthy person purchases health insurance, then the premiums go down as the cost of caring for that person over time decreases; conversely, if a healthy person does not purchase health insurance, that person adversely affects the market, as the premiums go up since only sick people are insured and the cost of caring for sick people must be off-set by higher premium prices. As *Wickard's* holding that has remained precedent deemed that spending money in a marketplace can be regulated by Congress to reduce the prices of that market, the spending of money on health insurance will lower the prices of health insurance in general for all Americans within that market. Therefore, Congress has the power to issue regulations and set market prices on health insurance.

Congress has limits to the power granted to it by the Commerce Clause via the Necessary and Proper Clause.[24] The substantial effects test created in *Wickard* is used to determine that there are outer limits of what is a necessary and proper use of Congress' ability to make rules on behalf of commerce. These outer limits were defined in the 1995 case *United States v. Lopez*.

[24] Article 1 Section 8 of the Constitution states: "The Congress shall have the Power To make all Laws which shall be necessary and proper for carrying into Execution the (Commerce Clause power).

Five years prior to *Lopez*, Congress enacted the Gun Free School Zones Act, which forbids individuals from knowingly being in a school zone with a firearm. In creating this act, Congress utilized its power to make rules under the Commerce Clause, contending that, among other things, firearms move easily throughout interstate commerce, have been found at increasing levels throughout schools, the occurrence of violent crime in schools results in a decline to quality in the school, and this decline in education subsequently has an adverse affect on interstate commerce.[cii]

In analyzing *Lopez*, the Court concluded that there were three broad categories of activity that Congress had the ability to regulate through the Commerce Clause: 1) Congress may regulate the channels of interstate commerce; 2) Congress may regulate "the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may only come from intrastate activity;" (e.g. the destruction of an aircraft) and 3) Congress may regulate "activities having a substantial relation on interstate commerce."[ciii] The Court addressed the third provision of this assessment in *Lopez*. Concluding that the Gun Free School Zones Act had "nothing to do with commerce" and that "the possession of a gun in a local school zone is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce," the court held that Congress had exceeded its limits of power granted through the Commerce Clause.[civ] This holding established precedent that the remoteness of the subject of regulation could not be far removed from actual commerce. Therefore, in *United States v. Lopez*, in broad terms, the

regulation of the "business of elementary and secondary education" was too far removed from the action of carrying guns within a prescribed distance of a school to come within Congress' Commerce Clause power.

Similarly, in the 2000 case, *United States v Morrison*, Morrison violated the Violence Against Women Act, which Congress created because victims of such violent acts made criminal through that legislation were significantly deterred from participating in certain types of commerce due to fear, abuse, and psychological concerns created by the violent acts.[cv] The plaintiffs in this case alleged that the Violence Against Women Act's ability to limit gender-motivated violence wherever it occurred substantially affected interstate commerce. The Court held that the Violence Against Women Act, like the legislation in *Lopez*, it was so far removed from actual commerce and "did not contain jurisdictionally limiting language," so Congress could not reach it through the commerce clause. Therefore, in *U.S. v. Morrison*, the regulation to limit abuse, assault, and gender-motivated violence was too far removed from the action of citizens participating in certain types of commerce to come within Congress' Commerce Clause power.

The action of buying health insurance does not fall within the limitations set by the *Lopez* and *Morrison* holdings. This action substantially affects interstate commerce on a whole as described by the impact to costs on national expenditures, the shifting of the costs of care to insured Americans by 1,100 dollars per year, the premiums that are increased to those insured due to the risk not being spread around, and the costs that directly result from the deaths of

those that are not insured. The regulation of the health insurance market by requiring individuals to purchase health insurance is not too far removed from the action of not buying health insurance. Therefore, Congress can regulate the action of buying health insurance as it falls under the standard of substantially affecting instate commerce.

The Activity/Inactivity Argument

Current legal analysis challenges that this action, the purchasing of health insurance, is in fact an economic inactivity, which is an action outside Congress' Commerce Clause powers.[cvi] In essence, this argument alleges that the individual responsibility requirement does not regulate insurance; it regulates the not purchasing of insurance. In the 2010 case *Florida v. United States Department of Health and Human Services*, that recently held that the individual responsibility requirement is unconstitutional, the court determined that the people have no choice but to either pay for the insurance or pay the penalty.[cvii] It is this definition of inactivity – a person not engaged in activity must become engage or face a fine – which the court used to demonstrate the individual responsibility requirement is unconstitutional.[cviii]

In order to determine that requiring activity from inactivity is unconstitutional, the court needed to hold that the failure of purchasing health insurance is not activity. The failure to purchase health insurance is conduct that, in its most basic nature, substantially affects interstate commerce. The conduct of not purchasing health insurance raises the overall risk

pool of the population prior to any person ever receiving care. In this form, there is no need for any further conduct other than not being in the market in the first place to have the effect of raising prices for everybody with insurance. For those uninsured that do seek care, the choice of not having health insurance makes other United States citizens pay for over 1,100 dollars every year. Judge Vinson, whom decided *Florida v. HHS*, even acknowledged that the uninsured receive 43 billion dollars in uncompensated care alone.[cix] All of these instances describe how the failure to purchase health insurance substantially affects interstate commerce.

As the failure to purchase health insurance substantially affects interstate commerce, the precedent in *South-Eastern* holds that Congress can regulate health insurance, and regulating health insurance is not outside the scope of the necessary and proper clause as determined by *Lopez* and *Morrison*, then Congress can choose the way to regulate healthy individuals in order for them to enter a marketplace they already substantially affect. Congress chose the method of an individual responsibility requirement, a rational ability to compel healthy individuals to stop directly negatively affecting fellow citizens.[25]

Judge Vinson disagrees. In his decision, he holds that:

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[25] Ideas such as universal healthcare, a single-payer system and health insurance cards are all other rational ideas that have been consistently seen in legislative history as a method for stopping the unsustainable costs that the uninsured population forces onto the United States as a whole. Another rational idea is a similar health provision, Medicare, that forces individuals to pay into a system in order to receive healthcare at a future date. One person could choose to try and forego that payment by not seeking a job and thereby not acquiring enough income to pay into Medicare through taxes and shifting the costs of care onto others. That choice does not dismiss the fact that Congress can (and does) still regulate persons to pay into Medicare.

> "the mere status of not having health insurance has absolutely no impact whatsoever on interstate commerce…if impact on interstate commerce were to be calculated mathematically, the status of being uninsured would necessarily be represented as zero. The uninsured can only be said to have a substantial effect on interstate commerce if 1) they get sick or injured; 2) they are uninsured at that point in time; 3) if they seek medical care at that point in time; 4) if they are unable to pay for the medical care received; and 5) they are unable or unwilling to make payment arrangements directly with the health care provider, or with assistance of family, friends, and charitable groups, and the costs are therefore shifted onto others."[cx]

Judge Vinson determines then that only by stacking "inference upon inference"[cxi] can the failure to purchase healthcare have a substantial effect on interstate commerce.[26]

This legal reasoning is the fundamental fallacy in the inactivity argument. The uninsured substantially effect interstate commerce prior to any other circumstance in two ways, both

[26] In *Lopez*, the Court held that the by piling inference upon inference, i.e. the possession of a gun in a school zone, then the conduct could substantially affect interstate commerce. This piling of inferences could lead anything into becoming commerce, thus completely refuting the idea that there is limited outer reaches of Congress' Commerce Clause power.

directly and indirectly.[27] The uninsured substantially effect interstate commerce directly through the rise in premiums other individuals pay due to the sheer nature of not being in that risk pool. This effect occurs prior to any individual ever "(getting) sick or injured." To expand that risk pool, thus lowering costs, healthy individuals must enter the marketplace. Congress determined they needed to expand that risk pool to fix the unsustainable costs of the healthcare system as a whole.

The uninsured also indirectly substantially affect interstate commerce. Being uninsured substantially affects every other American's economic activity. That is to say that being uninsured indirectly creates a negative economic impact on both individuals, as insured persons' costs of care increase through cost-shifting,[28] and the system as a whole as, half of the uninsured forego initial care treatments, which leads to more serious health problems that require hospitalizations for conditions that are considered preventable and thus drive up costs for the entire system, leading to an unsustainable health care crisis that has caused massive amounts of overhaul in an attempt to salvage the United States budget.

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[27] In *Wickard*, the Court held that 'direct' and 'indirect' are simple nomenclature that has no relevance on whether activity substantially affects interstate commerce.

[28] Judge Vinson held that this negative effect only occurred long after four other decisions were made by the uninsured (become needing of care, be uninsured, seek care, and do not have the ability to pay for that care). Fifty million American's are uninsured, and it only takes one person to go through that five-step process. As healthcare is something that one in fifty million Americans will incontrovertibly seek, there is a cost-shift, no matter how minimal, onto insured persons' cost of care for covering, at the very lowest, one uninsured American.

Secondly, Judge Vinson's holding does not adhere to legal precedent, as his holding offers the same argument as that in *Wickard*. In *Wickard*, Congress restricted the extent to which a person could forestall reporting to the market by producing wheat to cater to his own need, even if that regulation FORCED that some farmers purchase wheat when they could grow that wheat themselves. Yes, the farmers were already involved in the wheat marketplace as a whole. They were not involved in the purchasing of wheat market that Congress then decided to regulate, based upon how it substantially affects the overall interstate commerce of the nation. Similarly, uninsured are in the health insurance marketplace as their actions have both direct and indirect consequences on every other person in the United States. The uninsured are not involved in the purchasing of the health insurance market that Congress decided to regulate based upon how it substantially affects the overall interstate commerce of the nation. The two contexts are sufficiently analogous.

In conclusion, the failure to purchase health insurance plays substantially affects interstate commerce on its face as well as by direct and indirect methods. Congress has the ability to regulate this conduct through the Commerce Clause, the necessary and proper clause, and its ability to promote rules for the general welfare, as well as firm legal precedent set forth in *Wickard* and *South-Eastern*. The formation of an individual responsibility requirement is constitutional as it substantially affects interstate commerce and is not too far removed from the subject of regulation. Furthermore, an individual not having health insurance directly and indirectly substantially affects interstate commerce. As the individual responsibility

requirement is a constitutional means to regulate an action that substantially affects interstate commerce by itself, then Congress has the constitutional power to create this requirement through the Commerce Clause.

Conclusion

The Affordable Care Act provides a solution to the economically unsustainable way we provide, deliver and insure healthcare in America. If the ACA were to be repealed, or rescinded through an unconstitutional provision, then the country would very possibly be paying for one fourth of the costs of healthcare in ten years, and continue to grow at a rate that would either bankrupt this country or fragment it in a way that could force a governmental and budgetary restructuring that could destroy the ideals that this nation was founded upon. Through changes such as providing a primary care workforce that can care for our chronic-cost populations, the development of new delivery systems like accountable care organizations to ensure quality care is provided at lower costs, and the creation of state-based health insurance exchanges that grant insurance to almost 30 million people, Congress has enacted rules and regulations that have the ability to avoid this economic calamity. Any disruption to this reform would ensure a continued inevitability of economic disaster. Congress did not overstep any constitutional limitations when creating this bill, as the minimum coverage provision that establishes an

individual responsibility requirement, which provides a solution for the interlinked problem of unsustainable costs and inadequate access, satisfied all constitutional tests to date. By holding unconstitutional either the individual responsibility requirement or the entire ACA, our judicial branch would ensure a path of incontrovertible economic calamity.

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