Healthcare Reform Issue

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THE FACTUAL BASES FOR CONSTITUTIONAL CHALLENGES TO THE CONSTITUTIONALITY OF FEDERAL HEALTH INSURANCE REFORM

Mark A. Hall *

“Everyone is entitled to his own opinion, but not his own facts.”
- Sen. Daniel Patrick Moynihan

I. INTRODUCTION

From challenges to his citizenship to assertions about his religion, no U.S. leader has had to endure the relentless bombardment of fabrications and falsehoods that continue to stalk President Obama. The same is true for his signature domestic program, the Patient Protection and Affordable Care Act of 2010 (the “ACA” or “Affordable Care Act”). According to FactCheck.org, “We’ve seldom seen a piece of legislation so widely misrepresented, and misunderstood, as the new health care law. We stopped counting the number of articles and items we turned out on the subject after the total reached 100.”

Most prominent among the falsehoods and malicious misconstructions were Sarah Palin’s absurd claim that cost containment would result in government “death panels”; Representative Joe Wilson’s falsely-premised outburst “You

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5. Rachel Weiner, Palin: Obama’s “Death Panel” Could Kill My Down Syndrome Baby, THE HUFFINGTON POST (Aug. 7, 2009, 06:19 PM), http://www.huffingtonpost.com/2009/08/07/palin-obamas-death-panel_n_254399.html. Palin said: “[W]ho will suffer the most when they ration care? The sick, the elderly, and the disabled, of course. The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide, based on a subjective judgment of their ‘level of productivity in society,’ whether they are worthy of health care. Such a system is downright evil.”
“You Lie!” regarding funding for illegal immigrants, which Wilson made during the President’s 2009 State of the Union Address; and Representative Randy Neugebauer’s mean-spirited “baby killer” insult, which Neugebauer hurled on the floor of Congress at Representative Bart Stupak for Stupak’s support of a law that does not in fact directly fund abortions. More mundane, but equally mendacious, are unrelenting assertions that the new reform law constitutes a government takeover of the healthcare sector and is tantamount to socialized medicine. According to FactCheck.org, there appears to be no end to the “malarkey about health care” reform:

Our inboxes are filled with messages asking about assertions that the new law:

- Requires patients to be implanted with microchips. (No, it doesn’t.)
- Cuts benefits for military families and retirees. (No. The TRICARE program isn’t affected.)
- Exempts Muslims from the requirement to obtain coverage. (Not specifically. It does have a religious exemption, but that is intended for Old Order Amish.)
- Allows insurance companies to continue denying coverage to children with preexisting conditions. (Insurance companies have agreed not to exploit a loophole that might have allowed this.)
- Will require 16,500 armed IRS agents to enforce. (No. Criminal penalties are waived.)
- Gives president Obama a Nazi-like “private army.” (No. It provides a reserve corps of doctors and other health workers for emergencies.)


8. Abortion: Which Side is Fabricating?, FACTCHECK.ORG (Aug. 21, 2009), http://www.factcheck.org/2009/08/abortion-which-side-is-fabricating/ (“The truth is that bills now before Congress don’t require federal money to be used for supporting abortion coverage . . . . But it’s equally true that House and Senate legislation would allow a new ‘public’ insurance plan to cover abortions, despite language added to the House bill that technically forbids using public funds to pay for them.”).

9. See Letter from Diane S. Silver, MD, to patients, (Sept. 8, 2010) available at http://www.besthealthcarerates.com/Default.aspx?app=LeadgenDownload&shortpath=docs%2fDrSilver’s%5eLt%5ete%5eObamacare.pdf (alarming patients that “you will no longer be able to make your own health care decisions. This means that as your physician, I cannot exercise my best judgment for your care but must adhere to the federal government rules directing what drugs I may prescribe, and the diagnostic tests, the treatments and the specialist referrals that I will be authorized to recommend” and that “this legislation will end the patient-doctor relationship as we have known it and will transform American health care into a European socialist model.”). See also Henig, supra note 3.
• “Exempts” House and Senate members. (No. Their coverage may not be as good as before, in fact.)
• Covers erectile-dysfunction drugs for sex offenders. (Just as it was before the new law, those no longer in jail can buy any insurance plan they choose.)
• Provides federal funding for abortions. (Not directly. But neither side in the abortion debate is happy with the law.)

Against this backdrop of pernicious mythology, it is critically important for sober-minded legal analysts to navigate carefully when moving through the minefield of factual claims on which constitutional challenges to health insurance reform are based.

As reviewed elsewhere in this symposium, four basic sets of constitutional arguments currently are pending: (1) that requiring individuals to purchase health insurance is not “necessary and proper” to regulating how insurance is sold in interstate commerce; (2) that mandating coverage regulates the merely passive decision to remain outside the health insurance market and to pay for care out-of-pocket; (3) that various regulatory provisions violate individual rights that the Fifth Amendment protects; and (4) that federal requirements “commandeer” states and therefore violate states’ sovereign authority.

Each of these arguments is premised on certain factual claims or assumptions about what is in the law and how the law is likely to affect real-world conditions and behaviors. This article critiques these factual bases for constitutional arguments by documenting more accurately both what the Affordable Care Act actually does and the most credible projections of its probable impacts.

II. INSURANCE MARKET DYNAMICS

A. The Highly Concentrated Burden of Medical Costs

Understanding the structure and logic of the ACA and its likely effects requires some background understanding of how healthcare and insurance

14. Id. at 3-4.
markets function in the absence of reform. The single most important characteristic of those markets is the heavy concentration of overall medical costs in relatively few people who have very high costs. It is difficult to find the right words to describe this foundational statistical phenomenon in terms that are sufficiently compelling, so I will start with a graphic depiction (Figure 1).

Arraying the population by the cost of their individual health care in 2005, this figure shows that the top 1% (those who cost more than $43,000 each) accounted for almost one-fourth of total spending, the top 5% of people (who cost more than $14,000 each) accounted for half of all spending, and the top 20% of people (who cost more than about $4,000 each) accounted for 80% of spending. The bottom half of the population distribution (who cost less than $800 that year) incurred less than 4% of total costs.

16. Id.
17. Id. at 4 (citing Kaiser Family Foundations calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2005).
18. Id.
For convenience, I refer to this as “the 80/20 rule”: the top 20% of people account for 80% of total costs, and the bottom 80% of people account for only 20% of costs. 19 I call this observation a rule because the pattern is remarkably universal. 20 It holds true both for the population at large and for just about any subpopulation of significant size one might choose to examine. 21 For example, spending for Medicare recipients, spending for people in their 40s, and spending for just about any larger employer group all exhibit the same pattern. 22 As Exhibit 4 shows, this same essential pattern has persisted for more than 35 years. 23 The extreme concentration of health care costs is an economic law of nature that arises from the human biological condition and the vagaries of chance. 24 The 80/20 rule, or something like it, was evident as early as the 1930s, and it is likely to be with us for as long as anyone can foresee – regardless of how we deliver and pay for health care. 25

Because the distribution is so extreme, there is no easy way to reduce or eliminate the effects of concentrated medical costs. 26 Scholars, governments, and insurance providers have tried or proposed various techniques such as high-risk pools, reinsurance, and risk adjustment. 27 These measures can certainly help

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19. Id.
20. Id.
22. Id.
23. Id. at 8.
25. See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 4.
26. Id.
27. Id. See Mark A. Hall, Government-Sponsored Reinsurance, 19 Annals Health L. 465 (2010); William H. Dow, Brent D. Fulton, & Katherine Baicker, Reinsurance for High Health Costs: Benefits, Limitations, and Alternatives, 13(2) F. Health Econ. & Pol’y Art. 7 (2010),
to spread the burden somewhat, but the amount of money involved is too large to permit easy elimination of the basic underlying phenomenon. For instance, if the top 50% of expenditures were removed from the market, some of the remaining people’s expenses would be ten times greater than the middle of the distribution (see Figure 1). Removing even half the costs would not alter the basic dynamics created the remaining costs still being concentrated in a small portion of people. I stress the 80/20 rule because, as I have said elsewhere:

it is the most elemental fact of health insurance. It is as fundamental as gravity, and as pervasive as the weather. It is the endemic First Cause that reaches everywhere and explains just about everything of importance in the market for insurance. The high concentration of medical costs is why we need insurance in the first place. Pooling expenses across a population keeps them affordable for everyone, but the extreme cost at the high end also explains why insurance is so expensive, especially for those who anticipate no real need.

B. Risk Segmentation, Adverse Selection, and Medical Underwriting

The extreme magnitude of differential health risk also explains the private insurance market’s most perplexing dynamics – ones that the Affordable Care Act aims to remedy. The ACA targets several troubling phenomena, each of which derives from the basic fact that insurers stand to gain a great deal by avoiding or appropriately pricing people with higher risks. That is why competitive forces in health insurance markets unavoidably focus on selecting and pricing risk. These natural dynamics are so strong that risk sorting occurs even without overt evaluation of medical conditions. Product features such as deductibles and benefit design appeal differently to people with different health care needs. Therefore, purchasers tend to sort themselves by risk according to these features they find most appealing.

To counteract people’s selective and strategic purchase of insurance, insurers in unregulated markets engage in various forms of risk screening.


See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 4.

Id. at 3-4.


Id.


See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 6.

most visible form of risk screening is medical underwriting, which consists of evaluating the health risks specific to each subscriber to determine the terms of coverage and assign an actuarially fair price.\textsuperscript{35} In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage.\textsuperscript{36}

Medical underwriting is necessary because of adverse selection – the tendency of people to avoid the purchase of insurance unless they expect to need it, and the tendency of those with greater need to buy more insurance.\textsuperscript{37} In a phrase, a “health insurance market could never survive or even form if people could buy insurance on the way to the hospital.”\textsuperscript{38} Therefore, medical underwriting is needed to encourage people to subscribe while they are still healthy.

Subscribers who no longer can pass medical underwriting might be stuck with the insurance they have. Although in theory they can keep their coverage forever (or as long as the insurer remains in business), at some point mounting medical costs in the pool of covered subscribers make it no longer economical for the insurer to sell that particular policy to new subscribers.\textsuperscript{39} “And, once no new healthier subscribers are entering the pool, the costs skyrocket into what is called a ‘death spiral.’”\textsuperscript{40}

Employers can avoid premium spirals by shopping for new insurance, under market reforms since the 1990s that require insurers to cover all employers.\textsuperscript{41} But an individual who leaves a job with good benefits can easily find herself uninsurable, and those who go without insurance more than two months before taking a new job with health insurance are subject to exclusion of their pre-existing conditions for up to one year.\textsuperscript{42} These concerns lead to what is known as “job lock” – reluctance to change jobs for fear of losing health insurance.\textsuperscript{43} According to the most thorough analysis, workers with health insurance are

\textsuperscript{35} See MERLIS, supra note 34 at 3; AM. ACAD. OF ACTUARIES, supra note 34 at 4.

\textsuperscript{36} GEORGETOWN UNIV. INST. FOR HEALTH CARE RESEARCH AND POLICY, HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-THAN-PERFECT HEALTH?, Report to the Kaiser Family Foundation 11, 27 (June 2001).

\textsuperscript{37} MERLIS, supra note 34 at 5.

\textsuperscript{38} See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 5.

\textsuperscript{39} Id.

\textsuperscript{40} Id.

\textsuperscript{41} See Hall, Government-Sponsored Reinsurance, supra note 27 at 465; Dow et al., supra note 27.

\textsuperscript{42} See Hall, Government-Sponsored Reinsurance, supra note 27 at 465; Dow et al., supra note 27.

\textsuperscript{43} JONATHAN GRUBER, PUBLIC FINANCE AND PUBLIC POLICY 423 (Sarah Dorger et al., eds., Worth Publishers 2d ed. 2007) (“The final reason for caring about the uninsured is that becoming uninsured is a concern for millions of individuals who currently have insurance. Many individuals are afraid to search for or move to jobs where they may be more productive because they are afraid of losing their health coverage.”).
about 25% less likely to change jobs because of that insurance.\footnote{Id. ("Madrian’s (1994) estimates, for example suggest that [job lock] reduces mobility across jobs among those with health insurance by as much as 25%" (citing Jonathan Gruber & Brigitte C. Madrian, Limited Insurance Portability and Job Mobility: The Effects of Public Policy on Job-Lock, Massachusetts Inst. of Tech., Dept. of Econs., Working Paper No. 94-03, 1994).)} Job lock inevitably leads to some degree of mismatch between employers’ needs and workers’ skills and preferences, which results in substantial but undetermined macroeconomic constraints on economic productivity, not to mention considerable psychic dissatisfaction among unfulfilled or overstressed workers.\footnote{EXEC. OFFICE OF THE PRESIDENT, COUNCIL OF ECON. ADVISERS, THE ECONOMIC CASE FOR HEALTH CARE REFORM 36-7 (June 2009). See also GRUBER, supra note 44 at 235.}

In the 1990s, various limited reforms mitigated some of the worst excesses of these market-driven competitive dynamics, but these counteractive measures did not eliminate risk-selection practices entirely.\footnote{LEIGH WACHENHEIM & HANS LEIDA, THE IMPACT OF GUARANTEED ISSUE AND COMMUNITY RATING REFORMS ON INDIVIDUAL INSURANCE MARKETS 4-42 (Milliman Aug. 2007), available at http://www.americanhealthsolution.org/assets/Reform-Resources/Individual-Market/MillimanIndivMarket.pdf.} Risk selection flows directly from the very nature of how competitive markets should and must respond to highly concentrated health risks.\footnote{See MERLIS, supra note 34 at 3; AM. ACAD. OF ACTUARIES, supra note 34 at 4.} That is why the ACA aims to fundamentally restructure the insurance market.

### III. Reform’s Impact on the Insurance Market

With these market fundamentals in mind, it is easier to see that the core logic of mandating insurance coverage is not the purely paternalistic motive of requiring people to purchase a form of health protection they do not believe they need. Instead, the coverage mandate is part and parcel of reshaping the basic market rules for pricing and selling insurance.\footnote{See Reinhardt, infra note 57 and accompanying text.} Constitutional challengers maintain that the insurance mandate is not “necessary and proper” for the regulation of how health insurers structure, underwrite, price and sell their policies.\footnote{Barnett et al., supra note 11.} But, for that to be true, it would have to be the case that Congress clearly could have enacted the ACA’s core provisions—prohibiting medical underwriting and requiring community rating and coverage of pre-existing conditions\footnote{Patient Protection and Affordable Health Care Act, Pub L. No. 111-148, § 1201, 124 Stat. 119, 154-61 (2009).}—while still leaving completely voluntary peoples’ decisions whether to purchase insurance. If it is not possible or feasible to reform insurers’ practices without mandating coverage, then, empirically, the mandate is “necessary” in a very literal sense, and not just convenient, to regulating the sale of insurance in interstate commerce.

Previously, when states tried to eliminate medical underwriting without an insurance mandate, as Kentucky did in 1994, these markets suffered, shrunk, and
almost collapsed. Summarizing the experience in a range of states, actuarial
experts at Milliman documented that,

measured in terms of market size, level of premium, and availability of
insurance options, individual health insurance markets deteriorated after
the introduction of GI [guarantee issue] and CR [community rating]
reforms. Often, insurance companies chose to stop selling individual
insurance in the market after reforms were enacted which resulted in a
decrease in competition. Enrollment in individual insurance also
tended to decrease, and premium rates tended to increase, sometimes
dramatically. We also did not observe any significant decreases in the
level of uninsured persons following the enactment of these market
reforms.

New York is a prominent example, as chronicled by The New York Times:

New York’s insurance system has been a working laboratory for the
core provision of the new federal health care law — insurance even for
those who are already sick and facing huge medical bills — and an
expensive lesson in unplanned consequences [if insurance is not
mandated]. Premiums for individual and small group policies have risen
so high that state officials and patients’ advocates say that New York’s
extensive insurance safety net . . . is falling apart.

The problem stems in part from the state’s high medical costs and in
part from its stringent requirements for insurance companies in the
individual and small group market. In 1993, motivated by stories of
suffering AIDS patients, the state became one of the first to require
insurers to extend individual or small group coverage to anyone with
pre-existing illnesses.

New York also became one of the few states that require insurers within
each region of the state to charge the same rates for the same benefits,
regardless of whether people are old or young, male or female, smokers
or nonsmokers, high risk or low risk.

Healthy people, in effect, began to subsidize people who needed more
health care. The healthier customers soon discovered that the high
premiums were not worth it and dropped out of the plans. The pool of
insured people shrank to the point where many of them had high health
care needs. Without healthier people to spread the risk, their premiums


skyrocketed, a phenomenon known in the trade as the “adverse selection death spiral.”

Since 2001, the number of people who bought comprehensive individual policies through HMOs in New York has plummeted to about 31,000 from about 128,000, according to the State Insurance Department. At the same time, New York has the highest average annual premiums for individual policies: $6,630 for single people and $13,296 for families in mid-2009, more than double the nationwide average, according to America’s Health Insurance Plans, an industry group.53

Similarly, a thorough study of New Jersey’s law, by respected faculty researchers at Rutgers University and University of Medicine and Dentistry of New Jersey, reported the following:

The New Jersey Individual Health Coverage Program (IHCP) was implemented in 1993; key provisions included pure community rating and guaranteed issue/ renewal of coverage. Despite positive early evaluations, the IHCP appears to be heading for collapse. . . .

Our analysis strongly suggests that the IHCP is in the midst of an enrollment crisis that threatens its market stability and ability to fulfill its stated goals. . . . These trends appear consistent with a marketwide adverse-selection death spiral spurred by open enrollment and pure community rating.54

And, much the same has occurred in Maine.55 Based on this experience, Congress’ own research professionals advised that

[i]f insurers were required to accept all applicants, without any exclusions or waiting periods, . . . people would wait to buy insurance until they became injured or ill. They might also drop the insurance


55. ME. BUREAU OF INS., MAINE’S INDIVIDUAL HEALTH INSURANCE MARKET 3-4 (Jan. 2000) (explaining causes and aspects of market’s apparent or impending “death spiral” and concluding that “the future viability of the individual health insurance market in Maine is at serious risk.”).
when that episode of care was over . . . [Insurers] would respond by increasing their rates. If that too were prohibited, insurers . . . might leave the market entirely.56

Preeminent health economists across the country agree. One from Princeton testified to Congress that

leaving the individual free to choose whether or not to be insured is incompatible with a reorganization of the insurance market that imposes community rating and guaranteed issue on health insurers. Such an approach would invite egregious adverse risk selection on the part of the insured, who could afford to go without insurance when healthy in the comfort of knowing that they are entitled to health insurance at a community-rated premium when sick. As every economist and actuary appreciates, this type of adverse risk selection ultimately leads to the so-called “death spiral” of the community-rated risk pools.57

Two other health economists wrote separately in the nation’s leading medical journal that

[i]f insurers must sign up anyone who applies for coverage, and if variation in premiums is limited, people would have a powerful incentive to wait until the onset of serious illness to buy insurance at the regulated price. Such behavior would make it financially impossible for insurers to survive. Thus, sustaining insurance-market reforms virtually forces the government to implement a requirement that people carry insurance. And to make such a mandate affordable, subsidies are necessary to avoid causing gross hardship. In brief, the pledge to keep insurance-market reforms without both mandated coverage and subsidies is untenable.58

And


58. Henry J. Aaron, The Midterm Elections: High Stakes for Health Policy, 363 NEW ENG. J. MED. 1686 (Oct. 2010), available at http://healthpolicyandreform.nejm.org/?p=12756. Dr. Aaron is as Senior Fellow with the Brookings Institution, Member of the Institute of Medicine, Chairman of the Board of Directors of the National Academy of Social Insurance, and Member of the American Academy of Arts and Sciences.
The Affordable Care Act recognizes that adverse selection would wipe out voluntary insurance if people could wait until they contracted a medical condition to buy coverage and still obtain it at the same premiums they would have been charged had they bought it sooner — hence the mandate that all individuals obtain insurance.59

Even some conservative thought leaders agree,60 such as physician and former Republican Senator Bill Frist, who explained (in advocating an insurance mandate) that

[w]hen healthier people opt not to carry insurance, only those with poorer health, and thus higher costs, remain in. This leads insurance prices to spiral up. And it further impedes markets’ ability to mitigate risks and prevent personal economic catastrophe. The “free-riders” who do not purchase insurance and the “voluntarily uninsured” who depend on emergency room care paid by others would then pay their fair share for services received.61

More pointedly, an editor and writer for conservative publications such as Reason and National Review railed against “the idea of reforming the insurance market in a way that would be sold as prohibiting discrimination based on preexisting conditions”:

This is a terrible idea. Now, I’ve written harshly about the individual mandate, which would require every American to buy health insurance. But insurance reforms without a mandate would, in their own way, be just as bad, and twice as stupid.

Prohibiting preexisting conditions entails enacting two different regulations, known as “community rating” and “guaranteed issue.” There are variations on each, but in basic terms, these regulations mean that insurance companies have to charge everyone the same amount for the same policy, regardless of risk factors, and that they have to issue policies to everyone who’s willing to pay.

The problem is that with these regulations in place, there’s no incentive to buy insurance until you’re already very sick. After all, if the

59. Mark V. Pauly, Avoiding Side Effects in Implementing Health Insurance Reform, 362 NEW ENG. J. MED. 672 (Feb. 2010). Dr. Pauly is the Bendheim Professor of Health Care Management, Business and Public Policy at the University of Pennsylvania, where he is also a Professor of Economics and of Insurance and Risk Management.


insurance companies can’t turn you down or jack up your rates, why buy in early? So what happens is that, in hopes of saving money, some number of healthy people decline to buy insurance, creating a sicker, more expensive pool. That pushes a new wave of the healthy people to jump ship, which creates a pool that’s even sicker and even more expensive. Go through a couple iterations of this, and fairly quickly you have a very small, very sick, and very, very expensive insurance pool.

It’s called a “death spiral,” and we know it happens because we’ve seen it in every single state that has enacted those two insurance regulations. We’ve seen it in the state of New York, where, under community rating and guaranteed issue, the individual health insurance market declined from 4.7 percent of the state’s health insurance to 0.2 percent. Meanwhile, premiums skyrocketed; according to an October 2009 report from the insurance lobby, the state’s individual market premiums are now the highest in the nation.

And we’ve also seen the death spiral in Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, Vermont, and Washington. Over and over again, it’s the same story. Premiums spike. The market dries up. Everyone who has paid even the slightest attention to the most surface details of health care policy knows that the combination of these two seemingly innocuous regulations is disastrous.62

Perhaps things will not be this dire under the ACA. Its provisions guard against complete market collapse by heavily subsidizing the purchase of insurance for many people, by allowing (but not requiring) states to merge their individual and small group markets, and by allowing some variation in premium rates (by a factor of 3 for age, and by 50 percent for smoking).63 Accordingly, some analysts project that dropping the individual mandate while keeping the rest of ACA’s insurance market reforms would only moderately reduce coverage and have no effect on employer or government spending.64 For instance, based on extensive statistical modeling, researchers at RAND Corporation projected that eliminating the individual mandate would reduce coverage by 13 million people, which is 5% of the total; stated another way, it would increase the

64. CHRISTINE EIBNER, ET AL., ESTABLISHING STATE HEALTH INSURANCE EXCHANGES xi-xii, 32 (Rand Corp. 2010), available at http://www.rand.org/pubs/technical_reports/TR825/ (estimating that removing the individual mandate would reduce the number of newly insured from 35 million to 22 million and have no effect on total employer insurance spending or net new government spending).
number of uninsured by 72% from 18 million to 31 million. Similarly, the Urban Institute concluded that there “would be 17.8 million more people left uninsured after reform if the individual mandate were eliminated, with relatively little reduction in government spending.”

Nevertheless, the Urban Institute researchers concluded that this difference would be critical: “The bottom line is that the individual mandate is essential if health reform is to achieve its goal of greatly reducing the number of uninsured.” Likewise, a leading health economist at M.I.T. reasoned as follows, analogizing health insurance reform to a three-legged stool consisting of insurance regulation, subsidies to purchase, and the mandate:

Critics who propose to “repeal and replace” the Affordable Care Act don’t seem to understand that all three legs of the stool are critical for reform. Pulling out any of the legs while leaving one or two intact will critically undercut gains from reform. . . .

The simple logic imbedded in the law is that it is potentially destructive to reform insurance markets without mandating purchase because only the sick buy insurance and prices remain high. We have seen examples of this in states such as New York and Massachusetts (before its most recent reform), which both imposed modified community rating without a mandate and saw prices skyrocket in their nongroup markets. . . .

Removing the Affordable Care Act’s mandate would eviscerate the law’s coverage gains and greatly raise premiums. And going further by only keeping the market reforms and the small business tax credit would virtually wipe out those coverage gains and cause an enormous premium spike. Without all three legs, the stool— and effective health reform—will not stand.

This logic and experience have already begun to shape outcomes under the ACA. The ACA requires that, for minors, insurers may no longer refuse coverage based on health status or a pre-existing condition starting September

65. Id.
66. MATTHEW BUETTGENS, BOWEN GARRETT, AND JOHN HOLAHAN, WHY THE INDIVIDUAL MANDATE MATTERS 1 (Urban Inst. 2010), available at http://www.urban.org/UploadedPDF/412280-individual-mandate-matters.pdf. The analysis was based on the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM), which “simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms.”
67. Id.
2010, three years before parents are subject to the individual mandate. Recognizing the resulting potential for serious adverse selection, the major national, state and regional insurers, announced they would stop selling policies that cover only children. Thus, a requirement to cover all applicants without a commensurate requirement for people to purchase coverage has already caused a portion of the insurance market essentially to implode.

IV. REFORM’S IMPACT ON UNINSURED PEOPLE

Opponents of the individual mandate claim that it unconstitutionally regulates the passive “inactivity” of being uninsured. In an attempt to elevate the condition of being uninsured to constitutional protection, some opponents claim that uninsured people are not, in fact, free-riding on the pocketbooks of taxpayers or the good will of medical providers. Instead, opponents characterize uninsured people as not participating in commerce at all, or as preferring to pay for their own health care out-of-pocket rather than through insurance. Evidence from extensive health services research, however, shows just the opposite. Uninsured people move into and out of the insurance market, and they use substantial amounts of health care, much or most of which they do not pay for themselves.

A. Voluntary Spells With and Without Insurance

National data show that most uninsured people have not made settled decisions to remain out of the insurance market. Instead, of those who are uninsured at some point in a given year, about 63% have coverage at some other point during the same year. As a result, although about 15% of the nonelderly population is uninsured at any point in time, about twice as many people are...

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71. Crocker, supra note 13 at 3.


73. Id.

74. See infra note 81.


76. Id.

77. Id.
uninsured at some point over a two-year period,\textsuperscript{78} and about half of Americans are uninsured at some point over a decade.\textsuperscript{79} For most of these people, the period without insurance lasts less than a year (Table 1).\textsuperscript{80} According to researchers at the Urban Institute,

> [d]ata from the 1999 round of the National Survey of America’s Families (NSAF) showed that, of the 50 million people who lacked coverage at the time of the survey or at some time during the 12 months before the survey, 56 percent were uninsured for 12 months or longer, 24 percent for 6 to 11 months, and 20 percent for 5 months or less. . . . This paper updates the 1999 analysis with data from the 2002 round of NSAF. . . . A total of 49 million individuals were uninsured at some point during the year. Of these, over half (26 million) lacked insurance for 12 months or more, a group we refer to as the “long-term uninsured.” An additional 12 million lacked coverage for 6–11 months, and 11 million were uninsured for less than 6 months. We refer to these latter groups as the “short-term uninsured.”\textsuperscript{81}

\textsuperscript{78} FAMILIES USA, AMERICANS AT RISK: ONE IN THREE UNINSURED 2 (2009), http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf. The Lewin Group prepared these estimates using several data sources:

- National and state estimates were calculated using the Survey of Income and Program Participation (SIPP), the Current Population Survey (CPS), and the Medical Expenditure Panel Survey (MEPS). The SIPP was chosen because of its large sample size, state identifiers, and monthly reporting of health insurance status over a multi-year period. The CPS provides the most recent data on health insurance coverage, employment, income, and population estimates, and it supports state-level estimates. However, the CPS does not include data for 24 consecutive months. The MEPS longitudinal survey data file contains monthly reporting of health insurance status over a two-year period and has been used by the Agency for Health Care Research and Quality (AHRQ) to produce national estimates of the number of people who were uninsured at some time over a 24-month period. . . . National estimates were based on waves three through eight of the 2004 Panel of the SIPP (July 2004 through June 2006), which reported data for all 24 months of the period. The data were adjusted to account for the demographic and health insurance status of people who did not report data for the entire period. Final estimates were adjusted to match the results of the MEPS data as published by AHRQ and projected to the 2007-2008 period . . . We used SIPP in the analysis because it includes certain labor force information that is necessary for the analysis but that is not included in the MEPS.


\textsuperscript{80} \textit{id}

Table 1: Duration without Health Insurance for Uninsured People under Age 65, 2007-2008

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Months</td>
<td>25.3%</td>
</tr>
<tr>
<td>13-23 Months</td>
<td>19.5%</td>
</tr>
<tr>
<td>9-12 Months</td>
<td>15.4%</td>
</tr>
<tr>
<td>6-8 Months</td>
<td>14.3%</td>
</tr>
<tr>
<td>3-5 Months</td>
<td>20.1%</td>
</tr>
<tr>
<td>1-2 Months</td>
<td>5.4%</td>
</tr>
<tr>
<td>Uninsured 9+ months</td>
<td>60.2%</td>
</tr>
<tr>
<td>Uninsured 6+ months</td>
<td>74.5%</td>
</tr>
</tbody>
</table>

This pattern of temporary periods of going without insurance is becoming more common. According to a health economist at Harvard, from 1983 to 1986, “59.2% of those who were uninsured obtained insurance within 1 year, and 73.8% obtained insurance within 2 years; in the 2001–2004 panel, 61.7% obtained insurance within 1 year, and 79.7% within 2 years. The percentage of persons who were uninsured for 2 years or longer, for example, decreased from 26.2% to 20.3% between the two study periods.”

Higher income people are more likely to be uninsured for shorter periods, indicating that many are opting into and out of insurance. According to the Urban Institute (see Table 2), in 2001-2002 “two-fifths of the highest income uninsured [>300% poverty] were uninsured for a year or more, compared with over half of those in the middle income groups and nearly two-thirds of those in poverty.” Similarly, the Congressional Budget Office (under President Bush) reported that “[18] percent of uninsured spells among people with annual income of less than 200 percent of the federal poverty level exceed two years, about two-thirds higher than the figure for people whose income is 400 percent or more of the poverty level.” And the Treasury Department found that 45% of people in

82. David M. Cutler and Alexander M. Gelber, Changes in the Incidence and Duration of Periods without Insurance, 360 NEW ENGL. J. MED. 1740, 1745-46 (2009). According to the authors, we used two data sets from the Survey of Income and Program Participation of the U.S. Census Bureau: one that covered the period from 1983 through 1986 (25,946 persons), and another that covered the period from 2001 through 2004 (40,282 persons). For each set of years, we estimated the probability that a person would be uninsured for some period of time and the probability that a person would subsequently obtain private or public insurance. We also estimated the probabilities that persons in various demographic groups would become uninsured over the course of a year and would remain uninsured for various amounts of time.

83. Id.
84. Id.
85. Id.
86. CONG. BUDGET OFFICE, supra note 75 at 10.
households with income of $50,000-$100,000 were uninsured at some point over the decade 1997-2006.\textsuperscript{87}

Table 2: Rate and Length of Uninsurance Spells, by Family Income, Education, Health Status, and Age, Nonelderly Population, 2001-02

<table>
<thead>
<tr>
<th>% uninsured some point in prior year</th>
<th>Length of Uninsured Spell a year</th>
<th>% of uninsured without insurance less than a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19.90%</td>
<td>5.00%</td>
</tr>
<tr>
<td>Poverty Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% of FPL</td>
<td>40.3</td>
<td>6.3</td>
</tr>
<tr>
<td>100-200% of FPL</td>
<td>35</td>
<td>6.6</td>
</tr>
<tr>
<td>200-300% of FPL</td>
<td>23</td>
<td>5.2</td>
</tr>
<tr>
<td>300% of FPL</td>
<td>4</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Conservative policy analysts have embraced these findings to make the point that many uninsured people are not stuck in that status by economic necessity; instead many uninsured people make a calculated decision to “self-insure.”\textsuperscript{88}

Consider, for instance, the following conclusions from a detailed study by Dr. June O’Neill, an economist and director of the Congressional Budget Office under a Republican-led Congress:

Many people believe that the number of uninsured signifies that almost 50 million Americans are without healthcare simply because they cannot afford a health insurance policy . . . However this line of reasoning is based on a distorted characterization of the facts . . . More careful analysis of the statistics on the uninsured shows that many uninsured individuals and families appear to have enough disposable income to purchase health insurance, yet choose not to do so, and instead self-insure. We call this group the “voluntarily uninsured” and find that they account for 43 percent of the uninsured population.\textsuperscript{89}

\textsuperscript{87} U.S. DEPT. OF TREASURY, supra note 79.


\textsuperscript{89} JUNE E. O’NEILL & DAVE M. O’NEILL, WHO ARE THE UNINSURED?: AN ANALYSIS OF
B. Care Received by Uninsured People

Many people who choose to go without insurance still seek substantial amounts of health care, much of which they are unable to pay for themselves. Dr. O’Neill, again, explains that

while the uninsured receive fewer medical services than those with private insurance, they nonetheless receive significant amounts of healthcare from a variety of sources—government programs, private charitable groups, care donated by physicians and hospitals, and care paid for by out-of-pocket expenditures.90

Dr. O’Neill’s study supported these conclusions with data on middle-class uninsured people—those whose incomes are more than two-and-a-half times the federal poverty level.91 As Table 3 shows, the majority of those who were uninsured all year received some medical care in the prior two years.92

Table 3: Percent of Uninsured Adults Who Received Selected Medical Services in Past Two Years, 2005

<table>
<thead>
<tr>
<th>Service</th>
<th>Uninsured all 12 months</th>
<th>250% poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Check-Up</td>
<td>50.43</td>
<td>52.62</td>
</tr>
<tr>
<td>Blood Pressure Check</td>
<td>71.79</td>
<td>71.14</td>
</tr>
<tr>
<td>Pap smear (Women only)</td>
<td>62.81</td>
<td>68.04</td>
</tr>
<tr>
<td>Mammogram (Women over 39)</td>
<td>49.25</td>
<td>61.94</td>
</tr>
</tbody>
</table>

Although about half of people who are uninsured all year use no care that year, half do use care, including those who had the option to enroll in employer-sponsored health insurance.93 Overall, more than three-fifths (62.6%) of

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90. Id.
91. Id.
92. Id.
uninsured people under age 65 made at least one visit to a doctor or emergency room in 2007.\textsuperscript{94} And among those who do avoid insurance for longer terms, virtually all of them (at least 94\%) receive some medical care at some point.\textsuperscript{95}

C. Who Pays for Uninsured Care?

When uninsured people receive coverage, who pays? According to an analysis by the Urban Institute\textsuperscript{96}

\begin{quote}
[p]eople uninsured for any part of 2008 spent about $30 billion out of pocket and received approximately $56 billion in uncompensated care while uninsured. Government programs financed about 75 percent of uncompensated care. . . . Various private sources help subsidize uncompensated care. Physicians’ donated time and forgone profits amounted to $7.8 billion. After government payments to hospitals are subtracted, private philanthropy and profit margins were responsible for at least an additional $6.3 billion.\textsuperscript{96}
\end{quote}

No published account has criticized or questioned this widely cited and especially rigorous study.\textsuperscript{97} The prestigious Institute of Medicine relied on similar studies to conclude that

\begin{quote}
[p]eople who are uninsured for the full year pay 35 percent, on average, of the overall cost of medical services they receive. . . . This estimate includes the value of free hospital, physician, and clinic services that the uninsured use annually, adjusted to reflect spending in 2001. . . . The amount paid out of pocket varies by type of service. For example, uninsured individuals pay for nearly all (88 percent) of their prescription medications but for only 7 percent on average of hospital expenses they incur. Supports for care to uninsured patients come from federal, state, and local programs and grants; from organized
\end{quote}

\begin{footnotes}
\item[94] Nat’l Ctr. for Health Statistics, Health, United States, 2009, 318 (2010), available at http://www.cdc.gov/nchs/data/hus/hus09.pdf. See also Kaiser Comm’n on Medicaid and the Uninsured, Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years 1 (2010), available at www.kff.org/uninsured/upload/8083.pdf (noting that 62\% of the uninsured below 133\% of the Federal Poverty Level have used some medical care in the last two years).
\item[95] O’Neill, supra note 89 at 20-22.
\item[96] Jack Hadley, John Holahan, Teresa Coughlin and Dawn Miller, Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs, 27(5) Health Aff. 399, 406 (Sept. 2008).
\item[97] Id. Data came from the Medical Expenditure Panel Surveys (MEPS), a nationally representative survey conducted by the federal government, and from the American Hospital Association (AHA) Annual Survey of Hospitals, as well as from surveys of office-based private physicians and budget and program data from Medicare, Medicaid, and other government programs that serve the uninsured.
\end{footnotes}
philanthropy; and from the donated services and uncompensated care absorbed by providers.  

These “unreimbursed costs of caring for uninsured Americans are ultimately paid for by higher taxes and higher prices for services and insurance. Local communities tend to bear the main economic burden of subsidizing service delivery . . . .” One analysis, for instance, explained that

[r]esearch has shown that the uninsured often put off getting care for health problems—or forgo care altogether. When the symptoms can no longer be ignored, the uninsured do see doctors and go to hospitals. Without insurance to pay the tab, the uninsured struggle to pay as much as they can: More than one-third (35 percent) of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves. Who pays the rest? Families USA answers this question in Paying a Premium: The Added Cost of Care for the Uninsured. The remaining sum (almost $43 billion in 2005) is primarily paid by two sources: Roughly one-third is covered by a number of government programs, but two-thirds is paid by people with health insurance through higher premiums.

Hospitals often or usually bill uninsured people who receive care, but “[h]ospital administrators report that they collect only about ten percent of their charges to uninsured patients.” This highly subsidized care is not restricted to uninsured people without means to pay, but includes people well above poverty. Among adults who decline the option to enroll with employer-sponsored insurance, public sources and uncompensated care cover 72% of total costs. According to an in-depth analysis by a Johns Hopkins University health economist, “the high-income uninsured [those above 300% of federal poverty level] on average pay for [only about] one-half of the care they received.”

99. Id.
100. FAMILIES USA, PAYING A PREMIUM: THE ADDED COST OF CARE FOR THE UNINSURED (Jan. 2005), available at http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf. This analysis was conducted by Dr. Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management, Rollins School of Public Health, Emory University, using data from the U.S. Census Bureau, the federal Agency for Healthcare Research and Quality, and the National Center for Health statistics, and other credible sources.
102. See Herring, infra note 105 and accompanying text.
103. Id.
104. Bernard & Selden, supra note 104.
On account of this heavy load of cost-spreading, it is “both mistaken and dangerous to assume that the persistence of a sizable uninsured population in the United States harms only those who are uninsured.”106 Instead, according to the Institute of Medicine,

[the adverse effects of uninsurance have spillover effects on the community. The [IOM] believes it. Although the Committee calls for further research to examine the likely effects of uninsurance at the community level, it believes that the evidence available justifies the immediate adoption of policies to address the lack of health insurance in the nation.]107

Thus, the decision not to purchase insurance is more than simply a private consumption choice to pay for all care out-of-pocket or to not use health care at all. Instead, peoples’ decisions whether to purchase insurance affects not only themselves but also the rest of society. Most health care finance occurs through pooled mechanisms that inevitably spread costs broadly.108 And most people who do not purchase health insurance do, in fact, seek care, much of which they do not pay the full costs for.109 Therefore, those who fail to contribute to the insurance pool are free riding on the rest of society.

V. IMPACT ON INSURERS

Some individuals claim they have constitutional rights to be uninsured, but some commentators also invoke individual rights on behalf of insurers.110 The formidable Richard Epstein argues that tougher insurance standards are “confiscatory” rate regulations that violate the Takings Clause or substantive due process.111 He suggests this conclusion is firmly based in existing law (claiming “little doubt”),112 but Professor Epstein is well known for arguing far outside the legal mainstream that much of modern government is unconstitutional on much the same grounds.113 Thus, we need to take a closer look, to distinguish a libertarian view of what the ACA might do from a convincing view of what it actually does.

106. INST. OF MED., supra note 98.
107. Id.
108. Reindhardt, Statement before the U.S. Senate Finance Committee, supra note 57.
109. INST. OF MED., supra note 98; Hadley, supra note 96.
111. Epstein, Harry Reid Turns Insurance into a Public Utility, supra note 110.
112. Epstein, Impermissible Ratemaking in Health-Insurance Reform: Why the Reid Bill is Unconstitutional, supra note 110.
Epstein summarizes that an earlier version of the law in Congress, prior to the ACA, would have imposed
sharp limitations on the ability of health-insurance companies to raise fees or exclude coverage. Moreover, the [law] forces on these regulated firms onerous new obligations that they will not be able to fund from their various revenue sources. The squeeze between the constricted revenue sources allowable under the [law] and the extensive new legal obligations it imposes is likely to result in [sic] massive cash crunch that could drive the firms that serve the individual and small-group health-insurance markets into bankruptcy.114

But the ACA as enacted does not regulate what insurers charge. Instead, it limits how much of the insurance premium can go towards profits and overhead administrative costs. For insurance covering large groups, the maximum is 15%, and for policies covering small groups and individuals, it is 20%. Insurers must pay out the remaining revenue—the “medical loss ratio”—as medical claims.

The ACA limits medical loss ratios to 80% for individual and small-group insurance and 85% for large groups.115 This is tight, but not onerous. For group insurance, these ratios are broadly consistent with actual historical patterns and recent experience in the industry.116 A 2009 news story noted that “insurers spend an average of 87 cents of every premium dollar on direct medical care, according to the industry’s trade lobby, America’s Health Insurance Plans.”117 A recent Congressional report noted that only one of the thirteen major insurers it studied had a medical loss ratio of less than 80%.118

For individual (i.e., non-group) insurance, although most insurers have lower loss ratios (see Table 4),119 these conventional ratios do not reflect the calculus that will apply under the ACA. The ACA credits as medical expenses those administrative costs that insurers spend on quality improvement, broadly defined, and the ACA disregards certain taxes that conventional ratios include in


117. Id.

118. See AUSTIN & HUNGERFORD, supra note 32 at 42-46.

119. Table 4 is taken from U.S. Senate, Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations, Majority Staff, Implementing Health insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers (April 15, 2010), available at http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0f8052-4c6a-4c12-9f8b1-a5e4a9c0667. Data is based on regulatory filings made by the companies with the National Association of Insurance.
Therefore, loss ratios restated under the ACA’s formula would probably be several points higher. Moreover, some states may merge their individual and small group markets, producing ratios that are a weighted average of the two. And when the reform law takes full effect, it will remove the administrative expense of medical underwriting from the individual and small group markets, which will further ease pressure on loss ratios.

Table 4: Medical Loss Ratios by Market Segment for Largest National Insurers

<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>75.70%</td>
<td>73.90%</td>
<td>84.20%</td>
<td>82.00%</td>
<td>87.20%</td>
<td>82.00%</td>
</tr>
<tr>
<td>CIGNA</td>
<td>88.10%</td>
<td>86.90%</td>
<td>92.10%</td>
<td>---</td>
<td>85.20%</td>
<td>87.20%</td>
</tr>
<tr>
<td>Coventry</td>
<td>71.90%</td>
<td>65.80%</td>
<td>78.20%</td>
<td>79.10%</td>
<td>86.00%</td>
<td>82.70%</td>
</tr>
<tr>
<td>Humana</td>
<td>68.10%</td>
<td>71.90%</td>
<td>80.00%</td>
<td>77.20%</td>
<td>88.20%</td>
<td>82.40%</td>
</tr>
<tr>
<td>UnitedHealth</td>
<td>70.50%</td>
<td>70.30%</td>
<td>81.10%</td>
<td>78.70%</td>
<td>83.30%</td>
<td>83.50%</td>
</tr>
<tr>
<td>WellPoint</td>
<td>74.90%</td>
<td>73.10%</td>
<td>81.20%</td>
<td>79.00%</td>
<td>84.90%</td>
<td>85.20%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>73.60%</td>
<td>72.50%</td>
<td>81.20%</td>
<td>79.70%</td>
<td>85.10%</td>
<td>83.90%</td>
</tr>
</tbody>
</table>

Professor Epstein nevertheless claims “there is a near mathematical certainty that the scheme of health-insurance market regulation contemplated by [the law] will reduce the risk-adjusted rate of return below the level needed to keep these firms in the individual and small-group health-insurance markets.” Market signals clearly belie this doomsday prediction. In the two months prior to the Senate’s initial approval of the ACA on Christmas Eve 2009, health insurers’ stock prices outpaced the market’s overall substantial increase more than two-fold, and stock prices for the three largest health insurers increased even more. According to analysts, this surge reflected investor optimism in insurers’ business prospects under the anticipated regulations. These rosy prospects have continued throughout 2010 as regulations have been issued. Morgan Stanley maintains a Healthcare Payor Index designed to measure the performance of companies “involved in the business of managing the health care dollar,” such as HMOs (health maintenance organizations) and pharmaceutical

120. Id. at 5.
121. Epstein, Impermissible Ratemaking in Health Insurance Reform: Why the Reid Bill is Unconstitutional, supra note 110 at 3.
123. Id.
benefit managers. The index took a 3-week dive from 1,122 on February 16, 2009 to 682 on March 5, at the same time that the overall stock market dropped substantially (approximately 10%-20% depending on the index). Since then, while Congress and the President debated, enacted, and began to implement health insurance reform, the Payor Index has increased fairly steadily and steeply, reaching 1,646 as of November 26, 2010 – three days after the federal Department of Health and Human Services (HHS) issued its medical loss ratio rules. This level is almost 50 percent higher than before the February 2009 drop and more than twice the level of the index’s March 2009 low. Over the same period, the general stock market increased less than half from its mid-February levels and less than two-thirds from its early March lows.

Professor Epstein also asserts that “not one syllable in the [law] is dedicated to securing [a] constitutionally guaranteed minimum rate of return,” but careful reading reveals the following: (1) HHS may adjust the minimum loss ratio if it would “destabilize the individual market” (section 2718); and (2) a passel of provisions (reinsurance, risk adjustment, and stop-loss corridors) protect insurers against excessive high-cost claims, both initially (sections 1341, 1342) and on an ongoing basis (section 1343). These provisions will help protect particular insurers with unprofitable risk pools.

Finally, regulating administrative overhead is not the same as regulating total profits. Most health insurers make as much or more from their financial investments as they do from insurance operating margins. Therefore, breaking even on insurance, or even suffering an operating loss from time to time, is not at all unusual and does not necessarily deprive insurers of a reasonable rate of return. Moreover, health insurers’ profit margins should not be judged by those in other industries because their revenue does not fund large amounts of inventory, capital costs, research and development and the like. Instead, most insurance company revenue simply flows through in the form of claims payments, resulting in healthy profit margins that look much thinner than those in other sectors. Table 5 shows, for instance, that overall profit margins typically are lower than two percent.
Table 5. Operating Margins of Health Plans, 2007

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Weighted</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td>0.39%</td>
<td>0.22%</td>
<td>0.59%</td>
</tr>
<tr>
<td>Others</td>
<td>1.56%</td>
<td>1.16%</td>
<td>1.19%</td>
</tr>
<tr>
<td>Total</td>
<td>0.39%</td>
<td>0.32%</td>
<td>0.59%</td>
</tr>
</tbody>
</table>

VI. IMPACT ON STATES

So far we have considered constitutional challenges based on the rights of individuals and of insurers. In addition, some states argue that federal health insurance reform violates their sovereign rights under the Tenth Amendment. Under modern jurisprudence, the only established basis for this claim would arise if the federal reform were to “commandeer” state governments to carry out federal reform. Challenger states point to federal requirements to set up insurance exchanges and to regulate the insurance market, but those states mischaracterize or exaggerate these obligations. Far from imposing conscription to carry out federal objectives, the law leaves states many opportunities to opt out and ample discretion in implementing the key provisions. For example, section 1321, entitled “State flexibility in operation and enforcement of Exchanges and related requirements,” allows states to opt out of running insurance exchanges altogether by relying instead on a federal fallback exchange. Title 1, subtitle D, has a Part 4 entitled “State Flexibility To Establish Alternative Programs.” Section 1332 allows states to avoid even the federal exchange altogether, and instead to receive a direct pass through of federal funding to state coffers if the state obtains a waiver by showing that its alternative program will cover at least as many people as the federal law and will provide coverage and subsidies that are at least equally generous.

Finally, for states that choose to establish their own exchanges, although the basic requirements for exchanges must meet federal standards, states retain ample discretion to:

- Determine governance structure, e.g., whether a state, quasi state, or nonprofit entity runs the exchange (Section 1311(d));

132. Id.
133. Arts & Erwin, supra note 11.
136. Id.
137. Id. at § 1332, 124 Stat. at 187-92.
138. Id.
139. Id. at §1311(d), 124 Stat. at 176-78.
Choose whether to create two exchanges or to merge non-group and small-group exchanges (Section 1311(b)(2));  
Determine the cutoff size for small employers allowed to purchase health insurance in the exchange (Section 1304(b)(2), 1304(b)(3));  
Limit small employer group eligibility to those employing fewer than 50 employees until January 2016 (Section 1304(b)(3)), or open the exchange to businesses with more than 100 employees (Section 1312(f));  
Determine whether to have one statewide exchange or regional exchanges within a state (Section 1311(f)(1)(2)), or whether to participate in an interstate regional exchange (Section 1311(f));  
Identify and establish contractual or grant arrangements with partner organizations, including patient navigators and any other contractors necessary to carry out responsibilities of the exchange (Section 1311(i), 1311(f));  
Allow agents or brokers to enroll people into plans and assist people in qualifying for subsidy (Section 1312(e));  
Limit the number of insurance plans participating in the exchange (Section 1311(e)).

Aside from regulating private insurance, the states’ principal complaint is that the ACA’s expansion of Medicaid imposes excessive financial burdens. Starting in 2014, Medicaid will cover all citizens below 138% of the federal poverty level, roughly doubling its current size. Medicaid is jointly funded by federal and state funds, so any expansion of Medicaid’s minimum requirements entails some increased state funding for Medicaid. The only way this expansion can be struck down under the “anti-commandeering” principle, however, is if states were unable to drop Medicaid altogether, but they are not. States claim that dropping Medicaid is practically or politically infeasible, which they claim invokes a passage in *South Dakota v. Dole*. There, the Supreme
Court noted in dictum that, in setting regulatory conditions on federal spending, it might be possible for Congress to cross the line at which “pressure turns into compulsion.”\footnote{150} This hypothetical limit is still only speculative; the Supreme Court has never defined it, and most lower courts have refused to find compulsion, even in fairly extreme circumstances.\footnote{151}

Even if there were a compulsion test, the ACA’s requirements clearly are mild enough to fall well short of the line. The federal government pays 100% of the costs of expanded Medicaid for the first three years, and thereafter it will gradually reduce its support to 90% by 2020.\footnote{152} Moreover, if states were to drop out of Medicaid, most of the people who would lose coverage would still receive substantial subsidies from the federal government to purchase private coverage through the new insurance exchanges, greatly cushioning the blow.

Documenting the limited Medicaid costs to the states, an extensive analysis by the Urban Institute concluded that

\[
\text{[n]ationally and across states, this analysis shows that . . . the government will pay a very high share of new Medicaid costs in all states, [and] increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted. . . .} \footnote{153}
\]

Under one reasonable scenario, “federal spending would increase by $443.5 billion and state spending would increase by $21.1 billion between 2014-2019. Thus about 95 percent of all new spending would be by the federal government.”\footnote{154}

\footnote{150. Dole, 483 U.S. at 211.}
\footnote{152. K\textsc{aiser} Comm’n on Medicaid and the Uninsured, Medicaid Facts (Kaiser Family Found. June, 2010), \url{http://www.kff.org/medicaid/upload/7235-04.pdf}.}
\footnote{153. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133\% Poverty, (May 2010), \url{http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf}.}
\footnote{154. \textit{Id.} According to the authors,}

\begin{quote}
We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data for 2006 and 2007). . . . We then generate a 2009 dataset by growing the population to 2009. . . . We also benchmark to 2009 CPS total population estimates by state and estimate population growth to 2019 using growth rates based on Census population projections. To estimate the impact of health reform on states, we use a model developed at the Urban Institute’s Health Policy Center (Health Insurance Policy Simulation Model or HIPSM). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS to simulate the eligibility determination process. . . . Once we have identified individuals who are newly eligible for Medicaid, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to
\end{quote}
With the federal government paying so much of the costs for the newly insured, the ACA will actually save many states money compared with what they currently pay for care for low-income, uninsured individuals not currently eligible for Medicaid. As summarized by the Washington Post,

"the federal government will bear virtually the entire cost of expanding Medicaid under the new health-care law, according to a comprehensive new study by the Kaiser Family Foundation that directly rebuts the loud protests of governors warning about its impact on their strapped state budgets. . . . Governors of many of those states have predicted fiscal calamity for their budgets, . . . [but] even the small increase in Medicaid costs may be canceled out by the savings states will enjoy from no longer having to subsidize the uncompensated care of uninsured people who will be on Medicaid, study co-author John Holahan said. “It’s absurd,” Holahan, an Urban Institute researcher, said of the states’ doom and gloom predictions. “They come out ahead. It’s just crazy.” . . . Although Medicaid enrollment nationally is estimated to increase by 27 percent by 2019, state spending will increase only 1.4 percent, on average, and federal spending will increase by 22 percent, the report finds." 155

participate at relatively higher rates post-reform because they currently lack coverage but not all new participation will come from the ranks of the uninsured. . . . Under the standard scenario, we use a set of participation rates that attempt to approximate those used by CBO (57% participation from the uninsured and lower rates for other coverage groups). . . . We make estimates on the costs per enrollee using data from HIPSIM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. Estimates from MEPS are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Cost per enrollee is then grown to 2019 using growth rates taken from the CBO March 2009 baseline. . . . Baseline enrollment and national spending totals for the years 2009-2019 were calculated using published CBO estimates from March 2009 to grow data from the 2007 Medicaid Statistical Information Statistics (MSIS) and CMS Form-64 Medicaid Financial Report (CMS-64). Using published Federal Medical Assistance Percentages (FMAP) from the Department of Health and Human Services, we calculated the federal and state share of spending for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total spending amounts in 2009. This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year.

The Heritage Foundation,156 Republican Congressional leaders,157 and several states158 estimate vastly more expensive results for the states, but several of their assumptions are questionable. Also, these estimates fail to account for the substantial savings that states will enjoy when they are able to reduce existing support for uncompensated care for people who are currently uninsured. According to another Urban Institute analysis, in 2008 state and local governments paid for about 30% of the $56 billion in uncompensated care that the uninsured received.159 The Urban Institute also projects that, absent health insurance reform, the costs of uncompensated care for the uninsured would increase $81-$92 billion by 2014, and $106-$141 billion by 2019.160 With reform, uncompensated care will decline $16-$26 billion per year by 2019.161 Thus, reform will reduce the costs of caring for the uninsured by well over $100 billion a year. If states and localities continue to pay for 30% of that care, increased insurance coverage would save state and local governments roughly $30 billion a year.162

159. Hadley et. al, supra note 96. See also RANDALL BOVBJERG ET AL., CARING FOR THE UNINSURED IN NEW YORK (2006), www.urban.org/url.cfm?id=311372 (state and local governments in New York paid $1.3 billion in 2005 to care for the uninsured); JOHN HOLAHAN, RANDALL BOVBJERG, JACK HADLEY, CARING FOR THE UNINSURED IN MASSACHUSETTS (2004), www.urban.org/publications/1000981.html (state and local governments in Massachusetts paid $860 million in 2004 to care for the uninsured).
161. Id.
162. This estimate was confirmed generally by an Urban Institute researcher, who explained every single state and many localities - now spend a fair amount of money to provide for the uninsured. Much of the need to do that will go away. The need for state-funded insurance programs, like in Connecticut, Pennsylvania, Minnesota, and others will no longer be there and those states will benefit. . . . Other states that, one way or another, put money into hospitals or clinics to support the uninsured, will be relieved of much of that burden. So, I think that if we had been able to account for that, that we would show that the savings to states, from no longer having to bear as large a burden as they do now, for uncompensated care, would probably be greater than their new obligations for Medicaid spending.

Analyses that factor in these savings show much lower or no increased costs for states; in fact, they project significant savings. The Council of Economic Advisors estimated state and local spending impacts for 16 states (Arkansas, California, Florida, Idaho, Indiana, Iowa, Maine, Michigan, Minnesota, Montana, Nebraska, North Carolina, Oregon, Pennsylvania, Vermont, and Wyoming), using a conservative estimate of uncompensated care costs. It concluded that the 16 states would save $3.0 billion per year [in uncompensated care costs], with . . . the savings more than offsetting the additional Medicaid costs in every one of the sixteen states. Thus, health insurance reform, far from harming state budgets, would likely improve them substantially.

An analysis by the respected Lewin Group confirmed this, concluding that the ACA “will result in net savings to state and local governments of $106.8 billion over the 2010 through 2019 period.”

These analyses leave little or no basis for thinking that the ACA imposes unconstitutional conditions on states’ abilities to remain part of the Medicaid program.

VII. CONCLUSION

For some branches of constitutional law, social and economic facts matter little or not at all. This is not the case, however, for challenges to the Affordable Care Act. The constitutional claims depend heavily on how people and institutions behave, and on how insurance markets function, under the ACA as compared to prior to the reform law. Fortunately, the health care sector has been studied thoroughly, so a great deal of empirical information exists to evaluate the strength of constitutional attacks and defenses, avoiding the need for lengthy trials or uncertain speculation.

This article aims to collect the full range of available empirical data that sheds light on a range of legal challenges. This evidence demonstrates that major elements of these challenges have very weak or no factual support, by the standards of existing constitutional doctrine that courts will use to judge these challenges. Health insurance markets cannot be effectively regulated to

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165. Id.
eliminate medical underwriting without also requiring that most people purchase or obtain coverage. People who opt out of coverage are highly likely to use health care services for which they do not fully pay, imposing additional costs on those who do purchase or fund coverage. And, reform does not coerce states into implementing federal law. Instead, states retain numerous freedoms to craft market reforms to fit local market conditions, to fall back on federal default options, or even to opt out of Medicaid altogether if they believe that is truly in the best interests of their citizens. These facts undercut the majority of colorable constitutional claims that opponents have made.
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THE FACTUAL BASES FOR CONSTITUTIONAL CHALLENGES TO THE CONSTITUTIONALITY OF FEDERAL HEALTH INSURANCE REFORM

Mark A. Hall

“Everyone is entitled to his own opinion, but not his own facts.”
- Sen. Daniel Patrick Moynihan

I. INTRODUCTION

From challenges to his citizenship to assertions about his religion, no U.S. leader has had to endure the relentless bombardment of fabrications and falsehoods that continue to stalk President Obama. The same is true for his signature domestic program, the Patient Protection and Affordable Care Act of 2010 (the “ACA” or “Affordable Care Act”). According to FactCheck.org, “We’ve seldom seen a piece of legislation so widely misrepresented, and misunderstood, as the new health care law. We stopped counting the number of articles and items we turned out on the subject after the total reached 100.”

Most prominent among the falsehoods and malicious misconstructions were Sarah Palin’s absurd claim that cost containment would result in government “death panels”; Representative Joe Wilson’s falsely-premised outburst “You...
“You Lie!” regarding funding for illegal immigrants, which Wilson made during the President’s 2009 State of the Union Address; and Representative Randy Neugebauer’s mean-spirited “baby killer” insult, which Neugebauer hurled on the floor of Congress at Representative Bart Stupak for Stupak’s support of a law that does not in fact directly fund abortions. More mundane, but equally mendacious, are unrelenting assertions that the new reform law constitutes a government takeover of the healthcare sector and is tantamount to socialized medicine. According to FactCheck.org, there appears to be no end to the “malarkey about health care” reform:

Our inboxes are filled with messages asking about assertions that the new law:

- Requires patients to be implanted with microchips. (No, it doesn’t.)
- Cuts benefits for military families and retirees. (No. The TRICARE program isn’t affected.)
- Exempts Muslims from the requirement to obtain coverage. (Not specifically. It does have a religious exemption, but that is intended for Old Order Amish.)
- Allows insurance companies to continue denying coverage to children with preexisting conditions. (Insurance companies have agreed not to exploit a loophole that might have allowed this.)
- Will require 16,500 armed IRS agents to enforce. (No. Criminal penalties are waived.)
- Gives president Obama a Nazi-like “private army.” (No. It provides a reserve corps of doctors and other health workers for emergencies.)

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8. Abortion: Which Side is Fabricating?, FactCheck.org (Aug. 21, 2009), http://www.factcheck.org/2009/08/abortion-which-side-is-fabricating/ (“The truth is that bills now before Congress don’t require federal money to be used for supporting abortion coverage . . . . But it’s equally true that House and Senate legislation would allow a new ‘public’ insurance plan to cover abortions, despite language added to the House bill that technically forbids using public funds to pay for them.”).

9. See Letter from Diane S. Silver, MD, to patients, (Sept. 8, 2010) available at http://www.besthealthcarerates.com/Default.aspx?app=LeadgenDownload&shortpath=docs%2fDrSilver%2527s%2fLtr%2bre%2fObamacare.pdf (alarming patients that “you will no longer be able to make your own health care decisions. This means that as your physician, I cannot exercise my best judgment for your care but must adhere to the federal government rules directing what drugs I may prescribe, and the diagnostic tests, the treatments and the specialist referrals that I will be authorized to recommend” and that “this legislation will end the patient-doctor relationship as we have known it and will transform American health care into a European socialist model.”). See also Henig, supra note 3.
• “Exempts” House and Senate members. (No. Their coverage may not be as good as before, in fact.)
• Covers erectile-dysfunction drugs for sex offenders. (Just as it was before the new law, those no longer in jail can buy any insurance plan they choose.)
• Provides federal funding for abortions. (Not directly. But neither side in the abortion debate is happy with the law.)

Against this backdrop of pernicious mythology, it is critically important for sober-minded legal analysts to navigate carefully when moving through the minefield of factual claims on which constitutional challenges to health insurance reform are based.

As reviewed elsewhere in this symposium, four basic sets of constitutional arguments currently are pending: (1) that requiring individuals to purchase health insurance is not “necessary and proper” to regulating how insurance is sold in interstate commerce; (2) that mandating coverage regulates the merely passive decision to remain outside the health insurance market and to pay for care out-of-pocket; (3) that various regulatory provisions violate individual rights that the Fifth Amendment protects; and (4) that federal requirements “commandeer” states and therefore violate states’ sovereign authority.

Each of these arguments is premised on certain factual claims or assumptions about what is in the law and how the law is likely to affect real-world conditions and behaviors. This article critiques these factual bases for constitutional arguments by documenting more accurately both what the Affordable Care Act actually does and the most credible projections of its probable impacts.

II. INSURANCE MARKET DYNAMICS

A. The Highly Concentrated Burden of Medical Costs

Understanding the structure and logic of the ACA and its likely effects requires some background understanding of how healthcare and insurance

14. Id. at 3-4.
markets function in the absence of reform. The single most important characteristic of those markets is the heavy concentration of overall medical costs in relatively few people who have very high costs. It is difficult to find the right words to describe this foundational statistical phenomenon in terms that are sufficiently compelling, so I will start with a graphic depiction (Figure 1).

Arraying the population by the cost of their individual health care in 2005, this figure shows that the top 1% (those who cost more than $43,000 each) accounted for almost one-fourth of total spending, the top 5% of people (who cost more than $14,000 each) accounted for half of all spending, and the top 20% of people (who cost more than about $4,000 each) accounted for 80% of spending. The bottom half of the population distribution (who cost less than $800 that year) incurred less than 4% of total costs.


16. Id.

17. Id. at 4 (citing Kaiser Family Foundations calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2005).

18. Id.
For convenience, I refer to this as “the 80/20 rule”: the top 20% of people account for 80% of total costs, and the bottom 80% of people account for only 20% of costs. I call this observation a rule because the pattern is remarkably universal. It holds true both for the population at large and for just about any subpopulation of significant size one might choose to examine. For example, spending for Medicare recipients, spending for people in their 40s, and spending for just about any larger employer group all exhibit the same pattern. As Exhibit 4 shows, this same essential pattern has persisted for more than 35 years. The extreme concentration of health care costs is an economic law of nature that arises from the human biological condition and the vagaries of chance. The 80/20 rule, or something like it, was evident as early as the 1930s, and it is likely to be with us for as long as anyone can foresee – regardless of how we deliver and pay for health care.

Because the distribution is so extreme, there is no easy way to reduce or eliminate the effects of concentrated medical costs. Scholars, governments, and insurance providers have tried or proposed various techniques such as high-risk pools, reinsurance, and risk adjustment. These measures can certainly help

19. Id.
20. Id.
22. Id.
23. Id. at 8.
25. See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 4.
26. Id.
27. Id. See Mark A. Hall, Government-Sponsored Reinsurance, 19 Annals Health L. 465 (2010); William H. Dow, Brent D. Fulton, & Katherine Baicker, Reinsurance for High Health Costs: Benefits, Limitations, and Alternatives, 13(2) F. Health Econ. & Pol'y Art. 7 (2010),
to spread the burden somewhat, but the amount of money involved is too large to permit easy elimination of the basic underlying phenomenon. For instance, if the top 50% of expenditures were removed from the market, some of the remaining people’s expenses would be ten times greater than the middle of the distribution (see Figure 1). Removing even half the costs would not alter the basic dynamics created the remaining costs still being concentrated in a small portion of people. I stress the 80/20 rule because, as I have said elsewhere:

it is the most elemental fact of health insurance. It is as fundamental as gravity, and as pervasive as the weather. It is the endemic First Cause that reaches everywhere and explains just about everything of importance in the market for insurance. The high concentration of medical costs is why we need insurance in the first place. Pooling expenses across a population keeps them affordable for everyone, but the extreme cost at the high end also explains why insurance is so expensive, especially for those who anticipate no real need.

B. Risk Segmentation, Adverse Selection, and Medical Underwriting

The extreme magnitude of differential health risk also explains the private insurance market’s most perplexing dynamics – ones that the Affordable Care Act aims to remedy. The ACA targets several troubling phenomena, each of which derives from the basic fact that insurers stand to gain a great deal by avoiding or appropriately pricing people with higher risks. That is why competitive forces in health insurance markets unavoidably focus on selecting and pricing risk. These natural dynamics are so strong that risk sorting occurs even without overt evaluation of medical conditions. Product features such as deductibles and benefit design appeal differently to people with different health care needs. Therefore, purchasers tend to sort themselves by risk according to these features they find most appealing.

To counteract people’s selective and strategic purchase of insurance, insurers in unregulated markets engage in various forms of risk screening.

28. See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 4.
29. Id. at 3-4.
31. Id.
33. See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 6.
most visible form of risk screening is medical underwriting, which consists of evaluating the health risks specific to each subscriber to determine the terms of coverage and assign an actuarially fair price. In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage.

Medical underwriting is necessary because of adverse selection—the tendency of people to avoid the purchase of insurance unless they expect to need it, and the tendency of those with greater need to buy more insurance. In a phrase, “health insurance market could never survive or even form if people could buy insurance on the way to the hospital.” Therefore, medical underwriting is needed to encourage people to subscribe while they are still healthy.

Subscribers who no longer can pass medical underwriting might be stuck with the insurance they have. Although in theory they can keep their coverage forever (or as long as the insurer remains in business), at some point mounting medical costs in the pool of covered subscribers make it no longer economical for the insurer to sell that particular policy to new subscribers. “And, once no new healthier subscribers are entering the pool, the costs skyrocket into what is called a ‘death spiral.’”

Employers can avoid premium spirals by shopping for new insurance, under market reforms since the 1990s that require insurers to cover all employers. But an individual who leaves a job with good benefits can easily find herself uninsurable, and those who go without insurance more than two months before taking a new job with health insurance are subject to exclusion of their pre-existing conditions for up to one year. These concerns lead to what is known as “job lock”—reluctance to change jobs for fear of losing health insurance. According to the most thorough analysis, workers with health insurance are

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35. See MERLIS, supra note 34 at 3; AM. ACAD. OF ACTUARIES, supra note 34 at 4.
36. GEORGETOWN UNIV. INST. FOR HEALTH CARE RESEARCH AND POLICY, HOW ACCESSIBLE IS INDIVIDUAL HEALTH INSURANCE FOR CONSUMERS IN LESS-TAN-PERFECT HEALTH?, Report to the Kaiser Family Foundation 11, 27 (June 2001).
37. MERLIS, supra note 34 at 5.
38. See Hall, Statement Before the U.S. Senate Committee on Finance, supra note 15 at 5.
39. Id.
40. Id.
41. See Hall, Government-Sponsored Reinsurance, supra note 27 at 465; Dow et al., supra note 27.
42. See Hall, Government-Sponsored Reinsurance, supra note 27 at 465; Dow et al., supra note 27.
43. JONATHAN GRUBER, PUBLIC FINANCE AND PUBLIC POLICY 423 (Sarah Dorger et al., eds., Worth Publishers 2d ed. 2007) (“The final reason for caring about the uninsured is that becoming uninsured is a concern for millions of individuals who currently have insurance. Many individuals are afraid to search for or move to jobs where they may be more productive because they are afraid of losing their health coverage.”).
about 25% less likely to change jobs because of that insurance. Job lock inevitably leads to some degree of mismatch between employers’ needs and workers’ skills and preferences, which results in substantial but undetermined macroeconomic constraints on economic productivity, not to mention considerable psychic dissatisfaction among unfulfilled or overstressed workers.

In the 1990s, various limited reforms mitigated some of the worst excesses of these market-driven competitive dynamics, but these counteractive measures did not eliminate risk-selection practices entirely. Risk selection flows directly from the very nature of how competitive markets should and must respond to highly concentrated health risks. That is why the ACA aims to fundamentally restructure the insurance market.

III. REFORM’S IMPACT ON THE INSURANCE MARKET

With these market fundamentals in mind, it is easier to see that the core logic of mandating insurance coverage is not the purely paternalistic motive of requiring people to purchase a form of health protection they do not believe they need. Instead, the coverage mandate is part and parcel of reshaping the basic market rules for pricing and selling insurance. Constitutional challengers maintain that the insurance mandate is not “necessary and proper” for the regulation of how health insurers structure, underwrite, price and sell their policies. But, for that to be true, it would have to be the case that Congress clearly could have enacted the ACA’s core provisions—prohibiting medical underwriting and requiring community rating and coverage of pre-existing conditions—while still leaving completely voluntary peoples’ decisions whether to purchase insurance. If it is not possible or feasible to reform insurers’ practices without mandating coverage, then, empirically, the mandate is “necessary” in a very literal sense, and not just convenient, to regulating the sale of insurance in interstate commerce.

Previously, when states tried to eliminate medical underwriting without an insurance mandate, as Kentucky did in 1994, these markets suffered, shrunk, and

44. Id. (‘Madrian’s (1994) estimates, for example suggest that [job lock] reduces mobility across jobs among those with health insurance by as much as 25%) (citing Jonathan Gruber & Brigitte C. Madrian, Limited Insurance Portability and Job Mobility: The Effects of Public Policy on Job-Lock, Massachusetts Inst. of Tech., Dept. of Econs., Working Paper No. 94-03, 1994).

45. Exec. Office of the President, Council of Econ. Advisers, The Economic Case For Health Care Reform 36-7 (June 2009). See also Gruber, supra note 44 at 235.


47. See Merlis, supra note 34 at 3; Am. Acad. of Actuaries, supra note 34 at 4.

48. See Reinhardt, infra note 57 and accompanying text.

49. Barnett et al., supra note 11.

almost collapsed.\textsuperscript{51} Summarizing the experience in a range of states, actuarial experts at Milliman documented that,

measured in terms of market size, level of premium, and availability of insurance options, individual health insurance markets deteriorated after the introduction of GI [guarantee issue] and CR [community rating] reforms. Often, insurance companies chose to stop selling individual insurance in the market after reforms were enacted which resulted in a decrease in competition. Enrollment in individual insurance also tended to decrease, and premium rates tended to increase, sometimes dramatically. We also did not observe any significant decreases in the level of uninsured persons following the enactment of these market reforms.\textsuperscript{52}

New York is a prominent example, as chronicled by \textit{The New York Times}:

New York’s insurance system has been a working laboratory for the core provision of the new federal health care law — insurance even for those who are already sick and facing huge medical bills — and an expensive lesson in unplanned consequences [if insurance is not mandated]. Premiums for individual and small group policies have risen so high that state officials and patients’ advocates say that New York’s extensive insurance safety net . . . is falling apart.

The problem stems in part from the state’s high medical costs and in part from its stringent requirements for insurance companies in the individual and small group market. In 1993, motivated by stories of suffering AIDS patients, the state became one of the first to require insurers to extend individual or small group coverage to anyone with pre-existing illnesses.

New York also became one of the few states that require insurers within each region of the state to charge the same rates for the same benefits, regardless of whether people are old or young, male or female, smokers or nonsmokers, high risk or low risk.

Healthy people, in effect, began to subsidize people who needed more health care. The healthier customers soon discovered that the high premiums were not worth it and dropped out of the plans. The pool of insured people shrank to the point where many of them had high health care needs. Without healthier people to spread the risk, their premiums

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skyrocketed, a phenomenon known in the trade as the “adverse selection death spiral.” . . .

Since 2001, the number of people who bought comprehensive individual policies through HMOs in New York has plummeted to about 31,000 from about 128,000, according to the State Insurance Department. At the same time, New York has the highest average annual premiums for individual policies: $6,630 for single people and $13,296 for families in mid-2009, more than double the nationwide average, according to America’s Health Insurance Plans, an industry group.53

Similarly, a thorough study of New Jersey’s law, by respected faculty researchers at Rutgers University and University of Medicine and Dentistry of New Jersey, reported the following:

The New Jersey Individual Health Coverage Program (IHCP) was implemented in 1993; key provisions included pure community rating and guaranteed issue/renewal of coverage. Despite positive early evaluations, the IHCP appears to be heading for collapse . . . .

Our analysis strongly suggests that the IHCP is in the midst of an enrollment crisis that threatens its market stability and ability to fulfill its stated goals . . . . These trends appear consistent with a marketwide adverse-selection death spiral spurred by open enrollment and pure community rating.54

And, much the same has occurred in Maine.55 Based on this experience, Congress’ own research professionals advised that

[i]f insurers were required to accept all applicants, without any exclusions or waiting periods, . . . people would wait to buy insurance until they became injured or ill. They might also drop the insurance


55. Me. Bureau of Ins., Maine’s Individual Health Insurance Market 3-4 (Jan. 2000) (explaining causes and aspects of market’s apparent or impending “death spiral” and concluding that “the future viability of the individual health insurance market in Maine is at serious risk.”).
when that episode of care was over . . . [Insurers] would respond by increasing their rates. If that too were prohibited, insurers . . . might leave the market entirely.56

Preeminent health economists across the country agree. One from Princeton testified to Congress that

leaving the individual free to choose whether or not to be insured is incompatible with a reorganization of the insurance market that imposes **community rating** and **guaranteed issue** on health insurers. Such an approach would invite egregious adverse risk selection on the part of the insured, who could afford to go without insurance when healthy in the comfort of knowing that they are entitled to health insurance at a community-rated premium when sick. As every economist and actuary appreciates, this type of adverse risk selection ultimately leads to the so-called “death spiral” of the community-rated risk pools.57

Two other health economists wrote separately in the nation’s leading medical journal that

[i]f insurers must sign up anyone who applies for coverage, and if variation in premiums is limited, people would have a powerful incentive to wait until the onset of serious illness to buy insurance at the regulated price. Such behavior would make it financially impossible for insurers to survive. Thus, sustaining insurance-market reforms virtually forces the government to implement a requirement that people carry insurance. And to make such a mandate affordable, subsidies are necessary to avoid causing gross hardship. In brief, the pledge to keep insurance-market reforms without both mandated coverage and subsidies is untenable.58

And


58. Henry J. Aaron, **The Midterm Elections: High Stakes for Health Policy,** 363 NEW ENG. J. MED. 1686 (Oct. 2010), available at http://healthpolicyandreform.nejm.org/?p=12756. Dr. Aaron is as Senior Fellow with the Brookings Institution, Member of the Institute of Medicine, Chairman of the Board of Directors of the National Academy of Social Insurance, and Member of the American Academy of Arts and Sciences.
[The Affordable Care Act] recognizes that adverse selection would wipe out voluntary insurance if people could wait until they contracted a medical condition to buy coverage and still obtain it at the same premiums they would have been charged had they bought it sooner — hence the mandate that all individuals obtain insurance.59

Even some conservative thought leaders agree,60 such as physician and former Republican Senator Bill Frist, who explained (in advocating an insurance mandate) that

[when healthier people opt not to carry insurance, only those with poorer health, and thus higher costs, remain in. This leads insurance prices to spiral up. And it further impedes markets’ ability to mitigate risks and prevent personal economic catastrophe. The “free-riders” who do not purchase insurance and the “voluntarily uninsured” who depend on emergency room care paid by others would then pay their fair share for services received.]

More pointedly, an editor and writer for conservative publications such as Reason and National Review railed against “the idea of reforming the insurance market in a way that would be sold as prohibiting discrimination based on preexisting conditions”:

This is a terrible idea. Now, I’ve written harshly about the individual mandate, which would require every American to buy health insurance. But insurance reforms without a mandate would, in their own way, be just as bad, and twice as stupid.

Prohibiting preexisting conditions entails enacting two different regulations, known as “community rating” and “guaranteed issue.” There are variations on each, but in basic terms, these regulations mean that insurance companies have to charge everyone the same amount for the same policy, regardless of risk factors, and that they have to issue policies to everyone who’s willing to pay.

The problem is that with these regulations in place, there’s no incentive to buy insurance until you’re already very sick. After all, if the...

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59. Mark V. Pauly, Avoiding Side Effects in Implementing Health Insurance Reform, 362 New Eng. J. Med. 672 (Feb. 2010). Dr. Pauly is the Bendheim Professor of Health Care Management, Business and Public Policy at the University of Pennsylvania, where he is also a Professor of Economics and of Insurance and Risk Management.


insurance companies can’t turn you down or jack up your rates, why buy in early? So what happens is that, in hopes of saving money, some number of healthy people decline to buy insurance, creating a sicker, more expensive pool. That pushes a new wave of the healthy people to jump ship, which creates a pool that’s even sicker and even more expensive. Go through a couple iterations of this, and fairly quickly you have a very small, very sick, and very, very expensive insurance pool.

It’s called a “death spiral,” and we know it happens because we’ve seen it in every single state that has enacted those two insurance regulations. We’ve seen it in the state of New York, where, under community rating and guaranteed issue, the individual health insurance market declined from 4.7 percent of the state’s health insurance to 0.2 percent. Meanwhile, premiums skyrocketed; according to an October 2009 report from the insurance lobby, the state’s individual market premiums are now the highest in the nation.

And we’ve also seen the death spiral in Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, Vermont, and Washington. Over and over again, it’s the same story. Premiums spike. The market dries up. Everyone who has paid even the slightest attention to the most surface details of health care policy knows that the combination of these two seemingly innocuous regulations is disastrous.62

Perhaps things will not be this dire under the ACA. Its provisions guard against complete market collapse by heavily subsidizing the purchase of insurance for many people, by allowing (but not requiring) states to merge their individual and small group markets, and by allowing some variation in premium rates (by a factor of 3 for age, and by 50 percent for smoking).63 Accordingly, some analysts project that dropping the individual mandate while keeping the rest of ACA’s insurance market reforms would only moderately reduce coverage and have no effect on employer or government spending.64 For instance, based on extensive statistical modeling, researchers at RAND Corporation projected that eliminating the individual mandate would reduce coverage by 13 million people, which is 5% of the total; stated another way, it would increase the

64. CHRISTINE EBNER, ET AL., ESTABLISHING STATE HEALTH INSURANCE EXCHANGES xi-xii, 32 (Rand Corp. 2010), available at http://www.rand.org/pubs/technical_reports/TR825/ (estimating that removing the individual mandate would reduce the number of newly insured from 35 million to 22 million and have no effect on total employer insurance spending or net new government spending).
number of uninsured by 72% from 18 million to 31 million.65 Similarly, the
Urban Institute concluded that there “would be 17.8 million more people left
uninsured after reform if the individual mandate were eliminated, with relatively
little reduction in government spending.”66

Nevertheless, the Urban Institute researchers concluded that this difference
would be critical: “The bottom line is that the individual mandate is essential if
health reform is to achieve its goal of greatly reducing the number of
uninsured.”67 Likewise, a leading health economist at M.I.T. reasoned as
follows, analogizing health insurance reform to a three-legged stool consisting of
insurance regulation, subsidies to purchase, and the mandate:

Critics who propose to “repeal and replace” the Affordable Care Act
don’t seem to understand that all three legs of the stool are critical for
reform. Pulling out any of the legs while leaving one or two intact will
critically undercut gains from reform. . . .

The simple logic imbedded in the law is that it is potentially destructive
to reform insurance markets without mandating purchase because only
the sick buy insurance and prices remain high. We have seen examples
of this in states such as New York and Massachusetts (before its most
recent reform), which both imposed modified community rating without
a mandate and saw prices skyrocket in their nongroup markets. . . .

Removing the Affordable Care Act’s mandate would eviscerate the
law’s coverage gains and greatly raise premiums. And going further by
only keeping the market reforms and the small business tax credit
would virtually wipe out those coverage gains and cause an enormous
premium spike. Without all three legs, the stool—and effective health
reform—will not stand.68

This logic and experience have already begun to shape outcomes under the
ACA. The ACA requires that, for minors, insurers may no longer refuse
coverage based on health status or a pre-existing condition starting September

65. Id.

66. MATTHEW BUETGENS, BOWEN GARRETT, AND JOHN HOLAHAN, WHY THE INDIVIDUAL
MANDATE MATTERS 1 (Urban Inst. 2010), available at http://www.urban.org/UploadedPDF/
412280-individual-mandate-matters.pdf. The analysis was based on the Urban Institute’s Health
Insurance Policy Simulation Model (HIPSM), which “simulates the decisions of businesses and
individuals in response to policy changes, such as Medicaid expansions, new health insurance
options, subsidies for the purchase of health insurance, and insurance market reforms. The model
provides estimates of changes in government and private spending, premiums, rates of employer
offers of coverage, and health insurance coverage resulting from specific reforms.”

67. Id.

68. JONATHAN GRUBER, HEALTH CARE REFORM IS A “THREE-LEGGED STOOL”: THE COSTS OF
PARTIALLY REPEALING THE AFFORDABLE CARE ACT 3-4, 6 (Ctr. for Am. Progress, Aug. 2010),
2010, three years before parents are subject to the individual mandate.\textsuperscript{69} Recognizing the resulting potential for serious adverse selection, the major national, state and regional insurers, announced they would stop selling policies that cover only children.\textsuperscript{70} Thus, a requirement to cover all applicants without a commensurate requirement for people to purchase coverage has already caused a portion of the insurance market essentially to implode.

IV. REFORM’S IMPACT ON UNINSURED PEOPLE

Opponents of the individual mandate claim that it unconstitutionally regulates the passive “inactivity” of being uninsured.\textsuperscript{71} In an attempt to elevate the condition of being uninsured to constitutional protection, some opponents claim that uninsured people are not, in fact, free-riding on the pocketbooks of taxpayers or the good will of medical providers.\textsuperscript{72} Instead, opponents characterize uninsured people as not participating in commerce at all, or as preferring to pay for their own health care out-of-pocket rather than through insurance.\textsuperscript{73} Evidence from extensive health services research, however, shows just the opposite.\textsuperscript{74} Uninsured people move into and out of the insurance market, and they use substantial amounts of health care, much or most of which they do not pay for themselves.\textsuperscript{75}

A. Voluntary Spells With and Without Insurance

National data show that most uninsured people have not made settled decisions to remain out of the insurance market.\textsuperscript{76} Instead, of those who are uninsured at some point in a given year, about 63% have coverage at some other point during the same year.\textsuperscript{77} As a result, although about 15% of the nonelderly population is uninsured at any point in time, about twice as many people are

\begin{itemize}
  \item \textsuperscript{71} Crocker, supra note 13 at 3.
  \item \textsuperscript{72} Barnett, et al., supra note 11.
  \item \textsuperscript{73} Id.
  \item \textsuperscript{74} See infra note 81.
  \item \textsuperscript{75} CONG. BUDGET OFFICE, HOW MANY PEOPLE LACK HEALTH INSURANCE & FOR HOW LONG? 4, 9 (May 2003), http://www.cbo.gov/fdpdocs/42xx/doc4210/05-12-Uninsured.pdf.
  \item \textsuperscript{76} Id.
  \item \textsuperscript{77} Id.
uninsured at some point over a two-year period, and about half of Americans are uninsured at some point over a decade. For most of these people, the period without insurance lasts less than a year (Table 1). According to researchers at the Urban Institute,

> [data from the 1999 round of the National Survey of America’s Families (NSAF) showed that, of the 50 million people who lacked coverage at the time of the survey or at some time during the 12 months before the survey, 56 percent were uninsured for 12 months or longer, 24 percent for 6 to 11 months, and 20 percent for 5 months or less. . . . This paper updates the 1999 analysis with data from the 2002 round of NSAF. . . . A total of 49 million individuals were uninsured at some point during the year. Of these, over half (26 million) lacked insurance for 12 months or more, a group we refer to as the “long-term uninsured.” An additional 12 million lacked coverage for 6–11 months, and 11 million were uninsured for less than 6 months. We refer to these latter groups as the “short-term uninsured.”]

78. **Families USA, Americans at Risk: One in Three Uninsured** 2 (2009), http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf. The Lewin Group prepared these estimates using several data sources:

National and state estimates were calculated using the Survey of Income and Program Participation (SIPP), the Current Population Survey (CPS), and the Medical Expenditure Panel Survey (MEPS). The SIPP was chosen because of its large sample size, state identifiers, and monthly reporting of health insurance status over a multi-year period. The CPS provides the most recent data on health insurance coverage, employment, income, and population estimates, and it supports state-level estimates. However, the CPS does not include data for 24 consecutive months. The MEPS longitudinal survey data file contains monthly reporting of health insurance status over a two-year period and has been used by the Agency for Health Care Research and Quality (AHRQ) to produce national estimates of the number of people who were uninsured at some time over a 24-month period. . . . National estimates were based on waves three through eight of the 2004 Panel of the SIPP (July 2004 through June 2006), which reported data for all 24 months of the period. The data were adjusted to account for the demographic and health insurance status of people who did not report data for the entire period. Final estimates were adjusted to match the results of the MEPS data as published by AHRQ and projected to the 2007-2008 period. . . . We used SIPP in the analysis because it includes certain labor force information that is necessary for the analysis but that is not included in the MEPS.


80. *Id.*

Table 1: Duration without Health Insurance for Uninsured People under Age 65, 2007-2008

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Months</td>
<td>25.3%</td>
</tr>
<tr>
<td>13-23 Months</td>
<td>19.5%</td>
</tr>
<tr>
<td>9-12 Months</td>
<td>15.4%</td>
</tr>
<tr>
<td>6-8 Months</td>
<td>14.3%</td>
</tr>
<tr>
<td>3-5 Months</td>
<td>20.1%</td>
</tr>
<tr>
<td>1-2 Months</td>
<td>5.4%</td>
</tr>
<tr>
<td>Uninsured 9+ months</td>
<td>60.2%</td>
</tr>
<tr>
<td>Uninsured 6+ months</td>
<td>74.5%</td>
</tr>
</tbody>
</table>

This pattern of temporary periods of going without insurance is becoming more common. According to a health economist at Harvard, from 1983 to 1986, “59.2% of those who were uninsured obtained insurance within 1 year, and 73.8% obtained insurance within 2 years; in the 2001–2004 panel, 61.7% obtained insurance within 1 year, and 79.7% within 2 years. . . . The percentage of persons who were uninsured for 2 years or longer, for example, decreased from 26.2% to 20.3% between the two study periods.”

Higher income people are more likely to be uninsured for shorter periods, indicating that many are opting into and out of insurance. According to the Urban Institute (see Table 2), in 2001-2002 “two-fifths of the highest income uninsured [>300% poverty] were uninsured for a year or more, compared with over half of those in the middle income groups and nearly two-thirds of those in poverty.” Similarly, the Congressional Budget Office (under President Bush) reported that “[18] percent of uninsured spells among people with annual income of less than 200 percent of the federal poverty level exceed two years, about two-thirds higher than the figure for people whose income is 400 percent or more of the poverty level. And the Treasury Department found that 45% of people in

82. David M. Cutler and Alexander M. Gelber, Changes in the Incidence and Duration of Periods without Insurance, 360 NEW ENGL. J. MED. 1740, 1745-46 (2009). According to the authors, we used two data sets from the Survey of Income and Program Participation of the U.S. Census Bureau: one that covered the period from 1983 through 1986 (25,946 persons), and another that covered the period from 2001 through 2004 (40,282 persons). For each set of years, we estimated the probability that a person would be uninsured for some period of time and the probability that a person would subsequently obtain private or public insurance. We also estimated the probabilities that persons in various demographic groups would become uninsured over the course of a year and would remain uninsured for various amounts of time.

83. Id.
84. Id.
85. Id.
86. CONG. BUDGET OFFICE, supra note 75 at 10.
households with income of $50,000-$100,000 were uninsured at some point over the decade 1997-2006.87

Table 2: Rate and Length of Uninsurance Spells, by Family Income, Education, Health Status, and Age, Nonelderly Population, 2001-02


<table>
<thead>
<tr>
<th>% uninsured some point in prior year</th>
<th>Length of Uninsured Spell</th>
<th>% of uninsured without insurance less than a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19.90%</td>
<td>5.00%</td>
</tr>
<tr>
<td></td>
<td>4.40</td>
<td>10.60%</td>
</tr>
<tr>
<td></td>
<td>47.2</td>
<td></td>
</tr>
<tr>
<td>Poverty Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% of FPL</td>
<td>40.3</td>
<td>6.3</td>
</tr>
<tr>
<td></td>
<td>6.3</td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25.</td>
</tr>
<tr>
<td>100-200% of FPL</td>
<td>35.0</td>
<td>6.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>19.</td>
</tr>
<tr>
<td>200-300% of FPL</td>
<td>23.0</td>
<td>5.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11.</td>
</tr>
<tr>
<td>300% of FPL</td>
<td>4.0</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>59.6</td>
</tr>
</tbody>
</table>

Conservative policy analysts have embraced these findings to make the point that many uninsured people are not stuck in that status by economic necessity; instead many uninsured people make a calculated decision to “self-insure.”88 Consider, for instance, the following conclusions from a detailed study by Dr. June O’Neill, an economist and director of the Congressional Budget Office under a Republican-led Congress:

Many people believe that the number of uninsured signifies that almost 50 million Americans are without healthcare simply because they cannot afford a health insurance policy . . . However this line of reasoning is based on a distorted characterization of the facts. . . . More careful analysis of the statistics on the uninsured shows that many uninsured individuals and families appear to have enough disposable income to purchase health insurance, yet choose not to do so, and instead self-insure. We call this group the “voluntarily uninsured” and find that they account for 43 percent of the uninsured population.89

87. U.S. DEPT. OF TREASURY, supra note 79.
89. JUNE E. O’NEILL & DAVE M. O’NEILL, WHO ARE THE UNINSURED?: AN ANALYSIS OF
B. Care Received by Uninsured People

Many people who choose to go without insurance still seek substantial amounts of health care, much of which they are unable to pay for themselves. Dr. O’Neill, again, explains that

while the uninsured receive fewer medical services than those with private insurance, they nonetheless receive significant amounts of healthcare from a variety of sources—government programs, private charitable groups, care donated by physicians and hospitals, and care paid for by out-of-pocket expenditures.90

Dr. O’Neill’s study supported these conclusions with data on middle-class uninsured people—those whose incomes are more than two-and-a-half times the federal poverty level.91 As Table 3 shows, the majority of those who were uninsured all year received some medical care in the prior two years.92

Table 3: Percent of Uninsured Adults Who Received Selected Medical Services in Past Two Years, 2005

<table>
<thead>
<tr>
<th>Service</th>
<th>Uninsured all 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Routine Check-Up</td>
<td>50.43</td>
</tr>
<tr>
<td>Blood Pressure Check</td>
<td>71.79</td>
</tr>
<tr>
<td>Pap smear (Women only)</td>
<td>62.81</td>
</tr>
<tr>
<td>Mammogram (Women over 39)</td>
<td>49.25</td>
</tr>
</tbody>
</table>

Although about half of people who are uninsured all year use no care that year, half do use care, including those who had the option to enroll in employer-sponsored health insurance.93 Overall, more than three-fifths (62.6%) of

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90. Id.
91. Id.
92. Id.
uninsured people under age 65 made at least one visit to a doctor or emergency room in 2007.\textsuperscript{94} And among those who do avoid insurance for longer terms, virtually all of them (at least 94\%) receive some medical care at some point.\textsuperscript{95}

\textbf{C. Who Pays for Uninsured Care?}

When uninsured people receive coverage, who pays? According to an analysis by the Urban Institute

\begin{quote}
people uninsured for any part of 2008 spent about $30 billion out of pocket and receive[d] approximately $56 billion in uncompensated care while uninsured. Government programs finance[d] about 75\% of uncompensated care. . . . Various private sources help subsidize uncompensated care. Physicians’ donated time and forgone profits amount[ed] to $7.8 billion. After government payments to hospitals are subtracted, private philanthropy and profit margins [were] responsible for at least an additional $6.3 billion.\textsuperscript{96}
\end{quote}

No published account has criticized or questioned this widely cited and especially rigorous study.\textsuperscript{97} The prestigious Institute of Medicine relied on similar studies to conclude that

\begin{quote}
[person]s who are uninsured for the full year pay 35\%, on average, of the overall cost of medical services they receive. . . . This estimate includes the value of free hospital, physician, and clinic services that the uninsured use annually, adjusted to reflect spending in 2001. . . . The amount paid out of pocket varies by type of service. For example, uninsured individuals pay for nearly all (88\%) of their prescription medications but for only 7\% on average of hospital expenses they incur. Supports for care to uninsured patients come from federal, state, and local programs and grants; from organized
\end{quote}

\begin{footnotesize}
\textsuperscript{94} Nat’l Ctr. for Health Statistics, Health, United States, 2009, 318 (2010), available at http://www.cdc.gov/nchs/data/hus/hus09.pdf. See also Kaiser Comm’n on Medicaid and the Uninsured, Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years 1 (2010), available at www.kff.org/uninsured/upload/8083.pdf (noting that 62\% of the uninsured below 133\% of the Federal Poverty Level have used some medical care in the last two years).
\textsuperscript{95} O’Neill, supra note 89 at 20-22.
\textsuperscript{96} Jack Hadley, John Holahan, Teresa Coughlin and Dawn Miller, Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs, 27(5) Health Aff. 399, 406 (Sept. 2008).
\textsuperscript{97} Id. Data came from the Medical Expenditure Panel Surveys (MEPS), a nationally representative survey conducted by the federal government, and from the American Hospital Association (AHA) Annual Survey of Hospitals, as well as from surveys of office-based private physicians and budget and program data from Medicare, Medicaid, and other government programs that serve the uninsured.
\end{footnotesize}
philanthropy; and from the donated services and uncompensated care absorbed by providers.\textsuperscript{98}

These “unreimbursed costs of caring for uninsured Americans are ultimately paid for by higher taxes and higher prices for services and insurance. Local communities tend to bear the main economic burden of subsidizing service delivery . . . “\textsuperscript{99} One analysis, for instance, explained that

[r]esearch has shown that the uninsured often put off getting care for health problems—or forgo care altogether. When the symptoms can no longer be ignored, the uninsured do see doctors and go to hospitals. Without insurance to pay the tab, the uninsured struggle to pay as much as they can: More than one-third (35 percent) of the total cost of health care services provided to people without health insurance is paid out-of-pocket by the uninsured themselves. Who pays the rest? Families USA answers this question in Paying a Premium: The Added Cost of Care for the Uninsured. The remaining sum (almost $43 billion in 2005) is primarily paid by two sources: Roughly one-third is covered by a number of government programs, but two-thirds is paid by people with health insurance through higher premiums.\textsuperscript{100}

Hospitals often or usually bill uninsured people who receive care, but “[h]ospital administrators report that they collect only about ten percent of their charges to uninsured patients.”\textsuperscript{101} This highly subsidized care is not restricted to uninsured people without means to pay,\textsuperscript{102} but includes people well above poverty.\textsuperscript{103} Among adults who decline the option to enroll with employer-sponsored insurance, public sources and uncompensated care cover 72% of total costs.\textsuperscript{104} According to an in-depth analysis by a Johns Hopkins University health economist, “the high-income uninsured [those above 300% of federal poverty level] on average pay for [only about] one-half of the care they received.”\textsuperscript{105}

\begin{footnotes}
\footnote{99. Id.}
\footnote{100. FAMILIES USA, PAYING A PREMIUM: THE ADDED COST OF CARE FOR THE UNINSURED (Jan. 2005), available at http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf. This analysis was conducted by Dr. Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management, Rollins School of Public Health, Emory University, using data from the U.S. Census Bureau, the federal Agency for Healthcare Research and Quality, and the National Center for Health statistics, and other credible sources.}
\footnote{102. See Herring, infra note 105 and accompanying text.}
\footnote{103. Id.}
\footnote{104. Bernard & Selden, supra note 104.}
\footnote{105. Bradley Herring, The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance, 24 J. OF HEALTH ECON. 225, 231 (2005).}
\end{footnotes}
On account of this heavy load of cost-spreading, it is “both mistaken and
dangerous to assume that the persistence of a sizable uninsured population in the
United States harms only those who are uninsured.” Instead, according to the
Institute of Medicine,

[The adverse effects of uninsurance have spillover effects on the
community. The [IOM] believes it. Although the Committee calls for
further research to examine the likely effects of uninsurance at the
community level, it believes that the evidence available justifies the
immediate adoption of policies to address the lack of health insurance
in the nation.]

Thus, the decision not to purchase insurance is more than simply a private
consumption choice to pay for all care out-of-pocket or to not use health care at
all. Instead, peoples’ decisions whether to purchase insurance affects not only
themselves but also the rest of society. Most health care finance occurs through
pooled mechanisms that inevitably spread costs broadly. And most people
who do not purchase health insurance do, in fact, seek care, much of which they
do not pay the full costs for. Therefore, those who fail to contribute to the
insurance pool are free riding on the rest of society.

V. IMPACT ON INSURERS

Some individuals claim they have constitutional rights to be uninsured, but
some commentators also invoke individual rights on behalf of insurers. The
formidable Richard Epstein argues that tougher insurance standards are
“confiscatory” rate regulations that violate the Takings Clause or substantive due
process. He suggests this conclusion is firmly based in existing law (claiming
“little doubt”), but Professor Epstein is well known for arguing far outside the
legal mainstream that much of modern government is unconstitutional on much
the same grounds. Thus, we need to take a closer look, to distinguish a
libertarian view of what the ACA might do from a convincing view of what it
actually does.

106. INST. OF MED., supra note 98.
107. Id.
108. Reindhardt, Statement before the U.S. Senate Finance Committee, supra note 57.
109. INST. OF MED., supra note 98; Hadley, supra note 96.
110. Richard Epstein, Impermissible Ratemaking in Health Insurance Reform: Why the Reid
columns/archives/2009/12/impermissible-ratemaking-in-he.php; Richard Epstein, Harry Reid
Turns Insurance into a Public Utility, WALL ST. J., (Dec. 22, 2009, 8:16 PM),
111. Epstein, Harry Reid Turns Insurance into a Public Utility, supra note 110.
112. Epstein, Impermissible Ratemaking in Health-Insur ance Reform: Why the Reid Bill is
Unconstitutional, supra note 110.
113. See generally Richard Epstein, Foreword: Unconstitutional Power, and the Limits of
Epstein summarizes that an earlier version of the law in Congress, prior to the ACA, would have imposed

sharp limitations on the ability of health-insurance companies to raise fees or exclude coverage. Moreover, the [law] forces on these regulated firms onerous new obligations that they will not be able to fund from their various revenue sources. The squeeze between the constricted revenue sources allowable under the [law] and the extensive new legal obligations it imposes is likely to result in [sic] massive cash crunch that could drive the firms that serve the individual and small-group health-insurance markets into bankruptcy.114

But the ACA as enacted does not regulate what insurers charge. Instead, it limits how much of the insurance premium can go towards profits and overhead administrative costs. For insurance covering large groups, the maximum is 15%, and for policies covering small groups and individuals, it is 20%. Insurers must pay out the remaining revenue—the “medical loss ratio”—as medical claims.

The ACA limits medical loss ratios to 80% for individual and small-group insurance and 85% for large groups.115 This is tight, but not onerous. For group insurance, these ratios are broadly consistent with actual historical patterns and recent experience in the industry.116 A 2009 news story noted that “insurers spend an average of 87 cents of every premium dollar on direct medical care, according to the industry’s trade lobby, America’s Health Insurance Plans.”117 A recent Congressional report noted that only one of the thirteen major insurers it studied had a medical loss ratio of less than 80%.118

For individual (i.e., non-group) insurance, although most insurers have lower loss ratios (see Table 4),119 these conventional ratios do not reflect the calculus that will apply under the ACA. The ACA credits as medical expenses those administrative costs that insurers spend on quality improvement, broadly defined, and the ACA disregards certain taxes that conventional ratios include in

117. Id.
118. See AUSTIN & HUNGERFORD, supra note 32 at 42-46.
119. Table 4 is taken from U.S. Senate, Committee on Commerce, Science, and Transportation, Office of Oversight and Investigations, Majority Staff, Implementing Health insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers (April 15, 2010), available at http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0f052-4ca6-4c12-9f91-a5e4a90c6667. Data is based on regulatory filings made by the companies with the National Association of Insurance.
the denominator. Therefore, loss ratios restated under the ACA’s formula would probably be several points higher. Moreover, some states may merge their individual and small group markets, producing ratios that are a weighted average of the two. And when the reform law takes full effect, it will remove the administrative expense of medical underwriting from the individual and small group markets, which will further ease pressure on loss ratios.

Table 4: Medical Loss Ratios by Market Segment for Largest National Insurers

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Small Group</th>
<th>Large Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>75.70%</td>
<td>73.90%</td>
<td>84.20%</td>
</tr>
<tr>
<td>CIGNA</td>
<td>88.10%</td>
<td>86.90%</td>
<td>92.10%</td>
</tr>
<tr>
<td>Coventry</td>
<td>71.90%</td>
<td>65.80%</td>
<td>78.20%</td>
</tr>
<tr>
<td>Humana</td>
<td>68.10%</td>
<td>71.90%</td>
<td>80.00%</td>
</tr>
<tr>
<td>UnitedHealth</td>
<td>70.50%</td>
<td>70.30%</td>
<td>81.10%</td>
</tr>
<tr>
<td>WellPoint</td>
<td>74.90%</td>
<td>73.10%</td>
<td>81.20%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>73.60%</td>
<td>72.50%</td>
<td>81.20%</td>
</tr>
</tbody>
</table>

Professor Epstein nevertheless claims “there is a near mathematical certainty that the scheme of health-insurance market regulation contemplated by [the law] will reduce the risk-adjusted rate of return below the level needed to keep these firms in the individual and small-group health-insurance markets.” Market signals clearly belie this doomsday prediction. In the two months prior to the Senate’s initial approval of the ACA on Christmas Eve 2009, health insurers’ stock prices outpaced the market’s overall substantial increase more than two-fold, and stock prices for the three largest health insurers increased even more. According to analysts, this surge reflected investor optimism in insurers’ business prospects under the anticipated regulations. These rosy prospects have continued throughout 2010 as regulations have been issued. Morgan Stanley maintains a Healthcare Payor Index designed to measure the performance of companies “involved in the business of managing the health care dollar,” such as HMOs (health maintenance organizations) and pharmaceutical

120. Id. at 5.
121. Epstein, Impermissible Ratemaking in Health Insurance Reform: Why the Reid Bill is Unconstitutional, supra note 110 at 3.
123. Id.
The index took a 3-week dive from 1,122 on February 16, 2009 to 682 on March 5, at the same time that the overall stock market dropped substantially (approximately 10%-20% depending on the index). Since then, while Congress and the President debated, enacted, and began to implement health insurance reform, the Payor Index has increased fairly steadily and steeply, reaching 1,646 as of November 26, 2010 – three days after the federal Department of Health and Human Services (HHS) issued its medical loss ratio rules. This level is almost 50 percent higher than before the February 2009 drop and more than twice the level of the index’s March 2009 low. Over the same period, the general stock market increased less than half from its mid-February levels and less than two-thirds from its early March lows.

Professor Epstein also asserts that “not one syllable in the [law] is dedicated to securing [a] constitutionally guaranteed minimum rate of return,” but careful reading reveals the following: (1) HHS may adjust the minimum loss ratio if it would “destabilize the individual market” (section 2718); and (2) a passel of provisions (reinsurance, risk adjustment, and stop-loss corridors) protect insurers against excessive high-cost claims, both initially (sections 1341, 1342) and on an ongoing basis (section 1343). These provisions will help protect particular insurers with unprofitable risk pools.

Finally, regulating administrative overhead is not the same as regulating total profits. Most health insurers make as much or more from their financial investments as they do from insurance operating margins. Therefore, breaking even on insurance, or even suffering an operating loss from time to time, is not at all unusual and does not necessarily deprive insurers of a reasonable rate of return. Moreover, health insurers’ profit margins should not be judged by those in other industries because their revenue does not fund large amounts of inventory, capital costs, research and development and the like. Instead, most insurance company revenue simply flows through in the form of claims payments, resulting in healthy profit margins that look much thinner than those in other sectors. Table 5 shows, for instance, that overall profit margins typically are lower than two percent.

125. Id.
126. Id.
127. Id.
128. Data can be found at http://www.google.com/finance.
129. Epstein, Harry Reid Turns Insurance Into a Public Utility, supra note 110.
131. See AUSTIN & HUNGERFORD, supra note 32 at 46.
Table 5. Operating Margins of Health Plans, 2007

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Weighted</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td>0.39%</td>
<td>0.22%</td>
<td>0.59%</td>
</tr>
<tr>
<td>Others</td>
<td>1.56%</td>
<td>1.16%</td>
<td>1.19%</td>
</tr>
<tr>
<td>Total</td>
<td>0.39%</td>
<td>0.32%</td>
<td>0.59%</td>
</tr>
</tbody>
</table>

VI. IMPACT ON STATES

So far we have considered constitutional challenges based on the rights of individuals and of insurers. In addition, some states argue that federal health insurance reform violates their sovereign rights under the Tenth Amendment. Under modern jurisprudence, the only established basis for this claim would arise if the federal reform were to “commandeer” state governments to carry out federal reform. Challenger states point to federal requirements to set up insurance exchanges and to regulate the insurance market, but those states mischaracterize or exaggerate these obligations. Far from imposing conscription to carry out federal objectives, the law leaves states many opportunities to opt out and ample discretion in implementing the key provisions. For example, section 1321, entitled “State flexibility in operation and enforcement of Exchanges and related requirements,” allows states to opt out of running insurance exchanges altogether by relying instead on a federal fallback exchange. Title 1, subtitle D, has a Part 4 entitled “State Flexibility To Establish Alternative Programs.” Section 1332 allows states to avoid even the federal exchange altogether, and instead to receive a direct pass through of federal funding to state coffers if the state obtains a waiver by showing that its alternative program will cover at least as many people as the federal law and will provide coverage and subsidies that are at least equally generous.

Finally, for states that choose to establish their own exchanges, although the basic requirements for exchanges must meet federal standards, states retain ample discretion to:

- Determine governance structure, e.g., whether a state, quasi state, or nonprofit entity runs the exchange (Section 1311(d));

132. Id.
133. Arts & Erwin, supra note 11.
136. Id.
137. Id. at § 1332, 124 Stat. at 187-92.
138. Id.
139. Id. at §1311(d), 124 Stat. at 176-78.
Choose whether to create two exchanges or to merge non-group and small-group exchanges (Section 1311(b)(2));

Determine the cutoff size for small employers allowed to purchase health insurance in the exchange (Section 1304(b)(2), 1304(b)(3));

Limit small employer group eligibility to those employing fewer than 50 employees until January 2016 (Section 1304(b)(3)), or open the exchange to businesses with more than 100 employees (Section 1312(f));

Determine whether to have one statewide exchange or regional exchanges within a state (Section 1311(f)(1)(2)), or whether to participate in an interstate regional exchange (Section 1311(f));

Identify and establish contractual or grant arrangements with partner organizations, including patient navigators and any other contractors necessary to carry out responsibilities of the exchange (Section 1311(i), 1311(f));

Allow agents or brokers to enroll people into plans and assist people in qualifying for subsidy (Section 1312(e)); and

Limit the number of insurance plans participating in the exchange (Section 1311(e)).

Aside from regulating private insurance, the states’ principal complaint is that the ACA’s expansion of Medicaid imposes excessive financial burdens. Starting in 2014, Medicaid will cover all citizens below 138% of the federal poverty level, roughly doubling its current size. Medicaid is jointly funded by federal and state funds, so any expansion of Medicaid’s minimum requirements entails some increased state funding for Medicaid. The only way this expansion can be struck down under the “anti-commandeering” principle, however, is if states were unable to drop Medicaid altogether, but they are not. States claim that dropping Medicaid is practically or politically infeasible, which they claim invokes a passage in South Dakota v. Dole. There, the Supreme Court

140. Id. § 1311(b)(2), 124 Stat. at 173.
142. Id. at § 1304(b)(3), 124 Stat. at 172; Id. at § 1312(f), 124 Stat. 183-84.
143. Id. at §1311(f), 124 Stat. at 179.
144. Id. at §1311(i), 124 Stat. at 179-80.
146. Id. at §1311(e), 124 Stat. at 178.
149. 483 U.S. 203, 211 (1987); see Arts & Erwin, supra note 11; Crocker, supra note 13.
Court noted in dictum that, in setting regulatory conditions on federal spending, it might be possible for Congress to cross the line at which “pressure turns into compulsion.”\(^\text{150}\) This hypothetical limit is still only speculative; the Supreme Court has never defined it, and most lower courts have refused to find compulsion, even in fairly extreme circumstances.\(^\text{151}\)

Even if there were a compulsion test, the ACA’s requirements clearly are mild enough to fall well short of the line. The federal government pays 100% of the costs of expanded Medicaid for the first three years, and thereafter it will gradually reduce its support to 90% by 2020.\(^\text{152}\) Moreover, if states were to drop out of Medicaid, most of the people who would lose coverage would still receive substantial subsidies from the federal government to purchase private coverage through the new insurance exchanges, greatly cushioning the blow.

Documenting the limited Medicaid costs to the states, an extensive analysis by the Urban Institute concluded that

>nationally and across states, this analysis shows that . . . the government will pay a very high share of new Medicaid costs in all states, [and] increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted. . . . \(^\text{153}\)

Under one reasonable scenario, “federal spending would increase by $443.5 billion and state spending would increase by $21.1 billion between 2014-2019. Thus about 95 percent of all new spending would be by the federal government.”\(^\text{154}\)

\(^{150}\) Dole, 483 U.S. at 211.


\(^{154}\) Id. According to the authors,

We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data for 2006 and 2007). . . . We then generate a 2009 dataset by growing the population to 2009. . . . We also benchmark to 2009 CPS total population estimates by state and estimate population growth to 2019 using growth rates based on Census population projections. To estimate the impact of health reform on states, we use a model developed at the Urban Institute’s Health Policy Center (Health Insurance Policy Simulation Model or HIPSM). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS to simulate the eligibility determination process. . . . Once we have identified individuals who are newly eligible for Medicaid, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to
With the federal government paying so much of the costs for the newly insured, the ACA will actually save many states money compared with what they currently pay for care for low-income, uninsured individuals not currently eligible for Medicaid. As summarized by the *Washington Post*,

"[t]he federal government will bear virtually the entire cost of expanding Medicaid under the new health-care law, according to a comprehensive new study by the Kaiser Family Foundation that directly rebuts the loud protests of governors warning about its impact on their strapped state budgets. . . . Governors of many of those states have predicted fiscal calamity for their budgets, . . . [but] even the small increase in Medicaid costs may be canceled out by the savings states will enjoy from no longer having to subsidize the uncompensated care of uninsured people who will be on Medicaid," study co-author John Holahan said. "It's absurd," Holahan, an Urban Institute researcher, said of the states’ doom and gloom predictions. “They come out ahead. It’s just crazy.” . . . Although Medicaid enrollment nationally is estimated to increase by 27 percent by 2019, state spending will increase only 1.4 percent, on average, and federal spending will increase by 22 percent, the report finds.\(^{155}\)

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The Heritage Foundation, Republican Congressional leaders, and several states estimate vastly more expensive results for the states, but several of their assumptions are questionable. Also, these estimates fail to account for the substantial savings that states will enjoy when they are able to reduce existing support for uncompensated care for people who are currently uninsured.

According to another Urban Institute analysis, in 2008 state and local governments paid for about 30% of the $56 billion in uncompensated care that the uninsured received. The Urban Institute also projects that, absent health insurance reform, the costs of uncompensated care for the uninsured would increase $81-$92 billion by 2014, and $106-$141 billion by 2019. With reform, uncompensated care will decline $16-$26 billion per year by 2019. Thus, reform will reduce the costs of caring for the uninsured by well over $100 billion a year. If states and localities continue to pay for 30% of that care, increased insurance coverage would save state and local governments roughly $30 billion a year.
Analyses that factor in these savings show much lower or no increased costs for states; in fact, they project significant savings. The Council of Economic Advisors estimated state and local spending impacts for 16 states (Arkansas, California, Florida, Idaho, Indiana, Iowa, Maine, Michigan, Minnesota, Montana, Nebraska, North Carolina, Oregon, Pennsylvania, Vermont, and Wyoming), using a conservative estimate of uncompensated care costs. It concluded that the 16 states would save $3.0 billion per year [in uncompensated care costs], with . . . the savings more than offsetting the additional Medicaid costs in every one of the sixteen states. Thus, health insurance reform, far from harming state budgets, would likely improve them substantially.

An analysis by the respected Lewin Group confirmed this, concluding that the ACA “will result in net savings to state and local governments of $106.8 billion over the 2010 through 2019 period.”

These analyses leave little or no basis for thinking that the ACA imposes unconstitutional conditions on states’ abilities to remain part of the Medicaid program.

VII. CONCLUSION

For some branches of constitutional law, social and economic facts matter little or not at all. This is not the case, however, for challenges to the Affordable Care Act. The constitutional claims depend heavily on how people and institutions behave, and on how insurance markets function, under the ACA as compared to prior to the reform law. Fortunately, the health care sector has been studied thoroughly, so a great deal of empirical information exists to evaluate the strength of constitutional attacks and defenses, avoiding the need for lengthy trials or uncertain speculation.

This article aims to collect the full range of available empirical data that sheds light on a range of legal challenges. This evidence demonstrates that major elements of these challenges have very weak or no factual support, by the standards of existing constitutional doctrine that courts will use to judge these challenges. Health insurance markets cannot be effectively regulated to

165. Id.
eliminate medical underwriting without also requiring that most people purchase or obtain coverage. People who opt out of coverage are highly likely to use health care services for which they do not fully pay, imposing additional costs on those who do purchase or fund coverage. And, reform does not coerce states into implementing federal law. Instead, states retain numerous freedoms to craft market reforms to fit local market conditions, to fall back on federal default options, or even to opt out of Medicaid altogether if they believe that is truly in the best interests of their citizens. These facts undercut the majority of colorable constitutional claims that opponents have made.
CONSTITUTIONAL ATTACKS AGAINST THE PATIENT PROTECTION AND AFFORDABLE CARE ACT’S “MANDATING” THAT CERTAIN INDIVIDUALS AND EMPLOYERS PURCHASE INSURANCE WHILE RESTRICTING PURCHASE BY UNDOCUMENTED IMMIGRANTS AND WOMEN SEEKING ABORTION COVERAGE

Roy G. Spece, Jr.*

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I. INTRODUCTION: FOUR CONTEXTS FOR CONSTITUTIONAL ANALYSIS—(1) THE
   UNDOCUMENTED CAN’T PURCHASE IN EXCHANGES, (2) ABORTION
   REGULATIONS AND PROHIBITIONS IN EXCHANGES, (3) THE UNDOCUMENTED ARE
   BARRED FROM VOLUNTARY STATE PROGRAMS, AND (4) SUBSTANTIVE DUE
   PROCESS AND EQUAL PROTECTION ATTACKS AGAINST INDIVIDUAL AND
   EMPLOYER MANDATES

   Health care reform—in this instance the Patient Protection And Affordable
   Care Act (the “PPACA”)1 - is a contentious topic, and it is inevitable that major

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   Arizona James E. Rogers College of Law. Thanks to Michael H. Shapiro, Dorothy W. Nelson
   Professor of Law at the University of Southern California Gould School of Law for comments on a
changes such as those portended by the PPACA will lead to constitutional attacks. Given the tenor of the times, it may even meet with flat resistance in the form of civil disobedience. Several states, groups, and individuals quickly filed suits attacking the constitutionality of the new legislation, primarily arguing, on several grounds, that the federal government does not have the constitutional power to force persons to purchase insurance. (Some of these cases have been

draft of this article and to my colleague at the College of Law, Professor Nina Rabin, for reading an earlier draft of the portions of this article dealing with immigration law. Thanks also to the Salmon P. Chase College of Law and its faculty and law review members for conducting an excellent symposium on the constitutionality of the PPACA, at which I was able to present this paper and to enjoy the unparalleled hospitality of those folks.


2. Coons v. Geithner, No. 2:10-CV-01714-GMS (D. Ariz. filed Aug. 12, 2010) (Count I, violation of Fifth and Ninth Amendments medical decision-making autonomy; Count II, Fourth, Fifth and Ninth Amendments invasion of informational privacy; Count III, violation of Arizona legislators’ First Amendment Rights and imposing an unconstitutional condition; Count IV, tracking Count III but also pointing out alteration of constitutional rules regarding the legislative process; Count V, for exceeding Commerce Clause power; Count VI, exceeding Federal Government’s taxing power and arguing that the individual mandate penalty is neither an apportioned direct tax, nor an income tax, nor an excise tax, nor an impost or duty in arguing that if it were a tax it would be classified as an unapportioned direct tax for which the Federal Government would lack the taxing power to levy; County VII, for exceeding the federal government’s spending power; Count VIII, regarding the PPACA’s establishment of the Independent Payment Advisory Board (Board) and providing for expedited and altered legislative process concerning Board’s recommendations binding subsequent legislatures and embedding the Board’s recommendations into law if Congress does not act promptly as violating separation of powers; Count IX, for the PPACA exceeding the implied power granted by the Necessary and Proper Clause; Count X, for the PPACA’s violation of the Tenth Amendment; Count XI, for non-pre-emption) (see text between notes 419 and 421 for paraphrase of two of these Counts); Liberty Univ. Inc. v. Geithner, No. 6:10-CV-00015-NKM (W.D. Va. filed Mar. 23, 2010) (including Counts alleging that the PPACA violates the Republican Form of Government Clause, invades the free exercise of religion, freedom of association, freedom of speech and also constitutes an establishment of religion; alleging religious exemptions as violating equal protection); Florida v. United States Dep’t of Health & Human Serv., No. 3:10-CV-91-RV/EMT (N.D. Fla. filed June 23, 2010) (Order And Memorandum Opinion issued October 14, 2010 (1) rejecting Anti-Injunction Act defense and defendants’ argument that they had the power to pass the PPACA pursuant to the taxing power, observing that the PPACA’s supporters first said it was a penalty to avoid the notion of another tax for which they could be held accountable and then attempted, unsuccessfully, to contradictorily characterize the penalty as a tax; (2) rejecting standing and ripeness defenses; (3) dismissing plaintiffs’ claims that the PPACA (a) interferes with the States in their capacities as large employers, (b) coerces and commandeers the States by providing for exchanges, (c) lays a direct unapportioned tax (moot), and (d) violates substantive due process through the individual mandate; (4) finding that (a) the count for coercion and commandeering through expansion of Medicaid is plausible and cannot be dismissed; and (5) although the individual mandate is an unprecedented exercise of the commerce power that “does not automatically render it unconstitutional, [but] there is perhaps a presumption that it is”), Thomas More Law Center v. Obama, No. 2-10-CV-11156-GCS-RSW (E.D. Mich. filed Mar. 23, 2010) (Order Denying Plaintiffs’ Motion for Injunction and Dismissing Plaintiffs’ First and Second Claims for Relief [DOC. # 7], issued October 7, 2010, finding standing and rejecting ripeness and Anti-Injunction Act defenses, but rejecting plaintiffs’ arguments that the individual mandate exceeds Congress’s commerce power and that the mandate penalties constitute an unconstitutional unapportioned direct
decided, including decisions dismissing all claims as non-justiciable, dismissing all claims on the merits, and holding a centerpiece of the PPACA unconstitutional while severing the offending provision from the remainder of the Act.³ Moreover, prior to and after President Obama’s March 23, 2010, signing of the PPACA, a significant majority of states considered or passed constitutional amendments or legislative declarations purporting to nullify the Act or portions of it.⁴ Some plaintiffs have also asserted a bevy of additional constitutional arguments.⁵ The purpose of this article is not to examine each of the arguments extreme opponents of the PPACA have made; it is to examine four contexts within which colorable due process and equal protection arguments can be advanced against the PPACA. My aim is to provide a doctrinal analysis, within the Supreme Court of the United States’ current or reasonably foreseeable formulations, of certain critical PPACA provisions. I do not present any extended economic or policy analysis, except insofar as it bears on some plausible theory of constitutional interpretation and application of existing doctrine. Given the breadth of the PPACA and its status as an ongoing evolutionary process, I can only describe one version of its broadest policy, vision and goals. I will give additional background concerning the four contexts I will constitutionally examine.

³ See id.


⁵ See supra note 2 regarding arguments, inter alia, that the PPACA violates the Republican Form of Government Clause, the First Amendment freedoms of speech, religion, and assembly, establishes a religion, violates equal protection, violates medical decision-making and informational privacy guaranteed by the Fourth, Fifth, and Ninth Amendments, and is a result of coercion by President Obama or his staff to demand votes in favor of the PPACA.

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The PPACA, which contains provisions that are effective in 2010 and others that will be phased in over an eight or more year period, has the potential to benefit millions of persons.6 The PPACA will realize its potential if the U.S. efficiently and equitably implements it and then extends the PPACA “universally” to the over 23 million persons who will remain without insurance even after the PPACA’s full maturity.7 Some of the PPACA’s central goals are to extend affordable health insurance to a majority of the uninsured (who in 2009 numbered about 46.3 million),8 to ameliorate certain inefficiencies in health care delivery and financing, to reduce costs, and to ensure quality care.9

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7. Doug Trapp, Health Reform Reality: Forecast for Uninsured Includes Familiar Faces, AM. MED. NEWS, Apr. 19, 2010, vol. 53, # 16, at 1, col. 1 (about 16 million newly-eligible for Medicaid are expected to enroll in 2014, and 24 million others with higher incomes are expected to purchase coverage in the new insurance exchanges; approximately 23 million people (a third of whom will be undocumented immigrants) will remain uninsured in 2019, 32 million less than would be expected otherwise) (citing to a Mar. 20, 2010 Budget Office analysis)).


Some commentators caution that one must look closely at figures concerning the uninsured, See e.g., Editorial, Who Are the Uninsured?, THE WASH. TIMES, June 25, 2009, http://www.washingtontimes.com/news/2009/jun/25/who-are-the-uninsured (about 14 million of the uninsured are persons eligible for Medicaid who do not want to pay the small premium required, and they can just sign up when they need care. Furthermore, 27 million of the uninsured have personal incomes of more than $50,000 a year. Most of the remaining uninsured are “illegal immigrants.” Excluding those eligible for Medicaid, almost 70% of the remaining uninsured are without insurance for less than four months. Many of those are temporarily between jobs and just waiting for paper work. Finally, two thirds are between eighteen and thirty-four, persons who, on the average, are healthy and uninsured by choice).

9. Concerning these goals of mandates, see CCH, 1 CCH’s Law, Explanation and Analysis of the Patient Protection and Affordable Care Act [hereinafter “CCH’s Explanation of PPACA”] (2010), at Introduction (extend number of insured); ¶ 555-557 (“Medicaid Quality Improvement”); Chapter 3 (“Affordability of Coverage”); Chapter 7 (“Health Care Quality Improvement”); Chapter 13 (“Medicare Sustainability”); Chapter 17 (“Patient-Centered Outcomes Research”). At a more general level, it has been argued that the PPACA “is the continued push, begun with the American Recovery and Reinvestment Act of 2009, . . . to change the economic model for health care delivery. This push is to move toward ‘value not volume’—away from ‘fee for service’ and toward compensating providers based on the quality of treatment outcomes.” See Stephen M. Goodman, The U.S. Health Care Industry After Reform: Every Player Gets New Rules and the Details Matter, 2010 ASPATORE SPECIAL REP. 8 (May 2010) (referring to incentives for experimentation with alternative care delivery models, for creating awareness of best practices by “generating, collecting,
The PPACA may bring a measure of equity to our health care system because many of its beneficiaries are relatively poor, which includes a disproportionate number of minorities.\textsuperscript{10} The PPACA is designed to achieve these goals, in good part, through individual and employer “mandates” to purchase health care insurance\textsuperscript{11} as well as new taxes on businesses, insurers, and wealthy individuals.\textsuperscript{12}

\hspace{1cm} and publicizing treatment outcomes data,” and for encouraging adoption of health care information technology).

\textsuperscript{10} Regarding covering more persons, see \textit{supra} notes 7 & 8. Regarding the poor containing a disproportionate number of minority group members, see William Spriggs, \textit{Poverty in America: The Poor are Getting Poorer, the Crisis}, Feb. 2006, http://findarticles.com/p/articles/mi_qa4081/is_200601/ai_n17187830.

\textsuperscript{11} See CCH's Explanation of the PPACA, \textit{supra} note 9, at ¶ 405 (Starting in 2014 all applicable individuals are required to have minimal essential coverage for themselves and their children, and a penalty is imposed for each month they are not covered. All persons are covered except prisoners, undocumented aliens, health care sharing ministry members, and individuals who are members of a recognized religious sect that opposes private or public health insurance. Moreover, applicable individuals are exempt if they are members of an Indian tribe, they have a hardship for a certain time period, they are certain individuals outside the U.S., or they are individuals who make less than the threshold for filing taxes or who, through 2013, would have to spend more than eight percent of household income to purchase insurance. The penalty starts with “an applicable dollar amount,” which by 2016 will generally be $695. The monthly penalty is “1/12 of the greater of: (1) the flat dollar amount, which is equal to the applicable dollar amount for each of the individuals who were not properly insured by the taxpayer, up to a maximum of 300 percent of the applicable dollar amount, or (2) the applicable percentage of income . . . as added and amended by the Affordable Care Act.”); CCH's Explanation of the PPACA, \textit{supra} note 9, at ¶ 425 (employer with 50 or more full-time employees must pay a penalty if it: “fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any month, and (2) has at least one full-time employee who has been certified to the employer . . . as having enrolled for that month in a qualified health plan (a state exchange offered plan) with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid for the employee. . . .” This lasts until 2014 when there will be adjustments, “[t]he assessable payment is equal to the product of the applicable payment amount, which is 1/12 of $2,000 for any month . . . and the number of full-time employees for the month. . . .” There are also certain penalties for large employers who do offer employees an opportunity to enroll in an employer-sponsored plan that provides essential minimum essential coverage, but have “one or more full-time employees who have been certified to the employer . . . as having enrolled for the month in a qualified health plan (a state exchange offered plan) with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid for these employees . . .”).

\textsuperscript{12} Rob Wells & Shayndi Raice, \textit{Summary of Patient Protection And Affordable Care Act}, Dow Jones Newswires, Mar. 21, 2010, http://content.mkt922.com/lp/4021/6616/DowJones_Reports_HCR.pdf (“Tax increases: -New excise tax [on insurers] on high premium insurance plans raises $149.1 billion over 10 years. This tax would be 40% of premiums paid on plans costing more than $23,000 for family plans and $8,500 for individual plans. - New Medicare tax on wealthy: increases after December 31, 2012, the Medicare hospital insurance rate by 0.9 percentage points for individual taxpayers earning over $200,000, or married joint filers making more than $250,000. -Imposes an annual fee on manufacturers and importers of certain medical devices beginning in 2011. -Imposes an annual fee on certain makers of branded prescription drug [sic] beginning in 2010. . . . -Imposes a 10% excise tax on indoor tanning after July 1, 2010.”). There will also be a 3.8 percent hospital insurance tax on investment income of couples earning more than $250,000 a year and individuals making over $200,000 per year. Curtis Dubay, Heritage
These mandates are meant to persuade millions of the uninsured to purchase insurance, either individually or through plans employers offer pursuant to employer mandates. The hope is that the mandates will expand insured pools, reduce uncertainty and related risk, and thereby reduce per capita costs of health care coverage. Given that tens of millions of persons will remain uninsured, it may be difficult to reduce per capita and overall costs. One reason for this is that the uninsured will continue to obtain a significant amount of care—often through expensive hospital emergency room treatment—that insurance coverage might make unnecessary. In addition, many could wait until they become ill—and are more costly to treat—to purchase insurance once the PPACA’s prohibition on pre-existing condition exclusions takes full effect.

Some litigants argue that the mandates to purchase insurance covering specified items intrude on the freedom to forego coverage or to choose insurance’s source and content in a contract. Therefore, according to these litigants, the mandates violate the Fifth Amendment’s explicit due process and implicit equal protection components. These individuals attempt to buttress their claims with assertions that the PPACA invades their rights to medical decision-making and informational privacy either because of loss of discretionary income that often follows from the insurance enrollment process or from disclosure of confidential medical information. I will demonstrate that these arguments should fail because of the nature and weight of the PPACA opponents’ rights and interests and because the generally beneficial goals that the PPACA seeks to achieve justify whatever threshold invasion of

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14. *Id.* at 46-48 (generally expressing doubt that the mandates alone can achieve these results).
15. *See Doug Trapp, Health Reform Reality: Forecast for Uninsured Includes Familiar Faces, AM. MED. NEWS, Apr. 19, 2010, vol. 53, # 16, at 1, col. 1, (approximately 23 million people will still be without insurance despite implementation of the PPACA (citing to a March 20, 2010 Budget Office analysis)).
17. Trapp, *supra*, note 15 at 1 (“If minimum coverage standards are high and premiums are costly, people are more like to pay the penalty and wait until they get sick to get guaranteed coverage . . . .”) (citing to a Mar. 20, 2010 Budget Office analysis)). *But see,* Lawrence Singer, *The Aftermath of Federal Health Care Reform: The Challenge for States and the Private Sector*, 19 ANNALS HEALTH L. 67, 67-68 (2010) (arguing increased coverage will make it difficult to obtain an appointment with a physician, thus driving significantly more persons to emergency rooms); CCH’s Explanation of the PPACA, *supra* note 9, at ¶ 165 (pre-existing conditions will be prohibited for children and in 2014 for all other persons).
19. *See e.g.,* *id.*
20. *See e.g.,* *id.*
21. *See supra* note 9 and *infra* Part VII regarding these arguments.
constitutional interests there may be in the mandates and other PPACA provisions. The privacy claims are particularly unsupported.  

The PPACA does, however, contain three provisions that should be held unconstitutional. These are my primary, although not exclusive, targets. First, the PPACA contains a personhood-denying provision that is contradictory to a very humane and logical premise that otherwise generally pervades the Act, i.e., that persuading the uninsured to purchase health care insurance can improve the health care system.  

This is a critically important point in understanding and defending the PPACA, and I will further analyze it as we proceed. The first highly suspect provision prohibits undocumented immigrants - in operation all persons who cannot prove their legal status - from purchasing insurance from the exchanges that will be created pursuant to the PPACA. (Given that all participants are subject to screening as to citizenship or other legal status, this is generally not a context within which one can argue that government action ostensibly directed at undocumented immigrants actually reflects intentional discrimination against racial groups of significant size among the undocumented.)

The purpose of these exchanges, which will eventually cover the individual, small group, and large group markets, is to serve as a marketplace or clearinghouse through which insurers can offer comprehensive, affordable, and easily accessible health care insurance. The exchanges will also provide certain administrative services for the participating insurers. As I will explain below, it is possible that it will be flatly or practically impossible for virtually all undocumented immigrants to obtain insurance outside an exchange. (I will explain the nature of the exchanges and the changes they might bring below.) This makes the federal prohibition potent, and, in some cases, catastrophic or fatal to undocumented immigrants. Moreover, encouraged by the federal government’s prohibition, the states might prohibit purchase outside the exchanges. It is beyond the scope of this article to fully explore whether the

22. See infra Part VII (regarding the privacy arguments).
24. See infra Part IV.
25. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 220 (banning undocumented immigrants from state exchanges), ¶ 310 (undocumented immigrants not eligible for cost-sharing reductions and delineating formula for excluding undocumented immigrants from household eligibility amount), ¶ 315 (undocumented immigrants not eligible for premium tax credits), ¶ 250 (undocumented immigrants not eligible for State plans).
26. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 315.
28. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
29. Id.
30. See infra notes 259-64.
Federal prohibition would preempt such State action, but there is a chance that State restrictions would survive.\textsuperscript{31}

In the second constitutionally questionable provision, the PPACA requires that health insurance policies sold within exchanges offer abortion coverage only under separate accounting by insurers and discrete payroll deposits by employers when an employer’s payroll deposits pay an enrollee’s coverage premium.\textsuperscript{32} This is to ensure that no federal government monies are used to pay for abortions not involving rape, incest, or endangerment of the woman’s life.\textsuperscript{33} The PPACA also authorizes States to prohibit the sale of health insurance covering abortions within the exchanges, which too could make it impossible or difficult for persons to purchase coverage for, and thereby gain access to, abortion procedures.\textsuperscript{34} (One state has already prohibited coverage of abortion in its exchanges, and others have imposed severe restrictions concerning coverage in their exchanges and otherwise.)\textsuperscript{35} As I will explain, this is not because of the costs; abortion coverage is very cheap and actually might save insurers money.\textsuperscript{36} The intrusion on abortion would occur for several reasons depending on the size of one’s employer, the choice of one’s employer on whether to cover abortions, whether one’s state exercises its option to prohibit abortion coverage in the exchanges, in cases of unanticipated pregnancies, or the unavailability of abortion coverage outside the insurance exchanges.\textsuperscript{37}

\begin{footnotes}
\item[32] See CCH’s Explanation of the PPACA, supra note 9, at ¶ 210.
\item[33] \textit{Id}.
\item[34] \textit{Id}.
\item[35] \textit{Id}. See also 2010 Tenn. Pub. Acts 879 (banning coverage for abortion in the state exchange); Mo. Rev. Stat. § 376.805 (2010) (abortion insurance for abortions other than those to save a woman’s life must be sold only through separate policies for which a premium must be charged, and no abortion coverage other than that relating to saving women’s lives shall be offered in any form within an exchange); La. Rev. Stat. Ann. § 22:1014 (2010) (Louisiana has prohibited coverage of abortions in its insurance exchanges except for those abortions undertaken because the woman’s life is at risk).
\item[36] National Abortion Federation, Economics of Abortion, http://www.prochoice.org/about_abortion/facts/economics.html (“Correcting for inflation, legal abortions in 1991 cost only about half what they cost in the early 1970s.”) (last visited Sept. 28, 2010); Media Matters for America, Staff, \textit{Slate’s Noah Takes Apart Stupak’s Mandatory Abortion Fund Falsehood}, Mar. 5, 2010, http://mediamatters.org/blog/20100050001 (“The law stipulates that in calculating abortions’ cost, insurers may consider how much they spend to finance abortions but not how much they save in foregone prenatal care, delivery, or postnatal care . . . . This is to keep insurers from pondering the . . . reality—one they surely know already—that covering abortions actually saves them money.”) (last visited Apr. 11, 2011).
\item[37] \textit{See infra} Part V.
\end{footnotes}
A third viable argument against the PPACA is that it unconstitutionally mandates that states exclude undocumented immigrants (including children) from discretionary state basic health care programs that can offer coverage to persons not eligible for Medicaid if their household incomes exceed 133 percent but do not exceed 200 percent of the federal poverty level. It can be argued that this mandatory exclusion is unconstitutional, unwise and immoral, at least insofar as children are concerned, but nevertheless the exclusion might be upheld under current doctrine.

Section II of this article will briefly discuss certain historical events, situations, and processes within our health care system that preceded the PPACA, focusing on pressure for “health care reform” and “universal health care.” It will also discuss commentary that could relate to one or more of the four contexts referred to above. (Readers with expertise in health care law or policy might want to skip this section because it is very basic and meant to set the PPACA in context for those without such expertise.) Section III will describe certain prominent goals and features of the PPACA, with an eye toward elucidating the four contexts analyzed in this article. Section IV will explain (a) the elements necessary to state a due process or equal protection claim against a provision of a government-created health care plan, (b) the general decision-making approaches and standards of review that courts, including the U.S. Supreme Court, would probably use to decide such claims, and (c) will apply this body of law to the first of the four contexts. Sections V., VI., and VII., will apply the same body of law to contexts two through four. The four contexts are, again, substantive due process and equal protection attacks against:

1. the PPACA provisions that prohibit undocumented immigrants from purchasing health care insurance in the exchanges;

2. the PPACA provisions that allow states to bar abortion coverage from the exchanges and mandating that any abortion coverage therein be accompanied by separate funds, accounting, and paperwork for abortion and non-abortion segments of premiums paid;

38. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 250; The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 1331(e), 1312(f), 10104(o), signed March 23, 2010 (“[T]he term “eligible individual” means … or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of family involved but who is not eligible for the Medicaid program … by reason of such alien status….”).

39. See infra Part VI.

40. See infra Part II.

41. See infra Part II.

42. See infra Part III.

43. See infra Part IV.

44. See infra Parts V, VI, & VII.

45. See infra Part IV.

46. See infra Part V.
(3) the PPACA’s exclusion of undocumented immigrants from programs states are allowed to create, using contractors, for provision of health care or health care insurance to relatively poor persons who do not qualify for Medicaid;47 and
(4) the PPACA’s individual (primarily) and employer mandates to purchase health care insurance.48

II. CERTAIN HISTORICAL EVENTS, SITUATIONS AND PROCESSES THAT PRECEDED THE PPACA

Universal health care could be said to exist when virtually every person in a country has reasonable access to either private or public health care or insurance. The U.S., alone among wealthy industrialized nations, is without universal health care.49 This will remain true even with the PPACA because approximately 23 million will remain uninsured.50 Health care reform is altering a health care system to (1) increase the number of persons with reasonable access, (2) broaden the range of care, (3) improve the quality of care, (4) hold down the costs of care, or (5) enhance the health care system’s equity.51 The quest for universal care in the U.S. extends back to Theodore Roosevelt and the 1912 presidential election.52 Subsequently, several presidents supported programs to assure either universal or greatly expanded access to health care.53

The most significant health care reform prior to the PPACA was the legislation creating Medicare and Medicaid that President Lyndon B. Johnson signed on July 30, 1965.54 The federal government administers the Medicare program, and payroll taxes specifically earmarked for Medicare fund it.55 The federal and state governments jointly govern and fund Medicaid, the states being

47. See infra Part VI.
48. See infra Part VII.
50. See Doug Trapp, Health Reform Reality: Forecast for Uninsured Includes Familiar Faces, AM. MED. NEWS, Apr. 19, 2010, vol. 53, #16, at 1, col. 1 (approximately 23 million people will still be without insurance despite the PPACA’s implementation (citing a March 20, 2010 Budget Office analysis)).
51. See CCH’s Explanation of the PPACA, supra note 9, at Introduction.
55. HEALTH CARE LAW AND POLICY 109-13 (Clark Havighurst et al. eds., 2d ed. 1998).
subject to many federal directives. Medicare primarily covers those 65 and over, while Medicaid mainly insures large groups among the very poorest legal residents. Although the American Medical Association initially attacked these programs as allowing the government “to control [medical] providers”, the coverage the programs extended greatly increased our health care expenditures and thereby benefited physicians - not to mention patients.

The United States spends more on health care than any country in the world, total and per capita. Yet, prior to the PPACA, approximately 46.3 million Americans were uninsured and in 2010 the Commonwealth Fund rated our health care system’s overall performance as last among developed nations while in 2000 the World Health Organization ranked our system thirty-seventh for overall performance. These rankings could be subject to methodological and bias objections - I do not address this - but they are surprising nonetheless, especially concerning great costs but limited access. The costs of providing medical care and health care insurance have outpaced the general rates of inflation for many years, so that in 2010 it takes approximately $4,824 a year to cover an individual and $13,375 a year to cover a family in an employer-sponsored plan. (Premiums vary widely from these numbers depending on variables such as geographical region, scope of covered benefits, group or individual coverage, age, health status, and amount insureds have to pay out-of-pocket.)

56. Id. at 113-17.
57. Id. at 109-17.
59. Gerald Anderson et al., Why the United States is So Different from Other Countries, HEALTH AFFAIRS, June 2003, vol. 22, No. 3, at 103.
62. See Anderson et al. supra note 59, at 103; Reinberg, supra note 60.
65. Editorial, The Competition Cure, WALL ST. J., Aug. 24, 2009, at A12 (noting that an annual health care plan in New Jersey costs $5,880 for a twenty-five year old male while an annual
One of the reasons health care and health care insurance have been so costly is that medical providers and insurers have to spread the costs of treating or covering the uninsured to the insured population.\textsuperscript{66} This is called cross-subsidization.\textsuperscript{67} This phenomenon is exacerbated because some people who could afford some health insurance do not purchase insurance or save for health care expenses.\textsuperscript{68} At the same time, many persons wait until a problem develops or worsens to attempt to purchase insurance. These persons will probably be successful if the insurer does not learn that they have a pre-existing condition or risk factor. Moreover, even before this point individuals might know that they are more or less likely than average persons to make claims if they purchase insurance. Those with a higher probability are more likely to purchase insurance, while those with a lower probability might refrain from buying insurance. The term “adverse selection” captures these various situations.\textsuperscript{69}

Even if persons who develop serious conditions do not attempt to purchase insurance upon becoming ill, they often seek, obtain, and do not pay for expensive emergency treatment.\textsuperscript{70} Once insured, persons might not perceive a sufficient reason to limit their consumption of health care or to protect their health. As to consumption, they might go to the emergency room for what may be a cold, mistakenly believing insurance (the third party payer) will cover the treatment. Concerning preventive care, they might conclude that there is no reason to worry; medical costs will primarily be covered by an insurer. This is called “moral hazard.”\textsuperscript{71}

Moreover, patients usually agree with their physicians’ recommendations and physicians have incentives to recommend care that has any possibility of helping their patients regardless of cost, especially if the patients are insured.\textsuperscript{72}

\textsuperscript{66} This doesn’t necessarily affect total costs, though it almost certainly will. Assuming the uninsured in fact get medical care, the costs are borne disproportionately by the insured. In fact, one argument is that the total costs are greater now because of the costs of providing health care to the uninsured (emergency care; treatment started too late). This might be offset (by how much?) by some degree of getting to people before their conditions worsen. Institute of Medicine, Committee on Consequences of Uninsurance, \textit{Care Without Coverage: Too Little Too Late}, Washington D.C., 2002, at 28, http://www.iom.edu/Reports/2002/Care-Without-Coverage-Too-Little-Too-Late.aspx.

In any case, “costly” may refer to total cost (which could be constant) or to per capita costs on the existing insured. (lack of health insurance leads to irregular access to care and ultimately to poorer health). \textit{See Health Care Law and Policy} 62-66 (Clark Havighurst et al. eds., 2d ed. 1998) (insured population payments to hospitals cover the cost of care to uninsured patients).

\textsuperscript{67} \textit{Health Care Law and Policy} 62-66 (Clark Havighurst et al. eds., 2d ed. 1998).

\textsuperscript{68} \textit{Id.} at 82-84.

\textsuperscript{69} \textit{Id.} at 164-65, 181-82, 185-86.

\textsuperscript{70} \textit{Id.} at 45-47.

\textsuperscript{71} \textit{Id.} at 164-66.

\textsuperscript{72} \textit{Id.} at 160-63. \textit{But see} Marc Rodwin, \textit{Physicians’ Conflicts of Interest in HMOs and Hospitals, in Conflicts of Interest in Clinical Practice and Research} 197-227 (Roy Spece et
The doctor might hesitate to offer high cost, low benefit interventions if she knows the patient will have to pay out-of-pocket. If the patient is insured the physician will likely prescribe the high cost, low benefit intervention.73  Still more, physicians and patients are hampered even if they are cost conscious. Patients often can’t understand complicated comparative data relevant to diagnostic or therapeutic choice, and such data is often not even available to physicians, never mind patients.74  Another phenomenon that has driven up costs is the reality that, once seriously ill, persons are willing to spend almost anything to attempt to regain their health.75  This pushes health care costs upward and to an arguably irrational point where marginal costs outweigh marginal benefits.76  Still another inflationary impetus is the continued development and implementation of expensive treatments.77  Finally, decisions to limit health care inevitably impact or cost specific, identifiable persons their lives.78  These events are very visible and lead to publicity and pressure to vitiate the associated limitations. Limiting health care is therefore more difficult than restricting other potentially life-saving or safety measures such as carefully designing and maintaining highways. The latter generally only impacts unidentifiable or “statistical” persons and lives.79

The high cost of health care and health insurance leads to an inequitable system in which large portions of the very poorest legal residents and those age 65 and over have fairly comprehensive coverage through Medicaid and Medicare, while millions of the “working poor” are not eligible for any public program and cannot afford to purchase either insurance or adequate care.80

Medicaid and Medicare are not immune to the pressures of increasing costs. These two programs generally cover less than private plans do and have reimbursement rates that discourage many physicians from participation in the programs, particularly Medicaid.81

The private insurance market consists of large group/employer, small group/employer, and individual components.82 Although most private insurance is offered through employers, there has been a recent trend for employers to eliminate or limit health care coverage.83 The insurers’ risks are lower in the large group/employer market because these insurers can, by definition, spread their risks among a large group of persons who are young and healthy enough to work.84 Conversely, smaller individual market insurers take on more risk because they spread their risk among a relatively small group of persons who do not have insurance through work and invite adverse selection.85 Therefore more uncertainty exists, and uncertainty is a risk for which the insurer must be compensated.86 Small market insurers fall between the large and individual markets in risks.87 Individual policies entail substantially more out-of-pocket payments and wide variations in premiums depending on one’s health profile—assuming one will even be accepted for coverage.88 Individual policies’ premiums recently increased an average of twenty percent.89 Overall, individual, as opposed to large and small group, policies are more expensive dollar-for-dollar.90

Insurers often protect themselves against risk by excluding coverage of pre-existing conditions; refusing to insure persons who fall within high risk profiles; excluding coverage of certain high cost conditions; or offering coverage at greatly increased rates to persons whom insurers profile as higher risk.91 Of course, these practices are what insurance is traditionally about—matching

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82. Hoffman, supra note 13, at 17-19.
84. Hoffman, supra note 13, at 27-29.
85. Id.
86. Id.
87. Id.
88. Id. at 28-29. See also Diane Rowland & Adele Shartzer, America’s Uninsured: The Statistics and Back Story, 36 J.L. MED. & ETHICS 618, 622-23 (2008).
premiums with risks; the point here is that the end result is to leave many persons without insurance.92 Some insurers could also engage in questionable practices such as intentionally drawing out claims processes and rescinding policies for nonmaterial and trivial errors sought out in applications after insureds become ill.93 (There are laws that limit some insurers’ abilities to engage in these practices. For example, some states require insurers to cover certain conditions, while others, like the PPACA, limit rescissions.)94

Furthermore, having a plethora of public and private providers and insurers and insurance policies fragments the finance and delivery of health care and health care insurance.95 It drives up administrative costs and arguably leads to disjointed care.96 It is also difficult or impossible - because of lack of knowledge, health care providers’ and insurers’ technical jargon, and lack of comparative data - for most persons to shop around for the best health care or health insurance for each dollar they spend. This, in turn, stifles competition.97

Prior to the PPACA, a consensus emerged that something (the nature of which was hotly disputed) had to be done to alter our health care system, especially to counter its ever-increasing costs and the growing numbers of uninsured people.98 Private industry joined this consensus because large employers found their health care costs exploding.99 Health care providers, especially in emergency rooms, were often left with huge bills from patients without private or public insurance.100 Thus, even the American Medical and Hospital Associations called for health care reform.101 Individuals without

92. Id. at 654.
94. 10A COUCH ON INSURANCE § 144:38 (“growing number of mandatory coverage laws continues to shrink the allowable [coverage] exclusions”); see also CCH’s Explanation of the PPACA, supra note 9, at ¶ 107 (limiting insurance rescission to cases such as fraud and misrepresentation).
96. Id.
97. See Faden & Beachump, supra note 74, at 298-336; AREEN ET AL., supra note 74, at 867-68; McLaughlin, supra note 74, at 39-43.
99. Id.
insurance often had jobs and fairly good incomes, but arguably were forced into bankruptcy by huge medical bills that could arise from one illness or one hospitalization.102 Even those with insurance were subject to catastrophic cost-sharing and bankruptcy.103 Therefore, many consumer groups supported health care reform.104

Health care reform could have taken many forms. The primary components of a health care system are mechanisms to finance and deliver care. Funding can theoretically be wholly public or private, but in most systems it is both public and private.105 Public funding can come from general revenues, special taxes or charges, or a mixture of the two.106 Government employees, private health care providers, insurers, and administrators, or a combination of these groups can directly administer or deliver health care.107 There is usually a combination.108 For example, in Britain the government owns health care facilities, directly hires health care providers, and funds this delivery with general revenues.109 Another example of a universal health care system is Canada, where federal and provincial governments jointly finance health care out of general revenues and


102. Melissa Jacoby & Mirya Holman, 10 YALE J. HEALTH POL’Y & ETHICS 239, 240-41, 288-87 (2010) (“A clash over these methods [survey and search of court records] arose directly prior to the passage of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005. This bill was the most significant set of amendments to the Bankruptcy Code in a generation and substantially restricted debt relief for individual filers. Lawmakers who opposed the bankruptcy bill cited a 2005 study by Himmelstein, Thorne, Warren, and Woolhandler finding that approximately half of bankruptcies were medical-related. Supporters of the bankruptcy bill countered with a court record analysis conducted within the Department of Justice (DOJ). According to the DOJ analysis, over half of the sample (54%) had no medical debt at all, the average medical debt among those with any such debt was under $5,000, and medical debt comprised only 5.5% of the total unsecured debt of the sample.” The article goes on to explain the authors’ own study combining survey and court record methods; concludes that the court record method alone hides significant effects of medical bills; and generally concluding that court record studies alone were inadequate to justify the 2005 bankruptcy reforms); Christopher Robertson et al., Get Sick, Get Out, the Medical Causes of Home Mortgage Failures, 18 HEALTH MATRIX J.L. & MED. 65, 66 (2008) (“[W]e found that medical crises contribute to half of foreclosure filings. If these patterns hold nationwide, medical causes may put as many as 1.5 million Americans in jeopardy of losing their homes each year.”).

103. Katherine Porter & Deborah Thorne, The Failure of Bankruptcy’s Fresh Start, 92 CORNELL L. REV. 67, 108 (2006) (“Research suggests . . . that the vast majority of families who file medical bankruptcies do indeed have health insurance at the time of their illnesses or injuries.”).


105. See Hoffman, supra note 13, at 14-16.

106. Id. at 14-15.

107. Id. at 14-16.

108. Id.

109. Id. at 14.
contract with private health care providers who administer and deliver daily health care.110

Given this background, many U.S. health care reformers felt that health insurance premiums were becoming unaffordable.111 They wanted a “single payer” system, as in Britain and Canada, in which the government would be the lone financier of care within a “universal” plan.112 Health care reformers thought this would cut out enormous administrative costs associated with the health insurance industry and give the government the ability to pay providers at lower rates because much of the administrative costs are the result of a fragmented, for-profit health insurance system.113 Others advocated for a public option—a government insurance alternative to compete with private insurers.114 Proponents of the public option argued it would give consumers more choices, strongly compete with private insurers, and drive other insurers to be more transparent and accountable.114

Neither of these groups was totally successful. Instead, the PPACA does not provide a public option but for government created exchanges (which I will describe in Section III.); a co-operative program with the function of dispensing grants to help create new or expand old non-profit health care insurers; discretionary state-run low cost health care programs (which can consist of insurance) to serve the poor who are not eligible for Medicare or Medicaid; and mandatory multi-state plans, i.e., plans that provide coverage across state lines.116 With respect to the latter, there must be two multi-state plans offered through an exchange in each state, one of which must be non-profit.117

Having briefly described some of the most important factors leading to health care reform through the PPACA, I will summarize these factors and also list most other, additional specific concerns that informed the debate over the

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113. Id.
117. CCH’s Explanation of the PPACA, supra note 9, at ¶ 265.
PPACA and alternative legislation. It is beyond this article’s scope to determine the existence or extent of the problems that raised concerns or to speculate whether or not the PPACA will remedy these concerns. The factors and concerns that led to the PPACA include: unsustainable cost increases within both the public and private health care sectors;\(^\text{118}\) poor quality care leading to significant morbidity and mortality;\(^\text{119}\) inequity (e.g., for the working poor who could not afford insurance);\(^\text{120}\) inability of those with pre-existing conditions or falling within high risk profiles to obtain any affordable insurance;\(^\text{121}\) insufficient focus on preventive care;\(^\text{122}\) an abundance of private insurance options that many people were unaware of or could not understand because of complicated jargon;\(^\text{123}\) high administrative costs associated with the insurance industry;\(^\text{124}\) lifetime and annual limits on benefits and high deductibles and co-pays, resulting in limited access to care or bankruptcy for many persons with significant maladies;\(^\text{125}\) inability of insureds to contest or knowledgeably appeal from insurers’ adverse decisions;\(^\text{126}\) adverse selection;\(^\text{127}\) particularly poor access to care in rural areas;\(^\text{128}\) and fraudulent and abusive practices damaging to patients in public and private insurance programs.\(^\text{129}\)


121. This is evidenced by the PPACA’s provisions prohibiting pre-existing conditions exclusions six months after its enactment for those 19 and under, its prohibition of such exclusions as to all persons starting in 2014, CCH’s Explanation of the PPACA, supra note 9, at ¶ 165, and its prohibition of discrimination regarding health status beginning in 2014. See CCH’s Explanation of the PPACA, supra note 9, at 170.

122. This is evidenced by the PPACA’s multiple provisions relating to preventive care. CCH ¶¶ 109, 205, 771, 1407, 1409, 1417, 1419, 1421, 1423, 1431, 1435, 1439, 1470.

123. This is evidenced by the PPACA’s provisions concerning uniform standards for health plan summaries of benefits and coverage. CCH’s Explanation of the PPACA, supra note 9, at ¶ 113.


125. See Jacoby & Holman, supra note 102, at 240-41, 287-88; Porter & Thorne, supra note 103, at 108.


128. See CCH’s Explanation of the PPACA, supra note 9, at Chapter 9.

129. This is evidenced by the PPACA’s multiple provisions concerning “Medicare and Medicaid Transparency and Enforcement” and “Medicare, Medicaid, And CHIP Program
III. A BRIEF DESCRIPTION OF PARTS OF THE PPACA

A. Assumptions for Purposes of Analysis

The PPACA is hundreds of pages long, addresses a number of esoteric topics, and contains many provisions that will be phased in over eight years (or more). Here I do not undertake to summarize the entire PPACA or its step-by-step evolution over the coming years. Rather, I will make some global observations about the PPACA, identify the general areas the PPACA covers, some of its most prominent reforms, and how, once the PPACA is fully implemented in 2018 (or later), our health care system might emerge in certain areas relevant to the four contexts analyzed in this article. I will assume, for purposes of constitutional argument, that the PPACA turns out to substantially advance its various goals. I will also assume that the plaintiffs who attack various PPACA provisions sue after all of its provisions have been implemented in 2018 (or later), and that they, and the classes they might serve as representatives for, have suffered or will suffer immediate and substantial harm in fact. Therefore, no issues concerning justiciability, particularly standing, would arise. My assumptions concerning the efficacy and effects of various the PPACA provisions (e.g., the evolution and success of the exchange markets), the timing of any lawsuits (as noted above, many have already been filed; in addition, there have been decisions for and against the justiciability of claims and for and against the constitutionality of the PPACA), and the nature of the parties who sue and the harms they have or will immediately suffer could all be wrong. If so, the proper constitutional analysis and whether a suit is even viable should be obvious through application of the decision-making framework I will discuss. At many points it will be obvious how the constitutional analysis would differ if the PPACA provision at issue neither worked nor could be shown likely to become efficacious in the immediate future.

B. A Global Overview

and then focus on some of its most relevant features. My version of the PPACA’s overriding goals and rationales is as follows. It will build from and expand the present situation in which most persons are insured through government programs or their employers. In the public sector, certain changes will preserve Medicare and Medicaid. The groups eligible for Medicaid will expand. The States, moreover, will be allowed to create low cost health care programs for those who have relatively low incomes but do not qualify for Medicaid. In the private sector, increasing the number of insured people will be achieved, in large part, through individual and employer mandates either to purchase health care insurance or pay a “penalty” or tax.

Given that it is often difficult or impossible for many individuals or small employers to purchase coverage for themselves or their employees, some individuals will be exempt from the mandates, many individuals will be given certain subsidies to help them purchase health care insurance, and small employers will be offered tax credits to encourage them to provide coverage for their employees. The fragmentation of care, high administrative and other


133. See generally Hoffman, supra note 13, at 14-16 (discussing various health care models including the United States).
134. See CCH’s Explanation of the PPACA, supra note 9, at chs. 5, 18 (Medicaid); see also See CCH’s Explanation of the PPACA, supra note 9, at chs. 8, 10, 11, 12, 13, 18 (Medicare).
135. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 505.
136. Id. at ¶ 250.
137. Id. at ¶¶ 405, 425.
138. Id. at ¶¶ 305 ("Beginning in 2014, taxpayers with household income between 100 percent and 400 percent of the federal poverty line can qualify for a refundable health insurance premium assistance credit."). ¶ 310, pp. 190-94 ("Individuals who enroll in a qualified health plan … in an Exchange may be eligible for cost-sharing reductions (i.e., subsidies) if their household income does not exceed 400 percent of the poverty line. Reductions decrease annual out-of-pocket limits and, for lower-income individuals, further increase a plan’s share of total allowed benefits costs. The federal government will pay plan issuers for the value of the reductions they make."). ¶ 345 ("An eligible small employer may claim a 35 percent tax credit (25 percent in the case of a tax-exempt eligible small employer) for premiums it pays toward health coverage for its employees in tax years beginning in 2010 through 2013. An eligible small employer is an employer that has no more than twenty five full-time employees and the average annual compensation of these employees is not greater than $50,000."). ¶ 350 ("Employees who are exempt from the individual mandate but who do not qualify for premium subsidies are eligible for a voucher equal to the amount the employer would have spent on individual or family coverage. . . . The voucher provision as passed requires vouchers, but only from employers who provide health coverage and only to fill a “donut hole” caused by two other provisions: - some employees would have to spend more than 8 percent of their income on premiums for employer coverage, and thus, are free from the individual mandate, . . . but –some of these same employees would not have to spend more than 9.8 percent of income on health care, and thus, would not be eligible for premium subsidies. . . .


costs, and consumer confusion that result from a multitude of insurance companies offering numerous tailored programs that are expensive to construct and hard to understand will be remedied in several ways. First, there will be incentives for companies that implement more efficient methods of health care finance and delivery. Second, there will not be a public option. Once again, it was thought that a public option would be able to use already and to-be-negotiated low payments to health care providers and to force insurers to offer more compact, standard, and low cost policies. The expected benefits of the public option are pursued instead by the above-mentioned co-op program and the creation of multi-state insurers. Third, exchanges will be established in each state. They will serve as a consumer-friendly market place (assistance will be available through the internet and helpful, easy-to-reach individuals) open to virtually all consumers and to insurers. Insurers who market through the exchanges must cover specific care and offer easy-to-understand insurance policies.

The PPACA grandfathers existing plans and this exempts the grandfathered insurers from many of the PPACA’s strictures. Nevertheless, they will still be subject to a bevy of the PPACA’s provisions. It is also theoretically possible that new insurance or provider entities will be created with the design of avoiding entanglement with the system contemplated by the PPACA. The PPACA explicitly provides that persons and employers can meet their obligations to buy or provide insurance (or pay a tax/penalty) by contracting with insurers who operate outside the exchanges. It is possible, however, that such non-PPACA entities will find it difficult to compete with their counterparts who take advantage of the benefits provided by the exchanges. Eventually, perhaps, only a very few expensive programs providing or insuring “Cadillac” medicine will alone survive while avoiding entanglement with the exchanges.

This is central to contexts one, two, and three because if the exchanges develop to include virtually all insurers other than government programs such as

Employers who offer minimum essential coverage . . . to employees and pay any portion of the cost must provide free choice vouchers to each qualified [“donut hole”] employee . . . .”).

139. See supra Part II for a discussion of these issues.
140. See, e.g., CCH’s Explanation of the PPACA, supra note 9, at ¶ 743 (“Creation of Accountable Care Organizations Under the Medicare Shared Savings Program”).
141. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215 (exchanges), 235 (co-op programs), 250 (State programs for low-income individuals not eligible for Medicaid), 265 (multi-state plans); Hilzenrath & MacGillis, supra note 116, at A4.
142. Hamme, supra note 118, at 37:1.
143. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
144. Id. at ¶ 180 (required benefits), 113, 115 (requiring coverage to be presented in a “culturally and linguistically appropriate manner”).
145. Id. at ¶ 185.
146. Id.
147. Id. at ¶ 220.
149. Id.
Medicare, Medicaid, and State programs created pursuant to the PPACA, barring persons from the exchanges will result in no coverage for those who do not qualify for a government program. Insurers will be enticed into the exchanges by the latter’s performance of certain administrative tasks for insurers, the existence of a central marketplace, and the provision of government subsidies to individuals for purchase of private insurance that can only be used in the exchanges. The exchanges will tend to encourage insurers to offer standard or “off-the-rack” policies so they can hold down costs of tailoring many policy forms. This will enable them to compete with other frugal insurers. The variation in insurance policies will be reduced, their understandability will be enhanced, and competition will be facilitated. The number of entities offering insurance will be reduced and this will encourage consolidation and integration of health care delivery.

Most rating of customers based on their risk characteristics or medical conditions will be prohibited, and insurers will be required to accept all applicants and to refrain from rescinding their policies for reasons other than fraud. Premiums will be monitored and regulated. Cost-savings, primarily in Medicare, will be obtained through an Independent Payment Advisory Board (“IPAB”) that will make recommendations to reach specific targets for limitation of cost inflation. Its recommendations will become law through a unique, expedited legislative process. The idea seems to be that Congress can avoid political pressure to be profligate by placing responsibility for the austerity on the IPAB’s recommendations and the expedited, rigid legislative process. If Congress does not accept the recommendations, it must implement an equally austere set of actions that will reach the inflation control targets. The IPAB is required to consult with the Medicaid and CHIP Payment and Access Commission; it must also “create a public report by July 1, 2014 and annually,...

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150. Id.
152. See CCH’s Explanation of the PPACA, supra note 9, at ¶¶ 165 (no rescission based on pre-existing conditions), 170 (no discrimination on the basis of health status), 107 (rescission rules). See also CAL. INS. CODE § 10273 (West 2011); 21 DEL. CODE ANN. § 6101 (West 2011) (state rescission laws).
153. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 150.
154. Id. at ¶ 1385.
155. Id.
156. Kaiser Family Foundation, Explaining Health Reform: Medicare and the New Independent Payment Advisory Board, May 2010, at 2 (“The Independent Payment Advisory Board was established, at least in part, to mitigate the influence of politics and stakeholders on Medicare payment decisions and give authority to a group of outside experts to recommend savings proposals, rather than Members of Congress. In creating the new [IPAB], the Congress has established strict target growth rates for Medicare spending while ceding some of its authority over certain aspects of the Medicare program to an outside entity for the first time since the program was enacted in 1965.”). See supra note 2 for cases arguing that this process violates separation of powers doctrine.
157. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 1385.
allow comparison by region, service, provider type, and private payers and Medicare of the following information: (1) quality and costs of care at the most local level as feasible; (2) access and experience of care and the cost-sharing burden on beneficiaries; (3) epidemiological and demographic changes; (4) the increase, effectiveness, and utilization of technology; and (5) any other areas deemed by the Board to affect spending and quality of care . . . .”

The entire plan contemplates or at least clearly will require substantial cuts in health care provider compensation. Evidence for this conclusion is that the IPAB is not allowed to meet the inflation control targets by limiting benefits or by “rationing.” (Of course, rationing must, and will continue, to exist.) It is clearly impossible to achieve these targets by simply implementing new, more efficient methods of health care finance and delivery. Finally, revenue will be obtained by taxes on various businesses, insurance companies, and wealthy individuals. One tax that will occur in the future is placed on so-called “Cadillac” or high cost insurance policies. This tax will be placed on insurers, but they will obviously have to pass some of this to the insureds. The Cadillac tax is to encourage individuals and employers to purchase relatively modest coverage similar to that accessible to the majority of persons. If so, this in turn will, one hopes, hold down per capita costs and discourage use of marginally useful interventions.

158. Id.
159. Id. (“The proposal shall not include recommendations to ration health care, raise revenues or premiums, increase beneficiary cost-sharing, or restrict benefits, or modify eligibility criteria.”); Roy G. Spece, Jr., A Fundamental Constitutional Right of the Monied to “Buy Out Of” Universal Health Care Program Restrictions Versus the Moral Claim of Everyone Else to Decent Health Care: An Unremitting Paradox of Health Care Reform?, 3 J. HEALTH & BIOMED. L. 1, 14-17 (2007) [hereinafter Spece, Health Care] (examining the constitutionality of a limitation on health care insurance actually experienced in Quebec, Canada: prohibition of purchase of supplemental private health care insurance covering items already supplied in a government’s universal health care plan. This article draws on ideas and sources used in Spece, Healthcare. I have quoted that article when directly restating language from it, but I am not able to guarantee that I have not repeated a few phrases embedded in my brain. Also arguing as to rationing that setting reasonable limits on care is inevitable regarding health insurance.). See also Comment, The Good, the Bad, and the Ugly: How the Due Process Clause May Limit Comprehensive Health Care Reform, 77 TENN. L. REV. 413 (2010) (arguing, not necessarily correctly, that a de facto single payer system fostered by the government accompanied by exclusion of certain care or waiting lists and a private health sector decimated by the universal system would be unconstitutional as violating a due process right to personal medical decisions).
160. See supra note 12.
161. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 2205.
163. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 2205.
C. Additional Information about the PPACA Provisions Most Relevant Here

This subsection will provide additional information regarding the nature and possible effects of the exchanges, the co-op program, State low cost plans, and the multi-state insurers.

1. Exchanges

Given that primary issues in this article are the constitutionality of barring undocumented immigrants, and possibly persons desiring abortion insurance, from the exchanges, it is important to further describe the exchanges, the forms they might take, and effects they might have on the general insurance market, insurers, and consumers.

There are two categories of exchanges. American Health Benefit exchanges will service the individual market. Small Business Health Options Program exchanges will service businesses with 100 or fewer employees. (Starting in 2017 exchanges can allow participation by businesses with over a hundred employees.) States can have more than one exchange in each category provided they serve distinct geographical regions; the States can also combine their individual and small group exchanges. Each exchange must be administered by a state-created agency or nonprofit entity. The exchanges must be self-sustaining by January 1, 2015. They can achieve that requirement by charging assessments or user fees to participating insurers or otherwise generating revenue. States are required to create any exchange by the beginning of 2014, and if the federal government anticipates on January 1, 2013 that a State will not meet its deadline, the federal government will create and operate an exchange in the State. The exchanges are subject to a host of regulations relating to coverage offerings; required benefits; consultation with a broad category of stakeholders; and publication of costs of licensing, regulatory fees, and other charges they impose as well their own administrative costs. Their functions include: (1) implementing certification, recertification, and decertification of qualified health plans; (2) providing a toll-free telephone

164. Id. at ¶ 215.
165. Id.
166. Id.
167. Id.
168. Id.
169. CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
170. Id.
171. Id. at ¶ 230.
172. Id. at ¶ 215.
173. Id.
174. Id.
175. CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
176. Id.
line to respond to requests for assistance;\(^{177}\) (3) maintaining a website or internet portal to provide standardized comparative information on health plans (including ratings and results of consumer satisfaction surveys);\(^{178}\) (4) determining whether individuals and small employers are eligible for the exchange, and, if so, to direct them to plans and to determine qualification for a premium tax credit or cost-sharing reduction;\(^{179}\) (5) constructing a rating system and applying it to each plan in the exchange;\(^{180}\) (6) informing individuals about Medicaid, the Children’s Health Insurance Program, or any state or local public program and enrolling them if they qualify;\(^{181}\) (7) providing an electronic calculator to determine the cost of coverage after any premium tax credit or cost-sharing reduction;\(^{182}\) (8) certifying individuals as exempt from the mandate to obtain insurance;\(^{183}\) (9) receiving information from plans about proposed premium increases and from States concerning patterns or practices of excessive or unjustified increases, and using this data to determine whether plans should be allowed to offer coverage through the exchange;\(^{184}\) (10) requiring plans offered through the exchange to provide the public with timely and accurate information concerning payment policies and practices, finances, enrollment, disenrollment, number of claims denied, rating practices, cost-sharing and out-of-network payments, and enrollee rights;\(^{185}\) and (11) establishing a Navigator program within which it provides grants to non-insurer entities that will conduct education about availability of plans and enrollment, facilitate enrollment, and provide referrals to any appropriate state agency for individuals who have grievances, complaints, or questions pertaining to their health care plan.\(^{186}\)

The exchanges present advantages to enrollees and to insurers. As to enrollees, those who are eligible can only obtain premium tax credits and cost-sharing subsidies through the exchanges.\(^{187}\) They can do essentially one-stop, assisted shopping through the exchanges.\(^{188}\) Premiums might be lower in the exchanges because of the standardization and administrative services the exchanges provide to insurers in the exchanges.\(^{189}\) Moreover, there will be efficiencies because the exchanges will restrict themselves to a small selection of

\(^{177}\) Id.
\(^{178}\) Id.
\(^{179}\) Id.
\(^{180}\) Id.
\(^{181}\) CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
\(^{182}\) Id.
\(^{183}\) Id.
\(^{184}\) Id.
\(^{185}\) Id.
\(^{186}\) Id.
\(^{187}\) CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
\(^{188}\) Id. (requirement of a website for the exchange in which one can obtain standardized comparative information on health plans).
\(^{189}\) See Ron Chapman & Tom Christina, The Impact of Recent Legislation on Employer-Sponsored Health Coverage, 2010 ASPATORE SPECIAL REP. 8, 1 (May 2010).
plans that meet the PPACA requirements. 190 If a State requires small group or individual plans to cover benefits beyond what is demanded by the PPACA, enrollees are entitled to reimbursement. 191

Concerning employers, the exchanges, as noted above, provide certain administrative functions gratis. 192 The exchanges will, also as indicated above, offer a toll free telephone line to assist consumers (one hopes, superior to the vast majority of existing frustrating systems), provide a website where consumers can shop for and obtain information about their products, enroll applicants in the plan of their choice, and coordinate premium tax credits and cost-sharing reductions with the federal government. 193 (States might offer additional subsidies and the exchanges would handle these too.) 194

The PPACA “grandfathers” existing plans and allows them to operate outside the exchanges, but two commentators argue that most of these plans will vanish in time:

The freedom employers currently have to customize their group health plans to suit overall enterprise goals is about to be eroded quickly and steadily to the point of collapse. . . . By 2014, when government-sponsored health insurance exchanges will open for business in every state, most small employers and even some large employers will effectively be required to choose from among a small handful of “off the rack” insurance-based health plan models offered through the exchange. These “exchanges” will function as government-subsidized marketplaces for plans that satisfy eligibility, coverage, and cost-sharing requirements under the Act, and they will absorb market share due to the greater “efficiency” they achieve by restricting themselves to offering only a small selection of plans that satisfy new government mandates. The same narrow range of choices will become the predominant models for plans sponsored by large employers nationwide by 2017. . . . 195

The same commentators anticipate that THE PPACA will be the death knell for many plans. They observe:

[B]eginning in 2018, employers of individuals covered under grandfathered health plans will be at risk of a 40 percent non-deductible excise tax on part of the cost of their coverage that will discourage plans offering enhanced features that likely will not be available on the exchanges. This “Cadillac health plan tax” is calculated the same way, regardless of whether or how the employer and employee might split

190. Id.
191. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
192. See supra notes 187-188 and accompanying text.
193. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
194. Id.
195. Chapman & Christina, supra note 189, at 1 (Once again, any statements about the future effects of the PPACA provisions are perforce somewhat speculative.).
the cost of coverage. Thus, even if an employee elected coverage under a so-called “Cadillac plan” and voluntarily paid the entire cost with after-tax dollars the employer is exposed to precisely the same excise tax as it would be in the case of an executive covered under the plan at no personal cost. In our view, self-insured employer-sponsored plans will not be able to survive economically for very long after 2018, the inaugural year of the “Cadillac health plan” tax.  

The commentators go on to explain that grandfathered plans will face stiff competition from plans within the exchanges and that the exchange plans will siphon off “the best insurance risks such as younger employees and single employees.” The PPACA not only allows, but encourages this result and “compels the employer to facilitate it.” Beginning in 2014 employers who offer a plan must identify those employees who would have to contribute more than 8 percent and not more than 9.5 percent of their household income to participate in the employer plan. The Congressional Budget Office estimates that there will be approximately 100,000 eligible employees. The employers must give their employees free choice vouchers that the workers can use to purchase alternative coverage, but only within an exchange. The vouchers are “equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee [and family if applicable] were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan.”  

Furthermore, the PPACA will have a tendency to steer employees to the exchanges because, beginning in 2013, they will have to post notices concerning the availability of exchange-based coverage and provide a description of their plans in the format required within the exchanges. This will allow easy side-by-side comparisons. Furthermore, employees of large employers whose household income is below 400 percent of the federal poverty level will be given federal assistance—the health insurance premium assistance refundable credit and cost sharing mentioned above—that is only operative in the exchanges. If even one employee gets this assistance, the employer will be assessed a tax calculated based on the number of its employees. If the employer did not offer any plan with minimum essential coverage, the monthly tax amount is calculated

196. Id. at 2.
197. Id. at 4.
198. Id.
199. Id.
200. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 350.
202. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 350.
203. Chapman & Christina, supra note 189, at 4-5.
204. Id.
205. Id.
by multiplying the number of employees by $166.67.\textsuperscript{206} If the employer does offer a qualifying plan but has even one employee who receives a premium credit or cost-sharing reduction, the monthly taxable amount is calculated by multiplying the number of employees who receive a subsidy by $250.\textsuperscript{207}

All the above advantages of the exchanges will have the effect of “shrinking the size and selectively [worsening] the demographic characteristics of the group that remains covered. . . .”\textsuperscript{208} This “assessment spiral,” which might be better called a “death spiral,” consists of “successive echelons of good insurance risks [leaving] a group, driving up prices for the remaining members, thereby creating an incentive for the pattern to repeat itself.”\textsuperscript{209}

Even after all the above, some grandfathered employer insured plans might survive in 2017. These are plans that are “crucial to some employees because of individual circumstances, family and community resources, and other factors[,] for example, key employees may have dependents with chronic, life-threatening conditions that require ‘round-the-clock’ care or other costly and prolonged treatment.”\textsuperscript{210} Going full circle, the 2018 Cadillac tax is likely to deal a fatal blow to all or most of these remaining expensive policies.\textsuperscript{211}

The exchanges will take various forms in different states. Two possible exchange models are contained in a California State report. It observes that the PPACA gives states great leeway in constructing their exchanges. One model is that “the exchange could have the … limited role of connecting eligible persons to coverage via an Internet portal that provided standardized information on qualified plans and prices and then referred individuals and employers to the plan of their choice.”\textsuperscript{212} A second model is that the exchange could do everything in the first role and “play a more expansive role and operate a purchasing alliance, negotiating the best rates for exchange participants and enrolling individuals in plans, as well as administering subsidies, [and] collecting and paying premiums.”\textsuperscript{213}

2. Co-Op’s

Given that the entities created by the co-op program will offer health care insurance through the exchanges and that their existence could influence elements of the insurance markets, it is important to summarize that program.\textsuperscript{214}

\begin{footnotesize}
\begin{enumerate}
\item[206.] See CCH’s Explanation of the PPACA, supra note 9, at ¶ 425.
\item[207.] Id.
\item[208.] Chapman & Christina, supra note 189, at 5.
\item[209.] Id.
\item[210.] Id.
\item[211.] Id. at 5-6.
\item[213.] Id.
\item[214.] See CCH’s Explanation of the PPACA, supra note 9, at ¶ 235.
\end{enumerate}
\end{footnotesize}
The Secretary of Health and Human Services is required to award and begin to
distribute six billion dollars allocated to the co-op program for grants (to be paid
back in fifteen years) and loans (to be paid back in five years) by July 1, 2013.
The insurance companies the program seeks to create or expand will be required
to issue qualified health plans in the individual and small group markets.
The goal is to have at least one issuer in each state. These issuers must be owned
by their members/insureds, and decisions concerning their governance must be
made by majority vote of the members. They cannot be sponsored by a State
or local government. The rationale for the co-op program is that non-profit
insurers owned by their members and assisted by government grants and loans
will be driven by concern for consumers rather than interest in profits which
motivates for-profit insurers. All profits must be used to lower premiums or to
improve care delivered under the plans. Moreover, the hope is that co-op
programs will be able to use market forces—e.g., negotiating with health care
providers—to hold down premiums.

The insurers’ founding documents must contain conflict of interest and other
standards to prevent “involvement and interference” by the insurance industry.

3. State Created Plans

It is important to discuss state created plans because context three consists of
undocumented immigrants being excluded from this market, even if they meet
income guidelines and pay premiums without access to THE PPACA’s
subsidies. The states are allowed to offer one or more basic health programs to
“state residents who are not eligible for Medicaid and who have household
incomes that exceed 133 percent but do not exceed 200 percent of [the federal
poverty level]; who are offered employer-provided coverage that does not meet
the “affordable coverage” criteria under [the] Internal Revenue Code …; and
who are under age 65 as of the beginning of the plan year.” The insureds must
not pay premiums higher than would be charged for certain plans offered in an
exchange. They must be given the minimum essential benefits, and premiums

215. Id.
216. Id.
217. Id.
218. Id.
219. Id.
220. Website of U.S. Senator Kent Conrad, Issues, FAQ About the Consumer-Owned and -
Oriented Plan (CO-OP), http://conrad.senate.gov/issues/statements/healthcare/
090813_coop_QA.cfm.
221. Id.
222. Id.
223. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 235.
224. See id. at ¶ 250.
225. See id. at ¶ 205 (Insurers are required to offer plans covering different percentages of the
cost of care: bronze (60%); silver (70%); gold (80%); and platinum (90%).)
226. See id. at ¶ 250.
will be calculated after any premium assistance credits or cost-sharing reductions.227

State plans must have a competitive process for choosing which standard health plans to contract with, and this covers premiums, cost-sharing, and benefits beyond the essential benefits.228 If the plan provides health insurance coverage offered by a health insurance issuer, that entity must have a “medical loss ratio” of at least 85 percent.229 If a State plan meets all requirements, it will receive federal funds equal to 95 percent of premium tax credits and cost-sharing reductions its insureds would have received if they purchased through an exchange.230 These subsidies go to the States but they are for specific groups of relatively disadvantaged persons. Undocumented immigrants, if allowed to participate in the plan albeit without subsidies, presumably would be required to pay full market price. In that event, barring undocumented immigrants from the State plans would be tantamount to banning them from the exchanges.

### 4. Multi-State Insurers

It is also important to discuss the multi-state plans because they are offered through the exchanges and they might have substantial effects on the health care insurance markets. The provisions for multi-state insurers were promulgated to replace the “public option.”231 As noted above, two multi-state plans are required in each state, one of which must be non-profit.232 The plans will be offered in the exchanges and subject to contracts with the federal Office of Personnel Management.233 The Director of that department will negotiate with each plan concerning medical loss ratio, profit margin, premiums, and other terms and conditions.234 In this sense, they will fill some of the functions of a public option, i.e., a government run or regulated by contract insurance company that competes with and thereby channels the choices of private insurance

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227. See id.
228. Id.
229. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 250. See also Christopher Jennings & Katherine Hayes, Walking the Tightrope of Health Insurance Reform Between 2010 and 2014, NEW ENG. J. MED., July 21, 2010, healthcarereform.nejm.org/?p=3768 (medical loss ratios are “the percentage of premium dollars that are spent on medical benefits, as opposed to administrative costs and profits”; “Although it is clear that costs associated with marketing, enrollment, and claims processing are nonmedical and that payments to providers for services are medical, plans, providers, and consumers disagree on the status of expenditures for antifraud and antiabuse activities and quality-improvement activities. One question receiving particular scrutiny is whether care-management tasks performed by insurer-employed nurses are designed to reduce costs and utilization (in which case they would be nonmedical) or to improve patient care and ensure delivery of services (which would make them medical).”).
230. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 250.
231. Id. at ¶ 265.
232. Id.
233. Id.
234. Id.
companies. The plans must provide the essential benefits required by the PPACA, must meet the PPACA’s requirements for qualified health plans, and enrollees can qualify for premium reduction credits and cost-sharing reductions.

D. Some Overall Effects of the Exchanges, Co-op’s, State Plans, and Multi-State Insurers

Some observers from the insurance industry contend that the PPACA will force many insurers out of the market. It can be argued that the federal government’s goal is to reach a point at which an overwhelming percentage of insurance is only offered through the exchanges and state-created plans, and, even if there is no such intent, that this might occur in any event. (Of course Medicare, Medicaid, and similar public benefits programs or entities would continue to exist.) Although the exchanges will start with the individual and small group insurance markets, they will extend, over time and at the discretion of each state, to the large group markets. It is conceivable that federal or state governments will at some point (after amendment of the PPACA) require all “private” insurance to be offered only through the exchanges. They would only have to do this if the existing advantages of the exchanges, the substantial number of entities required to operate through the exchanges, and the dissipation of grandfathered programs does not achieve that result de facto.

Although the PPACA grandfathers existing health care plans, one authority has explicitly argued that the government intends grandfathering to be a transitional phenomenon. By the time the PPACA has been mostly implemented the exchanges will offer so many benefits that only rare investors/insurers might be able to resist them. These benefits include reduced overhead because of the services offered by the exchanges, wider pooling of

235. Id.
236. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 265.
238. See Chapman & Christina, supra note 189, at 1-6.
239. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215.
240. State legislation might be subject to a preemption challenge.
241. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 220 (consumers are not currently required to purchase health insurance through a state exchange).
243. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 185.
risks, and tax credits. Furthermore, insurers will be anxious to have a chance to sign up customers who probably will primarily look to the exchanges for the consumer help or subsidies they provide. The multi-state plans have to be within an exchange, and they have the advantage of being federal government contractors. Co-op insurers will also sell through the exchanges. Other insurers might feel that, in light of the advantages favoring co-op insurers and multi-state plans and the benefits these other insurers themselves can receive from the exchanges, they will only be able to compete if they join an exchange. Once in an exchange, insurers are required to charge the same for policies within and outside the exchange. This provides no monies to pay a sales force, and de facto prevents simultaneous operation in and outside an exchange.

Once again, this is important concerning the ban on undocumented immigrants and potential ban on women or couples seeking abortions from the exchanges. If insurance is only offered through the exchanges, then undocumented immigrants and many women seeking abortions (in States that elect the option to exclude abortion coverage from the exchanges) will have no chance whatsoever to purchase health insurance for the care they seek. Even if a few insurers remain outside the exchange, these are likely to be hardy grandfathered plans that have survived because they cater to the needs of wealthy individuals or their employers who seek to cover dependents with serious, chronic conditions. These plans will be prohibitively expensive for virtually all undocumented immigrants, and they likely will be subject to the “Cadillac” or excise tax on high cost policies that will eventually take effect. If separate abortion coverage were not offered outside the exchange, comprehensive policies, if they existed, would also likely be too expensive for many or most women seeking abortion coverage, and such policies might exclude abortion coverage at any rate.

Regardless, the individual insurance market will, on the whole, probably continue to fail to provide as much dollar-for-dollar actuarial value when

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245. See supra notes 187-194 and accompanying text.
246. Id.
247. See supra notes 231-235 and accompanying text.
248. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 235.
249. Sara Hansard, Exchange Plans to Enjoy Tax Credits Not Available for Non-Exchange Plans, Health Plan & Prov. Rep. (BNA), June 16, 2010, vol. 16, at 695 (exchange plans must charge same premiums in and outside the exchange; this limitation does not apply to non-exchange insurers, but they do not benefit from tax credits and reimbursements inside the exchanges); Id. (By 2019, 24 million of 35 million people purchasing individual plans are projected by the Congressional Budget Office to purchase from an exchange insurer).
252. See Chapman & Christina, supra note 189, at 5.
253. See id.
compared to small and large group insurance, individual insurance premium inflation recently has been well above that of other health insurance and general goods and services, insurance offered through the exchanges could be a better bargain than that offered outside the exchanges, and undocumented immigrants are prohibited from working and therefore cannot be considered eligible for insurance through their employers. It is therefore realistic to conclude that the PPACA’s ban on illegal immigrants purchasing from exchanges will make it impossible or impracticable for an overwhelming majority of undocumented immigrants to purchase health care insurance. It is also possible that the States will pick up on the PPACA’s prohibition on undocumented immigrants purchasing insurance in the exchanges and officially prohibit insurers that might exist outside the exchanges from selling to undocumented immigrants. They could argue that this would enhance the effect of the federal prohibition.

A similar line of reasoning applies to the abortion context. The states are allowed to prohibit purchase of abortion coverage in the exchanges. One might argue that women have the option to purchase separate abortion coverage outside the exchange given that abortion coverage is a very small part of the cost of comprehensive plans that cover abortion. However, it is not certain that such coverage will be available outside the exchanges. Companies that offer it as a separate plan once it is banned in a State’s exchange likely would be maligned like doctors who perform abortions. If general insurers continued to cover abortion, the few plans that might exist outside the exchanges could be exceptional ones with very high premiums. Furthermore, matters of conscience or inconvenience, spurred or created by the the PPACA intrusion, might lead to employers or insurers voluntarily dropping abortion coverage. At the very least, employers will have to deal with the the PPACA-created burden of making separate deposits and preparing related paper work concerning any abortion coverage paid through payroll withholding. Some or many would likely drop abortion coverage for just this reason. In any event, employers dropping coverage could leave many women without insurance covering abortion. Women might assume that they have coverage because customarily

254. See supra notes 84-90 and accompanying text.
255. See supra note 63.
258. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 220.
259. Here too there might be a preemption problem.
260. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 210.
262. See Chapman & Christina, supra note 189 at 5.
263. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 210.
almost 90 percent of policies cover abortion. If their individual insurer, employer plan, or spouse’s or parents’ plan moved to the exchanges, they might lose coverage without ever knowing it. Even if there were notices sent out, they could easily be discarded as junk mail.

Reaching upstream and prohibiting insurance is, moreover, highly intrusive on women’s thought processes and well-being. Many of them would have no plan to have an abortion or even a child. They can deal with the abortion issue if they become pregnant. That decision is very important to women, so important that the government has attempted to force women to receive certain information whether they desire it or not. It is intrusive for the government to intervene when a woman is making or has made an anguishing decision about abortion. At least in that context, however, there is the argument that the State has the power to intervene to protect the interests of the fetus and the sanctity of life. Intervening perhaps years before any abortion decision might be made, and even when in many cases such a decision will never be presented, intrudes into women’s minds, thoughts, and self-definition. It is an unnecessary and prohibited undue burden I will explore below.

IV. DUE PROCESS AND EQUAL PROTECTION OBJECTIONS AS APPLIED TO CONTEXT ONE: THE UNDOCUMENTED CAN’T PURCHASE IN EXCHANGES

It is helpful to discuss context one, the prohibition on undocumented immigrants purchasing insurance offered in an exchange, when going through each step of the due process and equal protection decision-making processes likely to be chosen among by the Court. I will also consider a situation in which

264. Note, If Men Could Get Pregnant: An Equal Protection Model for Federal Funding of Abortion Under a National Health Care Plan, 60 BROOK. L. REV. 349, 401 (1994) ("Since ninety percent of all private health insurance policies currently provides abortion coverage, women will have an expectation of continued coverage."). The 90% figure apparently comes from a federally supported study by the Guttmacher Institute focusing on employer provided insurance. A similar study by the Kaiser Family Foundation found that only 46% of insured employees had abortion coverage. The Guttmacher Institute insists that at least a majority of policies cover abortions. Guttmacher Institute, Guttmacher Institute Memo on Insurance Coverage of Abortion, July 22, 2009, www.guttmacher.org/media/inthenews/2009/07/22/index.html.

265. See infra Part V.

266. Id.

267. Id.

268. The Fifth and Fourteenth Amendments contain Due Process Clauses, while only the latter includes an Equal Protection Clause. Nevertheless, in what some have called “reverse incorporation,” the Court has held that the Due Process Clause of the Fifth Amendment contains the same equal protection principle that is made explicit in the Fourteenth Amendment. Bolling v. Sharpe, 347 U.S. 497 (1954). I will also point out that I have discussed the basic decision-making approaches of the Court, evolving over time with precedents, in several articles, the latest being Specre, Health Care A substantial amount of analysis of doctrine here comes from that article. I have quoted myself when I use specific excerpts, but I cannot guarantee that I have not inadvertently repeated myself from memory. I should point out that the iteration of doctrine here contains significant differences from my earlier discussions because of rethinking and elaboration.
a State prohibits undocumented immigrants’ purchase of health care insurance outside the exchanges and this bar is upheld against a preemption attack. After this, the same analysis will be applied to the other three contexts, with appropriate adjustments made insofar as there are unique issues that each poses.269

A. Prima Facie Claims and Standards of Review

1. Prima Facie Claims

A prima facie claim is a concept more likely to be used in torts than in constitutional law. It is useful, however, to consider the minimum allegations one must make to justify application of a standard of review—rational basis, compelling state interest, an intermediate test, or picking some point on a sliding scale.270 I refer to these allegations as prima facie cases if they establish the applicability of a particular standard of review.271 This concept is useful for a few reasons. First, it might be relevant to any consideration of sanctions against a party for making a frivolous claim.272 Second, it might convince a judge that there is a viable claim as to which there should be discovery, and discovery can adduce information supportive of a stronger claim than one that simply supports rational basis review.273 Third, the concept could assist in determining who has or should have the burdens of production and proof.274 Finally, especially when medical care and life are at stake, the Court might actually find constitutional level irrationality after discovery, at least in the equal protection context, where the Court has found certain government action to fail the rational basis test.275 (Rational basis analysis is very unlikely to result in invalidation of government action under the due process clauses.) One should not fall prey to the common misconception that if the Court states it is using the rational basis test but finds against the government, the Court is ipso facto applying a stricter standard of review. Some government actions are patently irrational and I will return to this issue later.276

There is also an argument that the Court should be hesitant to rubber stamp government action when “life” (or “just” health) is at stake. For example, in Roe

269. See infra Parts V, VI & VII.
270. See Spece, Health Care, supra note 159, at 29 n.93 (similar but distinct discussion of prima facie constitutional due process and equal protection claims).
271. Id.
272. Id.
273. Id.
274. Id.
275. See infra notes 482-85 and accompanying text (discussing a situation in which a law was invalidated on the basis of the rational basis test).
276. Id.
v. Wade, then Justice Rehnquist dissented and argued that the rational basis test should apply to the prohibition on abortion. He further reasoned, however, that it would be irrational within the meaning of the rational basis test if the government prohibited an abortion when it was necessary to save the life of the mother; it would be choosing a fetus over a person. Although I do not agree that such a decision would be irrational, this shows that even Justices who espouse judicial restraint might find a law irrational when life itself is concerned. Of course, health and life are concerned in three of the four contexts addressed in this article. This is another issue I will return to below.

One can establish a prima facie procedural or substantive due process claim by showing: (1) government action, (2) significantly intruding upon, (3) a person’s, (4) “life, liberty, or property.” A prima facie equal protection claim requires: (1) government action, (2) treating a person or group less favorably than other similarly situated persons or groups, and (3) causing harm the courts recognize as constitutionally sufficient (“harm in fact”).

Due process requires an impingement on a right to “life, liberty, or property,” while equal protection requires a classification that causes harm to an interest—“harm in fact” necessary to standing. Although an equal protection claim requires a classification rather than a simple intrusion, a due process claim is more difficult to establish because it requires proving a “life, liberty, or property” right rather than just “harm in fact.” Positive law almost always
creates rights and it is therefore often impossible to establish a “life,” “liberty,” or “property” right.288

Consider whether prima facie claims could be made out as to context one in which THE PPACA prohibits undocumented immigrants from purchasing health insurance through exchanges,289 with the result that they overwhelmingly have literally or virtually no other source of health insurance. Of course, if a State prohibits purchase outside the exchanges, there is a de jure across-the-board prohibition.

Undocumented persons, at least the mass of them who are relatively poor,290 could in principle establish substantive due process and equal protection claims. As to due process, they could show that government action (THE PPACA’s and a State’s de jure291 or de facto vitiation of the opportunity to purchase health care insurance) (2) significantly intruded upon (prohibition is the ultimate intrusion) (3) their (persons’) (4) rights to “life” and “liberty.”292 “Life” and “liberty” are impaired because insurance is the primary way persons in the U.S. access health care, it is often necessary to obtain care, and the absence of care frequently causes pain, injury, or (early) death.293 (It is assumed that the Court would not stretch the cases that reject positive claims to affirmative supply of government benefits to prevent a prima facie case in this context in which there is a bar from purchase in a market, especially a market that might de jure or de facto be the only market practically open to the plaintiffs.)

Concerning equal protection, the plaintiffs could show (1) government action (same as with due process) (2) classified by treating (3) them (persons) worse than other similarly situated persons (those allowed to purchase in the exchanges), (4) causing “harm in fact” (the risk of death and a litany of significant unprevented or unremedied maladies).294 One might argue that there are community health centers and other entities that dispense charity care and are open to undocumented immigrants.295 However, this is not true as to all

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288. See, e.g., Maher v. Roe, 432 U.S. 464, 471-75 (1977) (discussing the context in which seeking an abortion was part of a larger right to privacy); Michael H. v. Gerald D., 491 U.S. 110, 124 (1989) (Justice Scalia’s plurality opinion found no fundamental right for alleged biological father of child to visit the child when the woman was married to another man when the child was conceived).

289. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 220.


291. If the PPACA were amended to give the States broader power and some of them subsequently prohibited purchase of health care insurance outside the exchanges, there would be a de jure prohibition. The PPACA’s provisions regarding disallowance of purchase inside the exchanges (CCH ¶ 220) could be interpreted, moreover, not to preclude a state law barring all purchases by undocumented immigrants, and such a law might also survive a preemption attack.

292. See Speece, Health Care, supra note 159, at 29.

293. Id.

294. Id.

And one should not be too confident that these sources of care will not also eventually be denied to undocumented immigrants.

2. The Standards of Review and When They Apply

If there is either a substantive due process or an equal protection prima facie claim, the Court will determine the ultimate outcome by applying the rational basis test (which is presumptively applicable), strict scrutiny, i.e., the compelling state interest test, or some standard of review intermediate to the rational basis and compelling state interest tests.297

The rational basis test requires the person asserting a constitutional violation to show that there is no conceivable government interest imaginably advanced by the government’s action or classification.298 This test will be applied unless special justification is established to justify a higher degree of scrutiny.299 In due process and equal protection such justification is: (1) a significant intrusion on a fundamental right or interest300 (which triggers strict scrutiny as to both due process and equal protection), (2) a suspect classification (which calls for application of strict scrutiny in the equal protection context), (3) a significant intrusion on a quasi-fundamental right or interest (which seems to trigger intermediate scrutiny of some sort as to both tests although the Court has not officially said so), (4) a quasi-suspect classification (which triggers intermediate scrutiny in the equal protection context, i.e., the gender discrimination cases in which the Court has articulated an explicit form of scrutiny or other cases in which the intermediate scrutiny and the justification for it are opaque); or (5) both a quasi-fundamental right and a quasi-suspect classification (again, although the Court has not explicitly said so) intermediate scrutiny in equal protection.301 Sometimes the Court does not explain why it is applying some scrutiny beyond the rational basis test or what standard of review it is using.302

Strict scrutiny - the compelling state interest test - requires the government to meet the heavy burden of showing (1) its actual interest (2) is a compelling

296. See generally Corrine Parver, National Health Care Reform, 5 J. HEALTH & BIOMED. L. 207, 216 (2009) (health care reform law will address shortage of primary care physicians and promote rural health offices).
297. Spece, Health Care, supra note 159, at 29-34.
298. Id. at 29.
299. Id. at 30.
300. Id. at 30. Although the terms are often used interchangeably, it is more precise to distinguish between the “rights” (to life, liberty, or property) necessary in substantive due process and the “interests” (“harm in fact”) necessary in equal protection.
301. Id. at 29-34. See also infra notes 316-24 and accompanying text (regarding a quasi-fundamental right and a quasi-suspect classification).
302. Id. at 31.
interest (3) that the government’s action substantially advances, and (4) that there is no less restrictive means to accomplish that compelling state interest.303

Several forms of intermediate scrutiny can be derived from the Court’s precedents.304 The PPACA proponents might wish to invoke one or more of these tests.305 However, I will limit the analysis here to the intermediate tests applied in Plyler v. Doe and in the Court’s recent abortion opinions (the “undue burden test”). The Court created the Plyler test when considering the rights of undocumented immigrant children,306 while it created the undue burden test in the abortion context.307 One attacking the PPACA might want to invoke any one or more of the intermediate tests. If the Court decided to apply an intermediate test in the context of undocumented immigrants’ rights, the Plyler test would likely be at the top of or among those at the top of the Court’s list of possible standards.308 Similarly, if the Court were judging the PPACA’s and a State’s possible restrictions on abortion and the restrictions were unexpectedly not considered per se invalid as a prohibited prohibition (either before fetal viability or when the woman’s life or health is at risk), the undue burden test would apply.309 Plyler’s intermediate test can be “described either as a unique balancing test that weighs national and state interests as well as individual interests against the state’s asserted interests or as a test that requires more than a legitimate (“substantial”) interest and proof of a close connection between the state’s interest(s) and its classification, or an ill-defined combination of both.”310

The undue burden test the Court has articulated in its recent abortion opinions applies to government intrusions on the abortion choice but does not apply to total prohibition of either pre-viability abortions or of all forms of abortion necessary to protect the life or health of any specific set of women.311 The Court’s test asks whether the government’s actions unduly burden the exercise of constitutional rights at stake in abortion cases.312

We have already determined that context one creates prima facie due process and equal protection claims.313 Therefore, at least the rational basis test will

304. Id. at 31-34 (describing several intermediate tests).
305. Id.
309. See Casey, 505 U.S. at 878.
310. Spece, Health Care, supra note 159, at 31-32.
311. Id. at 33-34.
312. Id. (When I refer to (quasi) fundamental rights or (quasi) suspect classifications, I intend to refer to both full-fledged fundamental rights or suspect classifications or quasi-fundamental rights or suspect classifications.)
313. See supra notes 297-301 and accompanying text.
It is likely, however, that the Court would apply strict or intermediate scrutiny because of a (quasi) fundamental right to purchase health insurance. I have indicated that strict or intermediate scrutiny requires either a (quasi) fundamental right or (quasi) suspect classification. I will discuss these issues in order.

a. What is a (Quasi-) Fundamental Right?

The Court arguably could choose among five different approaches to determine whether there is a “fundamental right.” (A quasi-fundamental right will presumably - if not officially - be found when these approaches fall near to establishing a fundamental right.) The five approaches are:

1. The Court has said that fundamental rights are those that are essential either to the survival of our society or the functioning of important institutions within it. 

2. Washington v. Glucksberg’s test that fundamental rights must be “precisely” or narrowly described, “deeply rooted in this Nation’s history and tradition,” and “implicit in the concept of ordered liberty” such that ‘neither liberty nor justice would exist if they were sacrificed.”

3. Answering the question, Does the right or interest relate to intimate and crucial decisions about one’s life or relationships, or, if equivalent, decisions that fall within the rubric of “privacy”?

4. Answering the question, Is the right “essential to the very ability to formulate and express the intimate and important decisions” mentioned in method (3) immediately preceding?

5. Determine, via an expanded precedential approach, whether the right shares characteristics—in numbers and magnitude previously found sufficient to identify a fundamental right—said by the Court and other authorities to be relevant to identification of fundamental rights, including (a) characteristics identified in the first four methods, (b) having a close nexus to other fundamental rights, (c) being specifically mentioned in the Constitution, (d) being previously recognized as special in precedents, (e) being non-economic, (f) being individually important, (g) being a claim against paternalism, (h) being highly valued by other nations, and (i) being a negative (don’t bother me) rather

314. Id.
315. See infra notes 341-44 and accompanying text.
316. Spee, Health Care, supra note 159, at 35.
317. Id.
318. Id. at 36.
319. Id.; see also Note, Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana, 118 HARV. L. REV. 1985, 1987-90 (2003) (finding right of access to medical marijuana in patients who prove it as their only effective treatment because denial of access would impede the process of self-definition, trenching on fundamental rights to life, dignity at the end of life, and avoidance of pain).
than a positive right (give me something). These criteria overlap and may (or may not) identify the same triggers for heightened scrutiny.

b. What is a (Quasi-) Suspect Classification?

The Court has identified several criteria that are relevant to whether there is a suspect or quasi-suspect classification, generally without explicitly stating which of these is necessary or sufficient. However, the Court has explicitly held that classifications based on race, ethnicity, or national origin implicate sufficient criteria to be considered suspect, and that gender classifications embed enough criteria to be characterized as quasi-suspect. The relevant criteria for determining whether a classification is suspect include the following sometimes overlapping characteristics: the classification is (1) subject to negative stereotyping and stigma, (2) generally irrelevant to lawmaking, (3) related to an immutable characteristic, (4) related to a readily apparent characteristic, (5) directed toward the politically powerless, (6) aimed at vulnerable groups, or (7) burdensome to a minority group. (There may be no necessary and sufficient conditions; perhaps a hard-to-specify “quorum” of features governs the issue.) The Court sometimes uses the phrase “discrete and insular” to refer generally to several of these characteristics.

c. Plyler v. Doe: Mixing Criteria Relevant to Fundamental Rights and Suspect Classifications

In Plyler v. Doe the Court applied a version of intermediate scrutiny to strike down Texas’s bar of undocumented immigrant children from its schools. The Court did not specify why it was applying this particular version of intermediate scrutiny but it did emphasize that the undocumented children were a vulnerable, blameless group and that education was essential to any chance at equal opportunity. Reasonable arguments have been made that the Court applied

320. Spece, Health Care, supra note 159, at 36.
321. If any, it could be a “cluster concept” involving a quorum of features. See John Hospers, An Introduction to Philosophical Analysis 121-23 (3d ed. 1990).
326. Id. at 227-30.
327. Id. at 244-45. (Burger, J., dissenting). The Court apparently applied intermediate scrutiny because of the presence of a quasi-suspect classification that deprived blameless children of
intermediate scrutiny because it implicitly found Texas’s action to create a quasi-suspect classification barring innocent, vulnerable children from a quasi-fundamental right to education.328

B. Application to Context One

1. Extraordinary Court Role Considerations and the Symbolic Importance of Undocumented Immigrants’ Right to Purchase Health Care Insurance

Let’s apply the above decision-making processes to context one—prohibiting undocumented immigrants from purchasing insurance in the exchanges (and states possibly barring purchase, if available, from any other source). I must first address particular questions about the Court’s role in the areas of naturalization and immigration before attempting to apply the doctrine set forth above. When it is determining, or when it would be expected to determine, whether a right or interest is (quasi) fundamental or a classification (quasi) suspect, the Court sometimes “either engages in a pre-consideration of the strength of the government’s interest, a pre-balancing of the relative strength of the competing individual and state interests, or considers its limited capacity or traditional role in a specific category of cases.”329

Such considerations could, but should not, bear heavily against undocumented immigrants. The Court has often referred to Congress’s so-called “plenary power” over immigration and naturalization matters.330 The government might argue as follows. Congress has made a decision, pursuant to its plenary power, that undocumented immigrants should not be considered part of our community.331 Congress’s power to make such determinations in this area stems from inherent sovereignty over international affairs and national security.332 Given that they have been determined to be outside our community, undocumented immigrants should have, at most, very limited rights. They have a few basic human rights, such as (procedural) due process in the criminal justice
system and habeas corpus relief;\textsuperscript{333} but otherwise the Court should take a "hands off" approach to reviewing Congress’s power over immigration and naturalization.

The response is as follows. Court precedent, including cases decided as recently as 2001, shows that undocumented immigrants possess certain rights;\textsuperscript{334} therefore, Congress’s power here is axiomatically not literally "plenary." The Court, moreover, has not only protected undocumented immigrants’ basic rights;

\textsuperscript{333} Zadvydas v. Davis, 533 U.S. 678, 690-93 (2001) (construing Congressional enactment to implicitly place a “reasonable” six month limitation on detention of aliens who had been ordered removed from the country to avoid serious constitutional problems, and observing: “A statute permitting indefinite detention of an alien would raise a serious constitutional problem. The \textit{Fifth Amendment’s Due Process Clause} forbids the Government to “deprive” any “person . . . of . . . liberty … without due process of law.” Freedom from imprisonment - from government custody, detention or other forms of physical restraint - lies at the heart of the liberty that Clause protects. . . . And this Court has said that government detention violates that Clause unless the detention is ordered in a \textit{criminal} proceeding with adequate procedural protections . . . The serious constitutional problem arising out of a statute that, in these circumstances, permits an indefinite, perhaps permanent, deprivation of human liberty without any such protection [judicial review] is obvious. . . . [O]nce an alien enters the country, the legal circumstance changes, for the Due Process Clause applies to all “persons” within the United States, including aliens, whether their presence here is lawful, unlawful, temporary, or permanent.”); Immigration and Naturalization Serv. v. St. Cyr., 533 U.S. 289, 300 (2001) (alien subject to removal order benefits from Court’s construction of statutory provisions not to withdraw habeas corpus jurisdiction and not to apply abrogation of discretionary relief from deportation retroactively, and observing: “A construction of the amendments at issue that would entirely preclude review of a pure question of law by any court would give rise to substantial constitutional questions. Article I, § 9, cl. 2. of the Constitution provides: ‘The Privilege of the Writ of Habeas Corpus shall not be suspended, unless when in Cases of Rebellion or Invasion the public Safety may require it.’ Because of that Clause, some “judicial intervention in deportation cases” is unquestionably “required by the Constitution.” Heikkila v. Barber, 345 U.S. 229 (1953).”); Wong Wing v. United States, 163 U.S. 228, 238 (1896) (aliens found to be in the country illegally and ordered to do 60 days of imprisonment with hard labor followed by deportation to China were entitled to Due Process concerning the imprisonment, the Court observing: “And in the case of \textit{Yick Wo v. Hopkins, 118 U.S. 356}, it was said: ‘The \textit{Fourteenth Amendment to the Constitution} is not confined to the protection of citizens. It says: ‘Nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the law.’ These provisions are universal in their application to all persons within the territorial jurisdiction, without regard to any differences of race, of color, or nationality; and the equal protection of the laws is a pledge of the protection of equal laws. Applying this reasoning to the \textit{Fifth and Sixth Amendments}, it must be concluded that all persons within the territory of the United States are entitled to the protection guaranteed by those amendments, and that even aliens shall not be held to answer for a capital or other infamous crime, unless on a presentment or indictment of a grand jury, nor be deprived of life, liberty, or property without due process of law.”); Boumediene v. Bush, 553 U.S. 723, 739-93 (2008) (even enemy combatants held outside the United States (Guantanamo Bay) were entitled to writ of habeas corpus and Military Commission Act that denied federal courts of jurisdiction to hear pending cases violated the constitutional prohibition on the suspension of the writ).

\textsuperscript{334} See Zadvydas v. Davis, 533 U.S. 678, 693 (2001) (“the Due Process Clause applies to all ‘persons’ within the United States, including aliens, whether their presence here is lawful, unlawful, temporary, or permanent”). See also discussion \textit{of Plyler v. Doe, 457 U.S. 202 (1982)} in the text accompanying notes 304-310 supra, and other discussion in the text accompanying notes 330-33 supra.
it has decided several cases involving immigrants without any mention whatsoever about a Congressional “plenary power.” Furthermore, the Court has recognized that the Due Process Clause of the Fifth Amendment applies to Congress’s direct power over naturalization matters. These cases and the ones that protect undocumented immigrants’ basic rights show that the Court seems to perceive, as commentators have argued, that there is a difference between the power over immigration and a power over immigrants in spheres unrelated to immigration, e.g., contexts not involving international affairs or national security.


336. In Miller v. Albright, 523 U.S. 420 (1998), seven members of the Court agreed that, at a minimum, the rational basis test applied to federal statutes that gave citizenship at birth to a child born outside of the United States to one United States citizen and a non-citizen only if the mother of the child was a citizen. There was no Fifth Amendment violation because the distinction between mothers and fathers was held to further legitimate government interests. Moreover, “[t]he Court . . . has stricken several congressional attempts to provide for involuntary termination of citizenship.” John Nowak & Ronald Rotunda, Constitutional Law, § 14.11, at 787, 786-87 n.5 (6th ed. 2000).

Professor Gabriel Chin, in an award-winning article, carefully studies the U.S. history of the plenary power doctrine and its entanglement with immigration and racial discrimination. He observes:

1. “The cases that created the plenary power doctrine suggest racial bias on the part of the Justice Department that prosecuted the cases and the Justices of the Supreme Court who decided them;”
2. “The Asian Exclusion Laws were intended to minimize Asian-American population and influence, and they succeeded ... The similarities between racial classifications in immigration law and in domestic contexts suggest that there is no reason not to apply comparable legal standards to both areas;”
3. “The Court’s reliance on precedent to sustain the doctrine is tenuous because the plenary power doctrine has not been consistently or coherently applied. Indeed, many of the outcomes in the old immigration cases have been rejected even as the Court sustained the general principle that Congress has plenary power over immigration;”
4. “The internal logic of the plenary power cases themselves suggests that the plenary power doctrine should now change, at least to the extent that it would no longer justify discrimination on suspect grounds, ... but so far the Court has refused to apply domestic equal protection principles to immigration law;”
5. “In recent decades, the Supreme Court has recognized” that the plenary power doctrine is at least subject to rational basis review;
6. “The Court... has suggested that international law supplies the content of plenary power. Limits on congressional authority logically may be found there” [because that international law expresses antipathy toward racial discrimination];
7. “Racial discrimination would not now be permitted under the rational basis standard;” and
8. “In the Head Money Cases, decided only five years before Chae Chan Ping [one of the two fountainheads of the plenary power doctrine], the Supreme Court unanimously held that immigration was subject to federal regulation under the commerce power, not under the inherent sovereignty theory, which is the basis for the plenary power doctrine. The Head Money Court cited precedents dating back many decades that, it said, had taken the same approach. Because there is no question that the commerce authority is limited by the Bill of Rights, if the Court reverted to its original theory of immigration power, constitutional immigration law would be brought in to the mainstream.”

Professor Chin’s analysis is only strengthened by the Court’s opinions subsequent to his article cited just above. His final point about the commerce clause pedigree of the plenary power doctrine is interesting because the Court has called Congress’s commerce power a “plenary power,” and yet, as Chin

338. See Chin, supra note 330. This article won the 1998 American Association of Law School’s Scholarly Paper Competition.
339. Id. at 10-11, 56-57.
observes, the Court has held that power subject to other provisions of the Constitution. Both plenary powers should be treated the same; plenary cannot mean unchecked by the Constitution and its ultimate arbiter, the U.S. Supreme Court.

On another point, Professor Chin places his call for scrutiny beyond the rational basis test on the racial nature of the immigration laws. The Court might reason that Congress has purified itself of the rotten bile of racism as an essential element of the plenary power doctrine and is now, along with its relatively recent alterations of the immigration laws, without the discriminatory intent requisite to invigorated scrutiny. (Of course, it might find that the racism is even stronger now.) In the present context, the existence of a fundamental right to purchase health care and insurance necessary to obtain that care supplements Professor Chin’s reasoning. Just as Chin argues that suspect racial classifications should engender invigorated scrutiny, the existence of a fundamental right should do the same - regardless of the specific intent the Court requires in suspect classification cases. Similarly, just as Professor Chin argues that international law is pertinent and frowns on racial discrimination, it is relevant in the present context that international law also decrees restrictions on access to health care.

It is possible that restrictions on undocumented immigrants’ purchase of health care insurance, like racially discriminatory aspects of immigration law, would fail the rational basis test.

Logic and common sense also counsel that there is no Congressional power over immigration that is literally “plenary,” in the broadest sense of that word. Every adverse action against an undocumented immigrant or undocumented immigrants as a whole can be argued to fall within Congress’s power over

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340. Quill Corp. v. North Dakota, 504 U.S. 298, 305 (1992) (“While Congress has plenary power to regulate commerce among the States and thus may authorize State actions that burden interstate commerce, . . . it does not similarly have the power to authorize violations of the Due Process Clause”). This is not to say that Congress has a plenary police power under the Commerce Clause. See United States v. Morrison, 529 U.S. 598 (2000) (striking down a provision of the Violence Against Women Act of 1994 because it exceeded the commerce power and trenched on the States’ police power).


342. See infra notes 485-90 and accompanying text. I am not ignoring that there are racial considerations still at work in our immigration laws, and that the majority of immigrants are Latinos or Hispanics. See Kara L. Wild, Comment, The New Sanctuary Movement: When Moral Mission Means Breaking the Law, and the Consequences for Churches and Undocumented Immigrants, 50 SANTA CLARA L. REV. 981, 992-93 (2010) (discussing passage in 2005 by the House of Representatives of an immigration bill in response to American fear of immigrants who were mostly Latino), Juyen Pham, When Immigration Borders Move, 61 FLA. L. REV. 1115, 1121-22 (2009) (laws targeting undocumented immigrants “have had the ironic and unintended effect of devaluing all forms of legal status for Latinos and others who look like immigrants”). However, it would be difficult or impossible to establish that the PPACA provisions regarding undocumented immigrants were intentionally (in the constitutional sense) directed toward any racial or ethnic group.
immigration because it conceivably could further specific or general deterrence of illegal immigration or continued presence. If this is so and there is literally a plenary power in Congress, Congress can wreak any havoc it wants on undocumented immigrants. This presumably would include homicides committed by government personnel and actions, such as preventing the purchase of health insurance, that increase the probability of early death. This line of reasoning is contradicted by the cases and authorities referred to immediately above.

There are additional reasons that traditional role considerations should not alter application of the Court’s general approaches to standards of review in the context of a federal prohibition on purchase of health insurance. First, the undocumented immigrants’ interests are very important - life itself is at risk. This is a question of basic human rights. Second, the right to buy health insurance for basic, essential care does not pose medical or scientific puzzles as to which the Court should defer to Congress. To the contrary, it is clear (as will be established below) that the government’s interests, whatever they might be, are not significantly at risk in the context of prohibiting undocumented persons’ purchase of health insurance. This is not a case of undocumented immigrants nibbling away at our community and culture; it is not about giving them expensive benefits, but about allowing them to purchase health insurance so they do not become a burden. Third, to the extent that transmissible diseases or expensive late or emergency care is at issue, allowing undocumented immigrants to purchase coverage and obtain possible early intervention will benefit all members of the community.

The actual and possible limitations implicated in context one could provide the Court with an opportunity to recognize, once again, that undocumented immigrants are “persons,” and therefore are entitled to basic rights such as freedom from government assaults, the ability to defend themselves from private violence, the due process protections of our criminal justice system, and the right to purchase or contract for the necessities of life (including health care or insurance). The number of immigrants who could afford to purchase health insurance might be small proportionate to their numbers, but it could be a significant total number. (As to the proper focus of constitutional adjudication

343. See infra notes 412-430 and accompanying text.
on small numbers of persons within large groups, see the discussion below regarding abortion and spousal notification.\textsuperscript{345}

The symbolic value of affording all undocumented immigrants the right to purchase health insurance could be even more significant, dispelling the persistent misconception that Congress has a “plenary” power to do whatever it wishes concerning undocumented immigrants. Such talk arguably entices some States to seize undocumented immigrants to help the federal government in an unfettered assault on this vulnerable group.

The remainder of this article will assume for the sake of argument that the Court will not rubber stamp all federal actions against immigrants. It will assume that, at most, the fact that undocumented immigrants are the persons who are asserting claims might lead the Court to relax but not eliminate the scrutiny it would employ if documented persons or citizens were involved.

2. Badges and Incidents of Slavery

The 13\textsuperscript{th} Amendment can be invoked at this point as either a separate argument or to emphasize the egregious nature of prohibiting persons from contracting for the basic necessities of life such as health care or insurance. I am not an immigration scholar, and when I studied the topic to prepare this article I grappled for a conceptualization of undocumented immigrants’ status. The closest I could come to capturing their dire plight was through an analogy to escaped slaves prior to the Civil War. This led me to the 13\textsuperscript{th} Amendment where I found a rich literature and area for additional investigation. It is beyond the scope of this article to survey 13\textsuperscript{th} Amendment history and doctrine or to closely analyze the Amendment’s relationship to immigration. All I can do here is draw from the work of two scholars’ writings that I found particularly helpful and insightful for the current project. The first is self-described “African-American woman and legal scholar,” Rhonda Magee, whose article, \textit{Slavery As Immigration?}\textsuperscript{346} is both refreshing and edifying. She answers “yes” to the question put in the title of her article, which reads in part as follows:

My main claims here may be summarized as follows: the hundreds of thousands of people of African heritage forcibly transported to British North America under the chattel slavery system were a certain sort of immigrant; and chattel slavery was, among very many other things, a compulsory form of immigration, the protection and regulation of which, under federal and state law, was our nation’s first system of “immigration law.” As a consequence, the formal system that developed was inculcated with the notion of a permanent, quasi-citizen-

\textsuperscript{345} See infra notes 473-74 and accompanying text.

worker underclass and privileged white ethnics under naturalization
law—its legacies we can see up to the present day.347

Tracing the implications of her claims, she continues:

First, analyzing slavery as immigration … centers the demand of capital
for off-market labor as perhaps the most important of all shapers of
immigration policy in U.S. history . . . . Secondly, viewing slavery as
immigration promotes a more thorough consideration of how the
experiences of enslaved and free “noncitizen” Blacks shaped the
development of immigration policy in the founding generations. The
experiences of “free” and enslaved Blacks as immigrants and as present
and future candidates for citizenship in the slavery and post-slavery eras
yield important insights about the roots of social and cultural
construction of “noncitizens” and “quasi-citizens” reflected in
contemporary discourse and culture. . . . Finally, viewing immigration
as a function of slavery reveals an important irony: that with respect to
immigration, slavery—our racially based forced migration system—laid
a foundation for both a racially segmented, labor-based immigration
system, and a racially diverse (even if racially hierarchical) “nation of
immigrants”—legacies which the Founders may not have set out to
leave, but which are among our history’s most pernicious and most
precious gifts to civilization.”348

Professor Magee’s words obviously suggest parallels between enslaved
African Americans and their present day counterparts, undocumented
immigrants who too provide cheap labor and exist in the shadows. Professor
Maria Ontiveros makes this connection explicit in her article, The 13th
Amendment And Access To Education For Children Of Undocumented Workers:
A New Look At Plyler v. Doe,349 observing:

This Article rests on the theory that the institutionalized treatment of
undocumented immigrant workers in the United States has become
suspect under the Thirteenth Amendment. The presence and treatment
of undocumented workers in this country has become this century’s
“peculiar institution.” They are a caste of workers of color, laboring
beneath the floor for free labor, denied the rights of citizenship, and
subject to human rights abuses. Like slavery in the early nineteenth
century, the fact that the United States has a stated policy against
undocumented immigration and purportedly wants the undocumented
immigrants gone does not eliminate the facts that they are here, that the
state has set up a variety of structures that facilitate their subordination,

347. Id. at 276.
348. Id. at 297-99.
349. Maria L. Ontiveros & Joshua R. Drexler, The Thirteenth Amendment and Access to
Education for Children of Undocumented Workers: A New Look at Plyler v. Doe, 42 U.S.F. L.
Rev. 1045 (2008).
and that certain segments of society benefit from their presence. In fact, this institution has been established through a series of immigration and economic policies which encourage the presence of this exploitable caste of workers. Like slavery after the Civil War, the Constitution provides a legal framework for dismantling that institution.350

Professor Ontiveros next grounds her theory, first, on a “conservative” approach to the 13th Amendment, which she describes as follows:

The cases falling into the slavery line draw on very old Supreme Court language. Shortly after the passage of the Thirteenth Amendment, the Court stated that the Amendment decreed “civil and political freedom throughout the United States” and abolished not just slavery, but all “badges and incidents of slavery.” This language lay dormant for almost one hundred years. In 1968, in Jones v. Mayer, the Supreme Court used the Thirteenth Amendment to uphold a prohibition on private discrimination in real estate sales. . . . In Runyon v. McCrory, the Supreme Court prohibited private schools from discriminating on the basis of race, holding that such discrimination was prohibited as a badge and incident of slavery and constituted discrimination in the formation of contracts. In each of these cases, the Supreme Court upheld legislation passed by Congress pursuant to the slavery prong of the Thirteenth Amendment.351

Professor Ontiveros goes on to craft a broader, holistic approach to the 13th Amendment,352 but her words quoted thus far show how the 13th Amendment easily incorporates the notion that to deny discrete, insular groups basic civil rights such as the right to enter into contracts is a badge and incident of slavery. Professor Ontiveros also writes, in the context of a creative rewording of Plyler v. Doe, that Congress’s so-called plenary power should not enable the federal government to deny basic civil rights, stating:

The obvious need for delicate policy judgments has counseled the Judicial Branch to avoid intrusion into this field. However, congressional power in the area of immigration must not remain unfettered. To the extent that the plenary powers doctrine has been read to foreclose judicial review of congressional authority in matters relating to immigration, that policy is overstated. This conclusion is particularly true in situations where the policy on immigration runs afoul of other constitutional requirements and protections, such as those found in the Thirteenth Amendment.353

350. Id. at 1047.
351. Id. at 1063 (citing The Civil Rights Cases, 109 U.S. 3, 20 (1883), Jones v. Mayer, 392 U.S. 409 (1968), and Runyon v. McCrory, 427 U.S. 160 (1976)).
352. Id. at 1064-65.
353. Id. at 1061.
I will conclude this section by observing that the right to contract for health care coverage is just as important, if not more important, than the rights to contract for real property and for a private education. These latter rights are protected even against private action through Congressional legislation upheld by the Court in Jones v. Mayer354 and Runyon v. McCrary355 cited by Professor Ontiveros above. Denying the right to purchase health care or insurance that is the only way for certain persons to afford medical care is a badge and incident of slavery and should not be allowed to skulk behind the plenary power doctrine.

3. Is There a (Quasi-) Fundamental Right?

Let me begin by applying Glucksberg’s test, one of the most stringent of the five approaches to finding fundamental rights, which requires: (a) a narrow and precise description of the right, (b) that the right be deeply rooted in our traditions,356 and (c) is a necessary aspect of liberty and justice. The right at issue can be narrowly and precisely stated: to purchase health care insurance covering essential care. One can add to this articulation of the right or specify implied constraints on it and unpack justifications for it as follows. The care at issue has been released for marketing, insurance is the only way one can practically access such care, the care is necessary to avoid the risk of serious pain, injury, or (early) death (avoiding threats to bodily integrity and “life” itself), and such care will be implemented by making autonomous health care decisions after consultation with medical experts. One might argue that the suggested broadened articulation of the right is too wide and appends at least some of the reasons in support of a right to buy medical treatment (and insurance for it) to the right itself.

My answer is that at least if the implied limitations on and justifications for the right are made explicit upon its articulation, it is more likely to be narrow and precise rather than broad and vague. For example, the right to medical care might be construed to include an affirmative right to demand that the government supply care. By including the concept of the opportunity to purchase, it becomes clear that the specific right at issue does not include any such positive claim. The PPACA contains subsidies, tax credits, and certain exemptions on the basis of relative poverty. However, it excludes undocumented immigrants from these government-supplied benefits and I do not question those exclusions as unconstitutional under current doctrine. I question them on moral grounds I

356. This second requirement seems to embrace a kind of coherence assumption: no serious tensions in the various layers of tradition. Compare this to, say, Lawrence v. Texas, 539 U.S. 558 (2003), where there were still a fair number of laws on the books, but law enforcement conduct and general attitudes were moving in the other direction; there are traditions, sub-traditions, meta and overarching traditions. The test in Washington v. Glucksberg appears at 521 U.S. 702, 720-21 (1997).
hope are eventually recognized within constitutional doctrine. Thus undocumented immigrants’ purchases - assuming they could afford them at all - would be at full market value. Their constitutional right, defended here, is only a negative claim to be let alone to purchase in the market place.

Similarly, describing the right as including what might happen to a person as the direct result of being denied the right is relevant to both whether it should be recognized as a right, and, if so, whether it should be considered a special right. But if the right were articulated as including a right to maximum well-being, it would cover cosmetic surgery and other non-medically necessary treatment. Thus, reductio ad absurdum arguments can determine, to some degree, the breadth or narrowness of a right. In this case prevailing values concerning negative and affirmative rights determine the breadth or narrowness of the scope of those rights.

The policies available in the exchanges under the PPACA of course cover only “essential benefits,” and the right described here is only one to purchase essential care coverage. Moreover, recognizing that the right involves autonomy, bodily integrity, and health or life itself makes it more difficult for others to claim supposedly analogous rights that do not include this triumvirate of essential interests. Thus, the PPACA’s essential benefits would exclude routine cases of cosmetic surgery - for traits of aging, rather than socially disabling scars and deformities. Finally, describing the right as only extending to treatments that have been released for general consumption as opposed to experimental interventions distinguishes it from exotic claims such as a Second Amendment-based or inspired right to “self-defense” claims, including access to certain experimental treatments. The right fully articulated and explained above, and thereby made specific and narrow, will hereafter be called “the right to purchase health care insurance” for essential medical benefits.

Concerning the other two Glucksberg requirements (“tradition” and “necessary aspects of liberty and justice”), the Court, while formulating its approach, noted it had previously “assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment.” That is to say, the right to refuse treatment met its stringent criteria for fundamentality. Glucksberg relied upon Cruzan v. Director, Missouri Department of Health. In Cruzan the Court stated:

357. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 310 (cost-sharing), ¶ 305 (premium assistance credits).
358. See Alliance Abigail for Better Access to Developmental Drugs v. Von Eschenbach, 445 F.3d 470 (D.C. Cir. 2006), rev’d en banc, 495 F.3d 695 (D.C. Cir. 2007) (reversing panel decision that there was a fundamental right of access to stage two experimental drugs); Eugene Volokh, Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs, 120 Harv. L. Rev. 1813 (2007).
Before the turn of the century, this Court observed that “no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person . . . . “ This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment . . . . The informed consent doctrine has become firmly entrenched in American tort law. The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent.\[361\]

In *Cruzan* the Court reasoned that the right to refuse treatment is a corollary to the informed consent doctrine. In *Glucksberg* the Court reaffirmed the right to refuse treatment as meeting its strict criteria for “fundamental” rights. *Glucksberg* actually understates the force of *Cruzan* on the right to refuse treatment issue because it mischaracterizes *Cruzan* as making an assumption about the right to refuse treatment. *Cruzan* actually held that there is a fundamental right to refuse treatment. However, it also held that the state had a sufficient interest in protecting the lives of Ms. Cruzan and those like her to justify requiring clear and convincing evidence as to whether the incompetent patient has previously articulated a preference for non-treatment. It reasoned that the decision to refuse treatment results in the irreversible loss of life, while a decision to continue treatment could be subsequently changed.\[362\] This actually happened concerning Ms. Cruzan when further proceedings were held and additional information about her prior stated wishes was adduced.\[363\]

One must carefully analyze *Glucksberg* and *Cruzan* to appreciate their implications concerning a right to purchase health insurance. First, informed consent is not the core right recognized as special in *Cruzan* and *Glucksberg*. Rather, the core rights directly addressed were the rights to bodily integrity\[364\] and to self-determination regarding one’s bodily integrity.\[365\] These are the overarching concepts from which informed consent - which logically entails the right to refuse - are derived. Self-determination regarding one’s bodily integrity - sometimes life itself - obviously involves the rights to purchase or accept offered care and to choose among alternatives as well as to refuse care.

The discussion in this subsection leads to the conclusion that the right to purchase health insurance meets *Glucksberg’s* stringent requirements for

361. *Id.* at 269-70.
362. *Id.* at 283.
364. Perhaps bodily integrity is best understood as an autonomy interest. It is not a rigid concept which, for example, would prohibit donation of non-vital organs. It includes both protection against involuntary assaults on integrity and protections for voluntary compromise of such integrity. There is a grey zone, however, represented by deference that should be paid even to certain non-competent expressions concerning what treatments one should or should not be given.
recognition of fundamental rights. It is deeply rooted in our traditions and is a “necessary [aspect] of liberty and justice.” (It would be even easier to establish it as a quasi-fundamental right.)

Consider next application of the approach that fundamental rights must be “essential to the survival of our society or the functioning of important institutions within it.” The institutions referred to in the quoted language might only be constitutionally mandated structural institutions such as representative democracy and federalism. On the other hand, it is possible the Court would reason that the right to choose or refuse treatment after consultation with one’s physician is inextricably bound up with and necessary to the important institution of the physician-patient relationship.

A third approach stipulates that fundamental rights involve making intimate and important decisions concerning one’s life or relationships. The right to purchase health care insurance involves personal, intimate, and sometimes life-and-death decisions that might or might not affect important relationships. This approach most easily supports the right to purchase health care insurance.

The same right should qualify as fundamental even under the more specific criterion of method four, which finds fundamental only those interests that directly impact one’s ability to formulate and make intimate and important decisions. Being without health care insurance, which is, for all practical purposes in the near-term future, the only way one can access health care, poses risks of serious pain, loss of function, and even early death. These risks threaten the very ability to formulate and make decisions in any of these strongly protected fields of choice.

The right to purchase insurance is also fundamental under the fifth and final approach: considering all the factors within the first four methods and several other criteria the authorities have deemed relevant to finding rights to be fundamental and then comparing the application of the same criteria to prior cases where the Court has found fundamental rights. As I explained above, all the factors in the first four approaches can be argued to support finding the right to purchase health insurance to be fundamental. The same is true as to many other factors relevant in this approach. The right: (1) has a close nexus to previously recognized fundamental or special rights; (2) is within the core

368. Spece, Health Care, supra note 159, at 46-47.
meaning of “life” and “liberty” because it rests on bodily integrity and self-determination (sometimes implicating survival), which are among the interests “life” and “liberty” most obviously include (which is also part of the Glucksberg test but merits separate consideration and should be held sufficient to establish a fundamental right);370 (3) is non-economic although it involves “purchase;” (4) is personally important;371 and (5) is a negative (allow me to purchase health insurance) as opposed to a positive claim for provision of health care.

No previously recognized non-enumerated fundamental right has more methods of analysis and criteria pointing to its special status. It is most probable that the Court would hold it to be fundamental. At the least, the Court should find it to be quasi-fundamental or, in keeping with its current terminology, find it to be a “liberty interest” or “fundamental liberty interest” that draws heightened but less-than-strict scrutiny. This would be one way to give effect to a perceived need to protect Congress’s power over immigration. It would be misguided, however, because purchase of health care insurance has nothing to do with Congress’s immigration power, which should be interpreted to extend to entry, deportation, or violating specific legal prohibitions such as a mandate not to present fraudulent documents attesting to one’s legal status—matters within the areas of foreign affairs and national security.

4. Does Context One Involve a (Quasi-) Suspect Classification?

The classification here that supports an equal protection claim is that between, first, the vast majority of residents who are allowed to purchase insurance from the exchanges and, second, undocumented immigrants, the vast majority of whom can only access health care through the insurance they are not allowed to buy. If the State prohibits purchase outside the exchanges, there is a de jure bar. (I realize that many undocumented persons cannot even afford insurance, but some can.)372 Another classification is between, first, children of persons allowed to purchase health care insurance from an exchange and, second, children of persons who can only access care for their children through insurance they are not allowed to purchase.

Many criteria relevant to determining (quasi) suspect classifications apply to the groups that suffer from the ban on purchase from the exchanges: the undocumented and their children (hereafter assumed, unless otherwise stated, to


370. See supra notes 356-65 and accompanying text (discussing Glucksberg and Cruzan).
372. See supra note 344 and accompanying text.
be undocumented also) are subject to negative stereotypes and stigma; the undocumented children’s status is undeserved; changing status, as opposed to leaving the U.S., is virtually impossible for the vast majority of immigrants (thus a relatively immutable “illegal” status); the undocumented and their children are politically powerless; the undocumented and their children are an insulated and vulnerable group; and the undocumented and their children are distinct minorities. Although the majority of criteria relevant to identifying (quasi) suspect classifications apply to both the undocumented and their children, the Court is not likely to find either group protected under suspect or quasi-suspect classification doctrine. The Court has been loath to extend the range of (quasi) suspect classifications. It would likely unduly focus on the federal power involved, the adult undocumented being responsible for their “illegal” status, and on the fact that the status of both undocumented immigrants and their children is often relevant to lawmaking.

On the other hand, drawing on the protective interpretation or reconstruction of *Plyler v. Doe* discussed above, the Court might analyze the prohibition as if it creates a quasi-suspect classification impinging on a quasi-fundamental right to purchase health care insurance, at least insofar as children of the undocumented are concerned. It might do so without even mentioning the concepts of quasi-suspect and quasi-fundamental. *Plyler* can be nominally distinguished, however, because it involved state rather than federal power. The Court might refuse to apply *Plyler* to the context of children obtaining health care insurance because of a misperception that the distinctive federal powers and interests would outweigh countervailing considerations, unlike at the state level. I described above why the belief that there are distinctive federal interests in this context is a misperception. Furthermore, here the parents and children seek only to purchase health care insurance; they are not, as in *Plyler*, asking for a state-funded benefit such as education.

Finally, many children of the undocumented are citizens. The bar against their parents and their parents’ justified increased fear of the government as PPACA tightens its screws could well deter them from attempting to exercise their children’s eligibility. This is a substantial intrusion and should entitle the children to the protection of strict or intermediate scrutiny, assumed to apply based on the earlier fundamental/quasi-fundamental rights analysis, which they

373. See supra notes 306-10, 325-28 and accompanying text; Cindy Chang, Note, *Health Care for Undocumented Immigrant Children: Special Members of an Underclass*, 83 WASH. U. L.Q. 1271 (2005) (concluding that undocumented immigrant children would not have a right to be provided health care by the federal government, but arguing that giving such care is strongly supported by public health policy and moral concerns).

374. See supra text accompanying notes 335-48.

could pursue through guardians or their parents - using Plyler designations to protect the undocumented immigrants’ identities.

5. Application of Strict and Intermediate Scrutiny to the Prohibition on Purchase of Healthcare Insurance

a. What are the Relevant Interests?

The Court has held that the government must prove its actual interests under strict scrutiny. This is completely opposite from the rational basis test requirement that the government’s opponent must show that the government has no conceivable legitimate interest. Under heightened scrutiny there might be many conceivable legitimate interests and some of these might have actually been asserted in the litigation. However, if the Court finds that none of these legitimate interests was the actual interest the legislature addressed and that the actual interest or interests were illegitimate, the government’s action will be judged unconstitutional. The Plyler v. Doe intermediate test does not seem to call for probing the government’s actual interest, and I am assuming for purposes of analysis that Plyler would be used if the Court decided to apply intermediate scrutiny.

It is difficult to identify the government’s actual interest in prohibiting undocumented immigrants from purchasing health care insurance. The PPACA as a whole is intended to encourage purchase. Some indication can be found in a Rasmussen telephone poll of one thousand likely voters, 80% of whom answered no to the question: “Should the government provide health care coverage for illegal immigrants?” This could just mean that they did not want the government to pay for coverage. On the other hand, it could be taken to signal that the government, being aware of the poll, either thought it could not get the PPACA enacted or have it supported after enactment unless it excluded undocumented immigrants without qualification. The “bipartisan six” who led bipartisan negotiations on health care reform apparently thought that even allowing undocumented immigrants to purchase on the exchanges would jeopardize support for such legislation. This could mean that undocumented immigrants were excluded simply to secure passage of the remainder of the PPACA.

376. Vill. of Arlington Heights v. Metro. Hous. Auth., 429 U.S. 252, 270-71 n.21 (1977) (proof that a governmental decision was motivated in part by a racially discriminatory purpose [and by analogy any other illegitimate purpose] will lead to invalidation of the action unless the government meets “the burden of establishing that the same decision would have resulted even had the impermissible purpose not been considered”).

377. See supra note 310 and accompanying text (quoting the Plyler test).

378. As I have reasoned, were it not for the persistent loose talk by the Court and others about a Congressional plenary power, strict scrutiny should apply here. See supra text accompanying notes 335-60.
Such an interest would be similar to ones asserted in Chaoulli v. Quebec\(^{379}\) where, in light of substantial waiting lists, the Canadian high court struck down Quebec’s prohibition on purchase of supplemental insurance covering care available within its universal plan’s benefits package.\(^{380}\) There the government argued, among other interests, that it sought to (1) assure political support for the government mandated system by persons who would otherwise simply obtain supplemental care and lose concern about the system and (2) encourage political pressure for improvement of the government system by the same persons. As will be explained in the next subsection, however, the U.S. Supreme Court should usually consider arguments that government acted to convince a certain constituency or governmental actor to support enactment, improvement, or non-repeal of its actions to be either circular or impermissible.\(^{381}\) Conversely, there is a possibility that statements by legislative constituencies will be relevant to showing illegitimate actual interests.

Other possible actual interests are (1) to improve the siege against undocumented immigrants by adding non-access to health care to a litany of current disadvantages such as exclusion from jobs and, in some geographical locations, housing - this is evidently meant to make undocumented immigrants’ lives so brutal in the U.S. that they will either leave or never come; (2) to preserve health care resources or to save these resources for persons who are more likely to remain residents and contribute to our culture or economy; and (3) to preserve our societal integrity by preventing outsiders from eating away at our community and culture. I suspect that either the interest in political support or in strengthening the siege against undocumented immigrants was the government’s actual interest. As to an interest in political support, the PPACA was hotly contested and the Obama administration needed every constituency it could muster.\(^{382}\) It could have sacrificed certain interests of undocumented immigrants primarily to gain the support of people who have an irrational fear or hatred of undocumented immigrants. Concerning a siege, a desire to engage in one is reflected in a spate of federal and state laws meant to “freeze out” undocumented immigrants.\(^{383}\) Reflecting on the interest in protecting societal integrity, it is

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380. Id. at ¶¶ 46-99, 154-59.
381. See infra notes 384-88 and accompanying text.
382. While the PPACA was being debated and thereafter, the overwhelming majority of states considered constitutional amendments or legislation supposedly nullifying the expected and then new law. See Richard Cauchi, National Conference of State Legislatures, *State Legislation and Actions Challenging Certain Health Reforms, 2011*, http://www.ncsl.org/default.aspx?tabid=18906 (updated Apr. 11, 2011).
important but not actually advanced by inhumane treatment of undocumented immigrants. I will nevertheless assume that each of the interests mentioned here could be found to be the government’s actual interest, and will assess the legitimacy and weight of each.

b. Would the Court Find the Government’s Interests Legitimate?

All forms of scrutiny require at least a legitimate state interest. Consider first the possible interest in political support for the PPACA. This form of argument must be carefully analyzed. In a sense, it is circular in two ways. One is the implicit assumption that if the ultimate goal is acceptable (the PPACA in general), then any means of supporting it, including severely burdening undocumented immigrants, would be ok - but that is what is at issue. The second circularity is that it presumes the constitutional validity of the ultimate goal. One question when such arguments are made is what the constituency’s actual interest was. Otherwise, in some situations the government could come into court and simply state that its interest in a particular provision of a legislative program was to ensure the passage, implementation, or continued existence of the entire program by obtaining the vote of Senator X or the support of a certain industry. Although some persons persuasively argue that this is the way our political system works, the Court has rejected this bring-home-the-bacon or pork-barrel conception of democracy when undertaking due process and equal protection analysis. It has assumed that legislatures act to further beneficial goals rather than to make political payoffs.384 (The traditional rational basis test usually does nothing to enforce this ideal.) Therefore, to assert the support of a certain person or group is circular because it suspends all Constitutional inquiry or reduces it to “this is what we have to do to get what we want, and if what we want is valid, so is the means of achieving it.” It must be emphasized that the Court has made it clear that means as well as ends can be held illegitimate.385

The relevant questions are what the interests of these constituencies were and whether they were embraced by the legislators. The constituencies might have thrown in their support in hopes that enactment would disadvantage persons who they consider enemies out of irrational hatred or fear (undocumented immigrants). Such interests are obviously illegitimate.386 On the other hand, the constituencies might have supported legitimate interests sought

bills have been approved in at least thirty-three states. These ordinances include those similar to the one in Hazelton, Pennsylvania, which imposes fines on landlords who lease apartments . . . “).


by the enactment’s legislative “sponsors” and their legislative colleagues who supported the legislation. If the legislators had good purposes in mind but their constituencies’ interests were illegitimate, the latter’s interests should not be automatically imputed to the legislature. If there is no imputation, the question about the constituencies’ interests is not directly relevant. The central question goes back to: What were the legislature’s interests? Once again, the constituencies’ interests might be relevant evidence concerning the legislature’s actual interests, but they are not controlling.

Encouraging or bargaining for political support for enactment of health care reform and continuing support for it if enacted sound innocuous. However, these goals might actually be illegitimate. They can be characterized as intentions to manipulate persons or to bargain with them to support, advocate, or vote for enactment, maintenance, and actual extension of health care reform even if they object to or consider unconstitutional important parts of it. This commandeering conceivably could be found to interfere with constitutional freedoms to think, speak, refuse to speak, or vote of the persons who are enticed to cynically bargain to support legislation they generally oppose, who are manipulated, or who partake in good faith in the political process. To some extent this is just ordinary political persuasion. However, to the extent it is conceding to unconstitutional goals to get laws passed, it is not just ordinary legislative horse-trading or everyday politics.

On the other hand, the Court might determine that the disputed goals represent legitimate government interests in channeling public attitudes toward favoring a government mandated health care program that will help millions of persons, including many of those currently not covered by public or private insurance. The Court has reasoned in the abortion funding cases that the government can structure health care programs in a way to encourage childbirth

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387. See Vill. of Arlington Heights v. Metro. Hous. Auth., 429 U.S. 252, 267-68 (1977) (not mentioning constituents’ interests but mentioning “minutes of . . . meetings” and noting that its list of relevant criteria was undertaken “without purporting to be exhaustive . . . ”).

over abortion to further a strong interest in supporting the sanctity of life.\textsuperscript{389} In \textit{Rust v. Sullivan}\textsuperscript{390} the Court also allowed the government great leeway in directly controlling what physicians can say about reproductive options within government funded health care programs. It might be found, however, that indirect but intentional channeling of persons’ attitudes, beliefs, behavior, and voting are more objectionable than explicit programs. The former are insidious manipulations, and being sub visible, are thus to that extent insulated from attack. Explicit programs are visible, welcome challenge, and at least require explanation and consequent accountability.

Turning to a possible government interest in mounting or enhancing a pervasive siege against undocumented immigrants, this should be characterized as illegitimate. The government certainly has interests in deterring illegal immigration and encouraging the exit of persons who are not legally here. But these ends do not justify any and all possible means. For example, all but the most xenophobic bigots would admit that it would be constitutionally impermissible for government personnel to shoot undocumented immigrants randomly and on sight. If one thinks it through, preventing the purchase of health insurance needed to access possibly life-saving care is virtually of the same order of barbarity. If such a means to the end of reducing the number of undocumented immigrants were held legitimate, there would be no stopping point. If the government can prevent the purchase of health care insurance as part of an overall legislative scheme, it can prohibit the direct purchase or provision of health care, food, water, or police protection.

Deprivations of vital necessities such as health care and insurance necessary to access it would be barbarous and would debase those who countenance it. It is illegitimate because it is a limitless and horrendous burden—“no health care for you”—inflicted on a specific, despised group. It violates their rights to substantive due process and equal protection. It is a badge and incident of slavery prohibited by the 13\textsuperscript{th} Amendment. At the least, it should be held to embrace an irrational hatred or fear of an entire subgroup of millions of persons present in the U.S. Such hatred or fear is deemed illegitimate by cases such as \textit{Romer v. Evans},\textsuperscript{391} \textit{City of Cleburne v. Cleburne Living Center},\textsuperscript{392} and \textit{Lawrence v. Texas}.\textsuperscript{393}

A thought experiment might help make my point. Assume arguendo that it is, standing alone, constitutionally invalid to single out undocumented immigrants by excluding them from the opportunity to purchase health care.

\begin{footnotesize}
\begin{enumerate}
\item Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 450 (1985) (“irrational prejudice against the mentally retarded”).
\item Lawrence v. Texas, 539 U.S. 558, 575 (2003) (\textit{Bowers v. Hardwick} “demeans the lives of homosexual persons” and is, therefore, overruled).
\end{enumerate}
\end{footnotesize}
insurance. Would this become valid if the exclusion were enacted in order to secure passage of the entire the PPACA (assuming the PPACA is otherwise valid)? The answer is obviously “no,” but “yes” must be the answer from those who invoke a government interest in securing political support for the PPACA.

It is worth noting that the only other group currently not eligible to purchase health care insurance through the exchanges is prisoners, who, of course, at least are, by law, supposed to be given basic necessities of life and health care. Carried to its logical conclusion, the siege would deny undocumented immigrants, including children, basic necessities that are guaranteed to prisoners, even prisoners of war. The current administration has spoken out against recent state laws targeted at undocumented immigrants that are clearly within the category of a siege, e.g., prohibiting rental of shelter to undocumented immigrants. But health care can be just as important as shelter, if not more so, and the current Administration’s attack on such state laws—even seeking an injunction against enforcement of legislation in my own State of Arizona - should make the Court wary of any argument that federal legislation of the same (or greater) level of barbarity is not illegitimate.

Consider next the interest in protecting societal integrity. Many citizens believe that our very existence as a community or culture - our “societal integrity” - is threatened by undocumented immigrants. The stronger position is that it is palpably apparent that the government’s community integrity

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394. CCH ¶ 220 ("Individuals who are incarcerated, other than those whose incarceration is pending the disposition of charges, are not to be treated as qualified individuals").
399. Jason Lee, Unlawful Status as a “Constitutional Irrelevancy”? The Equal Protection Rights of Illegal Immigrants, 39 GOLDEN GATE U. L. REV. 1 (2008) (most undocumented immigrants are Latino (n.8); there has been a spate of laws detrimental to undocumented immigrants; City of Escondido, California in 2006 adopted a law penalizing any person or business that rented to undocumented immigrants; earlier that year the City of Hazelton, Pennsylvania passed a similar law and required documents to be in English only (p. 4); estimated 12 million in 2005 (p. 2); acknowledging and critically analyzing Schuck’s view that giving too many rights and constitutional protections to legal, and thus even more so illegal, immigrants weakens formal citizens’ ability to create a “bond among individuals in a polygot society like ours in which there are relatively few other affective linkages or commonalities;” also acknowledging and critically analyzing Perry’s view that non-citizenship and illegal presence are morally relevant to identifying the principle behind equal protection law (pp. 24-27); discussing body of state and federal cases “in support of the irrelevancy of an illegal immigrant’s unlawful status” (p. 18); noting consensus that undocumented immigrants are “persons” protected by the U.S. Constitution (p. 8)).
interests, whatever they are, are not significantly at risk in the context of prohibiting undocumented persons’ purchase of health insurance.

As noted above, this is not a case of undocumented immigrants eating away at our community and culture; it is not about participation in governance or giving them expensive benefits, but is about allowing them to purchase health insurance so they do not become a burden. Furthermore, although at times we have fallen prey to xenophobia and the voice of prejudice currently shrills loudly in many quarters, the deepest and best tradition of our community and culture embraces the notion of constitutional protection and civility toward “outsiders”—after all they are “persons” even in the constitutional sense. The supposed interest in societal integrity should be found illegitimate insofar as government purports to protect it by denying undocumented immigrants basic necessities of life such as the insurance essential for securing health care. Such attempts actually besmirch societal integrity—more precisely, society as it is understood in American tradition.

The only interest that seems legitimate is the one in preserving medical resources for legal residents (who, in addition, might be more likely to remain in our country and contribute to our culture or economy). As will be argued below, however, this interest is speculative and slight at best. It therefore likely would be impossible for the government to prove that it was an actual interest and that it is put at significant risk. This leaves only the interests analyzed above and shown likely to be illegitimate as the government’s actual interest.

c. Would the Court Find the Government’s Interests Compelling or Substantial?

Strict scrutiny requires a compelling government interest. The Plyler v Doe test seems to require a “substantial” government interest, and it makes reference

400. See Emma Lazarus, The New Colossus, Poem, http://www.libertystatepark.com/emma.htm (a poem by Emma Lazarus graven on a tablet within the pedestal on which the Statue of Liberty National Monument stands: “Not like the brazen giant of Greek fame,With conquering limbs astride from land to land;/ Here at our sea-washed, sunset gates shall stand/ A mighty woman with a torch, whose flame/ Is the imprisoned lightning, and her name/ Mother of Exiles. From her beacon-hand/ Glows world-wide welcome; her mild eyes command/ The air-bridged harbor that twin cities frame:/ ‘Keep ancient lands, your storied pomp!’ cries she/ With silent lips. ‘Give me your tired, your poor,/ Your huddled masses yearning to breathe free,/ The wretched refuse of your teeming shore./ Send these, the homeless, tempest-tost to me,/ I lift my lamp beside the golden door!’”); Mike Unger, American University Campus News, Obama Speaks on Immigration at AU, July 2, 2010, http://www.american.edu/americantoday/campus-news/20100701obama-immigration-reform.cfm (we must “shape a system that reflects our values as a nation of laws and a nation of immigrants”); Andrea Orr, Economic Policy Institute, A Nation of Immigrants, Aug. 31, 2010, www.epi.org/analysis_and_opinion/entry/making_immigration_work (focus on Arizona’s controversial immigration law and illegal immigration “misses the tremendous benefit that the United States gets from immigrants. America’s diversity is one of its greatest strengths . . . .”).

401. In Plyler, discussed in the text at Part IV(A)(2) supra, the government argued that undocumented immigrants were not persons within the jurisdiction of the U.S., but the Court rejected this argument. Plyler v. Doe, 457 U.S. 210 (1982).
to balancing throughout the test. Therefore its requirement as to sufficiency of the government’s interest can be interpreted to mandate that the government’s interests outweigh its opponent’s interests.

Although establishing fundamental rights is an elusive endeavor, there is even more ambiguity in identifying compelling state interests. The Court has characterized certain interests as compelling (e.g., survival of the nation)\(^ {402}\) or not compelling (e.g., fiscal concerns and administrative convenience, at least in most cases).\(^ {403}\) It is also clear that compelling interests must lie toward or at the top of a hierarchy of interests.\(^ {404}\) Beyond this, and possibly an uncertain and unemphasized role for tradition, the Court has not offered any methods for identifying compelling interests, and it is not apparent that any systematic account can be given because of irremediable value uncertainties. A good place to start, however, is to posit that governmental interests in preserving fundamental rights and protecting important equality values are compelling.\(^ {405}\) (Of course, this is not without difficulty because it is often hard to identify fundamental rights or suspect classifications.) However, compelling interests obviously cannot be limited to the protection of fundamental rights and equality values.

A particular ambiguity exists concerning whether identifying compelling interests requires a comparison with the competing fundamental right or equality interest involved in each case, and, if so, whether one is to compare the competing values in the abstract or in light of how intense the threat to the right or interest is. I assume that, to be classified as compelling, a government interest must be at a position in a hierarchy of values roughly equivalent to the position of the competing fundamental right or interest with respect to political, social, and moral importance. (The community obviously has overwhelmingly

\(^{402}\) Korematsu v. United States, 323 U.S. 214, 216-21 (1944), \(reh'g den.\), 324 U.S. 885 (1945) (internment of Japanese-Americans, including U.S. citizens, in World War II upheld as necessary to our defense against sabotage and invasion). \(But see John E. Nowak & Ronald D. Rotunda, Constitutional Law \(\S\) 6.11, n.5 (“Korematsu should not be considered good law as to its specific result”).

\(^{403}\) Schneider v. New Jersey, 308 U.S. 147, 162-63 (1939) (burden of cleaning and caring for streets - obviously a fiscal concern - not sufficient to justify ban on leafleting, an activity within the fundamental right to freedom of speech); Carrington v. Rash, 380 U.S. 89, 94 (1965) (states may not casually deprive a class of individuals of the right to vote because of some remote administrative benefit to the State).

\(^{404}\) Wisconsin v. Yoder, 406 U.S. 205, 215 (1972) (“The essence of all that has been said and written on the subject is that only those interests of the highest order . . . can overbalance legitimate claims to free exercise of religion.”); Swanner v. Anchorage Equal Rights Comm’n, 513 U.S. 979, 982 (1994) (Thomas, J., dissenting) (preventing discrimination on the basis of marital status not compelling because not “of the highest order”).

\(^{405}\) See, e.g., Grutter v. Bollinger, 539 U.S. 306, 324-28 (2003) (academic freedom concerning educational diversity a compelling state interest justifying law school’s affirmative action program in which race was taken into account along with other factors); Roberts v. Jaycees, 468 U.S. 609, 628 (1984) (preventing gender discrimination was compelling interest justifying limitation on fundamental right of freedom of association).
important interests in preserving individual freedom—no paradox here.) In other words, both fundamental rights and compelling government interests are in the top tier of a hierarchy of values. I also assume that the ultimate strength of the government interest is considered at the stage of determining whether it has been substantially advanced, and that, for a substantial advancement to be found, the degree of the government interest at risk and likely to be preserved must outweigh the loss involved with respect to the nature and degree of the fundamental right or equality value at stake.406

Given the above thoughts about identifying compelling state interests, I return to consideration of the possible government interests in the PPACA’s prohibition on undocumented immigrants purchasing health care insurance in the exchanges: garnering political support, effecting or enhancing a siege against undocumented immigrants so they will leave or never come here, preserving societal integrity, and allocating health care resources to individuals who might be more likely to stay in the U.S. Even if one or more of these interests were shown to be both an actual and a legitimate interest, none of them should be considered compelling or weighty enough to withstand any scrutiny beyond the rational basis test and its legitimate government interest requirement. None of these interests embeds equality interests associated with the strict scrutiny doctrine and none of them is necessary to survival of the nation, or meets the requirements of any of the five approaches to divining fundamental rights discussed above.407

One might argue that preserving health care resources is at the top of a hierarchy of interests—and indeed the importance of health care is at the core of my argument in favor of undocumented immigrants’ right to purchase health insurance. The answer, however, is that health care resources might actually be preserved by allowing immigrants to purchase health care insurance. Their participation could help hold down the per capita costs of health insurance, while their non-participation might increase the ultimate consumption of health care resources through undocumented immigrants’ use of expensive delayed or emergency care. For example, the federal Emergency Medical Treatment And Labor Act408 is explicitly preserved in the PPACA; it protects undocumented immigrants, and it requires hospitals to accept all women in labor and to screen all other persons who present in emergency rooms as to the need for emergency

406. Spece, Health Care, supra note 159, at 55 n.168 (“This incorporates balancing into the means-ends analysis prong of strict scrutiny, but this is not the equivalent of generalized balancing, i.e., a single balance that alone defines the standard of review. For example, in order to be considered relevant, government interests have to be actual, and to be characterized as compelling they have to lie toward the top of a metaphorical hierarchy of interests or values.”).

407. See supra notes 316-20 and accompanying text.

care. If there is an emergency, the hospital must supply stabilizing care regardless of ability to pay, through insurance or otherwise.\footnote{Id. at §§ 1395dd(a) & (c).}

Regardless, it is likely that the government could not prove that allowing undocumented immigrants to purchase health care insurance would significantly reduce scarce health care resources for those persons likely to remain in the U.S. because there is no preponderance of evidence that immigrants come here for health care, would leave after receiving health care secured through private insurance, or would consume enough medical resources to cause a shortage of those resources.\footnote{The appellate court in Plyler v. Doe cited to evidence and studies that indicated: (a) undocumented immigrants did not come to the U.S. for purposes of obtaining an education for their children; and (b) there was no special burden to the State or its educational system because of undocumented children. Doe v. Plyler, 458 F. Supp. 569, 573-79 (D.C. Tex. 1978), aff’d, 628 F.2d 448 (C.A. Tex. 1980). Similarly the government could not show that undocumented immigrants come here to purchase health insurance or that those relatively few who would buy insurance would cause a shortage of health care resources. Their priorities are survival and helping their family members left behind. Steven Wallace et al., The Consequences of Color-Blind Health Policy for Older Racial and Ethnic Minorities, 9 STAN. L. & POL’Y REV. 329, 337 (1998) (immigrants are drawn to the U.S. by prospects of work, not government benefits); John Lahad, Dreaming a Common Dream, Living a Common Nightmare: Abuses and Rights of Immigrant Workers in the United States, the European Union, and the United Arab Emirates, 31 HOUS. J. INT’L L. 653, 678-79 (survival of themselves and those they leave behind). In fact, even the larger group of undocumented immigrants who do not have insurance have not been shown to present any special burden: “Immigrants across-the-board use fewer health care resources—from office visits to emergency room visits—than U.S. Citizens.” Marshall Fitz, Center for American Progress, Fact Check: Health Care and Undocumented Immigrants, Sept. 11, 2009, http://www.americanprogress.org/issues/2009/09/immigration_health.html. Furthermore, as indicated in the text at note 419 infra, the States would probably benefit by covering undocumented immigrants who meet low income guidelines with public resources.}

\footnote{Plyler v. Doe, 457 U.S. 202, 227-29 (1982).}


In Plyler the Court observed that the State had not even shown that undocumented school children would likely leave the state or that they posed any unique burden on the state.\footnote{Plyler v. Doe, 457 U.S. 202, 227-29 (1982).} This suggests that, similarly, the government could not show that denying purchase of health care would encourage undocumented immigrants to leave or that they pose any distinct burden. Instead, they would likely remain, uninsured, and seek only late, expensive, emergency care. One might argue that a siege on undocumented immigrants is necessary to deal with huge general financial costs or security risks argued by some to be associated with undocumented immigrants and their children,\footnote{Richard Wolf, Rising Health Care Costs Put Focus on Illegal Immigrants, USA TODAY, updated Jan. 22, 2008, http://www.usatoday.com/news/washington/2008-01-21-immigrant-healthcare_N.htm (“At the state and local level, illegal immigrants already cost more in public services such as education and health care than they pay in taxes . . . .” but the amount spent varies among the States); Fox News.com, L.A. Emergency Rooms Full of Illegal Immigrants, Mar. 18, 2005, http://www.foxnews.com/printer_friendly_story/0,2566,150750,00.html (“Overburdened by the uninsured and overwhelmed by illegal immigration, public health care in Los Angeles is on life support.”); Judith Gans, Immigration and U.S. Health Care Costs, Udall Center Fact Sheet No. 2, Sept. 2006, at 2, 4 http://udallcenter.arizona.edu/immigration/publications/} or to preserve our societal integrity, or, once again, that preserving
scarce health care resources for legal residents is bound up with the fundamental right to make health care decisions. 413 However, these arguments are, to a large extent, about saving money. As explained above, fiscal considerations are not considered compelling. 414 It might be argued that these are more than fiscal considerations because they involve general security, the ideal of societal integrity, and preservation of scarce health care resources for those likely to remain in the U.S. However, these interests, including the interest in preserving health care resources, will be shown to be relatively slight, or actually cut the other way, in this context. This will be established below when I examine further whether they are actual problems, if so, how big these problems are, and how weighty they are compared to undocumented immigrants’ rights to purchase health care insurance. 415 Recall also the arguments above concerning the 

fact_sheet_no_2_health_care_costs.pdf ("[A]n estimated 41 percent of unauthorized adults, 47 percent of unauthorized children, and 75 percent of native-born children of unauthorized parents do have health insurance . . . . Unauthorized immigration is not the major cause of increases in uninsurance or uncompensated care costs in the United States."); Executive Office of the President, Council of Economic Advisers, Immigration’s Economic Impact, June 20, 2007, at pp. 1, 2, & p. 1 n.1. http://georgewbush-whitehouse.archives.gov/cea/cea_immigration_062007.html ("This document will use ‘immigrant’ and ‘foreign born’ interchangeably. The terms encompass both legal and illegal migrants. Because it is difficult to determine the legal status of migrants in standard data sets, the economics literature generally assesses all foreign-born workers together.” “Immigrants are a critical part of the U.S. workforce and contribute to productivity growth and technological advancement.” “Many immigrants are entrepreneurs.” “Immigrants and their children assimilate into U.S. culture.” “Immigrants have lower crime rates than natives.” “Immigrants slightly improve the solvency of pay-as-you-go entitlement programs such as Social Security and Medicare.” “The long-run impact of immigration on public budgets is likely to be positive.” “[I]t is not easy to distinguish the influence of immigration from that of other economic forces at work at the same time. Nor is it easy to project costs and benefits far into the future. Nonetheless, economists and demographers have made headway on many of the measurement problems. This white paper assesses immigration’s economic impact based on the professional literature and concludes that immigration has a positive effect on the American economy as a whole and on the income of native-born American workers.”); Daniel Griswold, Cato Institute, As Immigrants Move In, Americans Move Up, Free Trade Bulletin No. 38, July 21, 2009, http://www.cato.org/pub_display.php?pub_id=10650 (“Ironically, illegal immigrants who break U.S. immigration laws to enter the United States appear much more likely than native-born Americans to respect our domestic criminal code once they are inside the country. Once here, low-skilled immigrants, as a rule, get down to the business of earning money, sending home remittances, and staying out of trouble. The wider benefit to our society is that, in comparison to 15 years ago, a member of today’s underclass, standing on a street corner, is more likely to be waiting for a job than a drug deal. Contrary to popular notions, low-skilled immigration has not contributed to a swelling of the underclass, or any increase at all, nor has it contributed to a rise in crime or other antisocial behaviors. In fact, it would be more plausible to argue that low-skilled immigration has actually accelerated the upward mobility of Americans on the lower end of the socioeconomic ladder. At the same time, the influx of low-skilled immigrants has helped to transform the American underclass into a demographic group that is still poor—but more inclined to work and less prone to crime.”); Nina Rabin et al., Understanding Plyler’s Legacy: Voices from Border Schools, 37 J.L. & EDUC. 15, 30-32 (2008) (speaking to “the rich culture and life experiences that undocumented students bring to schools they attend”).

413. See supra text accompanying notes 408-12.
414. See supra note 403 and accompanying text.
415. See infra notes 424-26 and accompanying text.
possible illegitimacy, in the present context, of manufacturing or cynically bargaining for political support, implementing a siege, and supposedly preserving societal integrity.\[^{416}\] The analysis here and below is relevant both to determine whether an interest is compelling and whether it is substantial or sufficiently weighty.

The \textit{Plyler v. Doe} test requires that there be a “substantial” interest and that the interests of both parties must be weighed.\[^{417}\] The \textit{Plyler} Court also weighed certain State interests as supporting its opponents’ rights.\[^{418}\] Here too certain government interests seem to support its opponents and the balance seems to tip in favor of the undocumented immigrants. The government might actually benefit by allowing them to purchase health care insurance.\[^{419}\] Therefore, the Court would likely find the government’s interest not substantial or sufficiently weighty.

\[^{416}\] See supra notes 382-400 and accompanying text.
\[^{418}\] Id.

\[^{420}\] Griswold, supra note 412.
\[^{421}\] Janet Dolgin & Kathrine Dietrich, \textit{When Others Get Too Close: Immigrants, Class, and the Health Care Debate}, 19 CORNELL J.L. & PUB. POL’Y 283, 304-05 (2010) (“Undocumented immigrants, in particular, feared, and continue to fear, being reported to federal immigration authorities as a result of identifying themselves to any government agent.”).
d. Would the Court Find a Substantial or Close Means-Ends Connection?

The compelling state interest test requires a “substantial” means-ends connection, while the Plyler test requires a “close connection.” Substantial and close connection are ambiguous and possibly overlapping. Still, attorneys must address these requirements in actual litigation, and therefore it is necessary to shed some light on their possible meaning. Arguably, the only way to cabin “substantial” and prevent it from being a concept within the absolute discretion of judges to define case-by-case is to interpret it to mean sufficient to make the amount of government interest at stake weightier than or proportionate to the individual interests at issue. Nevertheless, “substantial” might just mean a connection within a range of magnitude considered significant by the Court, or marked off and indicated to be sufficient by an emerging line of precedents. “Close connection” might be construed to be something akin to, but a little less than, “substantial.” Such an interpretation could be based on the rationale that if the compelling state interest requires a “substantial” connection, an intermediate test should require something less than, but similar to, a “substantial” connection. On the other hand, “close” seems to connote at least the same level of rigor as “substantial.”

I obviously cannot resolve the meaning of these various terms here. (Complete resolvability is impossible, in any case.) I can nevertheless examine how the possible meanings of the terms suggested here might apply to the various government interests at issue. As to political support, even in light of the legislative fight over the PPACA, it is highly unlikely the government could show that allowing undocumented immigrants to purchase health care insurance would have, to any significant extent, threatened the passage of or undercut future support of the PPACA. It is also unlikely that the government could show that disallowing purchase of health insurance would tighten the siege on them sufficiently to force significant numbers of them to leave or never come to the U.S. Their overwhelming priorities are sustenance and helping their families who remain behind.

It is likely that proportionally small numbers of undocumented immigrants would even have the resources or willingness to purchase insurance. They are commonly hesitant to engage with formal institutions, such as insurance companies, that inevitably demand a certain level of detailed information from the undocumented immigrants that the latter fear may spur their deportation. It is equally improbable that the government could show that the number of undocumented immigrants who might access health care through insurance is great enough so that they would utilize health care resources to an extent that would significantly effect or affect any scarcity of health care resources. In fact, the PPACA is premised on the notion that forcing persons to purchase insurance
will lead to lower premiums, greater access to preventive and general health care, and amelioration of the over utilization of expensive emergency care. The PPACA requires plans to cover specified preventive services without any cost-sharing by insureds, with more requirements as to certain care for women and for children. The rationale is that this broad-based preventive or ordinary care will be more efficient than later more complex or expensive care. There is no reason this rationale should not apply to undocumented immigrants, especially when all persons must be given emergency services pursuant to federal statute.

One might suggest that if few undocumented immigrants can or will purchase insurance, the issue is entirely symbolic. Even if so, symbolism is essential to reinforcing American principles. Protecting the fundamental rights of even a small number of persons is part of the notion of securing a (quasi) fundamental right. (This will be discussed in Section V. below.) It is inherently unjust to deny someone his fundamental right just because there aren’t too many others in a position to exercise it. It is also an assault on one’s rights to be foreclosed from an opportunity that one is only remotely or contingently foreclosed from pursuing—and one has standing to pursue this.

Turning to arguments about overall (not just medical) costs or benefits associated with the presence of millions of undocumented persons, these points are vehemently contested. There is, no doubt, an irregular distribution of costs and benefits over geographical and other categorizations, but the better view is that there is an overall net benefit to the presence of undocumented immigrants. Concerning security risks, it is absurd on its face to think that terrorists or drug thugs would refrain from coming to the U.S. because they could not buy health insurance. It is noteworthy that not many terrorists are from Latin America (which includes Mexico and the Caribbean).

Concerning preservation of societal integrity, I have shown above that, in this context, supposed pursuit of it would besmirch us and our deepest traditions.

In summary, the government would have a difficult time showing either that any of its interests is at risk or that prohibiting undocumented immigrants’ purchase of health care insurance would more than slightly advance any interest that was actually at risk. Recall that a minimal advance is not enough, assuming it even occurs. The government’s slight, if not suspect, interests are outweighed

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422. See John T. Palter, The Health Care Act of 2010: A Timeline of Implementation and Critical Review, 2010 ASPATORE SPECIAL REP. 9, 1-2 (May 2010); see also CCH’s Explanation of the PPACA, supra note 9, at ¶ 109 (must be specified preventive services, including additional ones delineated for women and children, without cost-sharing), ¶ 205 (by 2014 basic health services in qualified plan must include preventive and wellness services).

423. See supra note 412.

424. The authorities in note 412 that argue undocumented immigrants actually provide net benefits include government and respected think tank studies associated with both liberals and conservatives.

425. See supra notes 399-401 and accompanying text.
by the strong assault on undocumented immigrants’ fundamental (or quasi-fundamental) rights or interests. Therefore, there is no “substantial” or “close” means-ends connection.

e. Would the Court Find Less Restrictive Alternatives?

The compelling state interest test requires use of less restrictive or better tailored alternatives.426 Judging how the Court might view possible alternatives is particularly difficult, and I can do little more here than speculate regarding some points the Court might make or consider. The Court generally will not force the government to use alternatives that are appreciably more expensive or less effective.427

Turning to the interest in political support, an alternative way to encourage support for the government mandated system and its continued success might be to educate people about the positive aspects of the system and to better constantly monitor and improve it.428 However, these alternatives might be rejected as ineffective or too expensive.

As to government interests in improving the siege against undocumented immigrants and their children and preserving scarce health care resources, a less restrictive alternative would be giving documented persons priority in scheduling and distribution of health care. I believe the Court would find this approach unconstitutional as well. However, it would at least allow some access to undocumented immigrants and would not seem to be any less effective than either the generally unsuccessful siege already in place or the siege as strengthened by the the PPACA.

Regarding the preservation of societal integrity, this is another area where education might enlighten individuals who believe undocumented immigrants, all approximately twelve million of them,429 are criminals or at least parasites that threaten our body politic. This alternative, however, would be more expensive and perhaps unlikely to work.

6. Summary

Undocumented children are a particularly vulnerable group seeking access to the crucial right to access medical care by purchasing health care insurance. This alone should entitle them to protection under the Plyler v. Doe intermediate test. Children of undocumented immigrants who are citizens should receive the

426. Spece, Health Care, supra note 159, at 60.
427. Id. at 61.
428. The PPACA does contain provisions for an ombudsperson for insureds and potential insureds and for monitoring of care by exchange insurers. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2793, signed Mar. 23, 2010 (ombudsperson); see also CCH’s Explanation of the PPACA, supra note 9, at ¶ 215 (exchange insurers must have quality assurance program, which entails monitoring).
429. See supra notes 399-401 and accompanying text.
protection of strict scrutiny. In fact, undocumented immigrant children and adults should be protected with the most rigorous scrutiny. The right to purchase health care insurance meets almost every approach one could consider relevant to identifying fundamental rights, as I argued above. The government’s interests are abstract and remote. Some of them might not even be legitimate. Similarly, some of the government’s interests might be found not at risk or not advanced by the ban. The government’s position obviously fails under strict scrutiny or the Plyler test. The prohibition should therefore be held unconstitutional. The prohibition should also be struck as a badge and incident of slavery under the 13th Amendment. All this, however, might be swept away by invocation of the talisman—“Congress’s plenary power.”

V. APPLICATION TO CONTEXT TWO: ABORTION REGULATIONS OR PROHIBITIONS

A. The Nature of Context Two

Context two involves the PPACA requirement that health insurance policies sold within exchanges offer abortion coverage only under separate accounts and employers use discrete payroll deposits and paperwork concerning general and abortion coverage to assure that federal monies are not used to subsidize or fund abortions. These requirements could convince insurers or employers not to offer abortion coverage. Moreover, I have noted that one state has already exercised its PPACA option to exclude abortion coverage from the exchanges and that others have severely restricted abortion coverage in their exchanges; it is likely that other states will copy these early limitations. This alone could result in a de facto prohibition given the possibility of coverage not being available outside the exchanges. Court precedent dealing with what constitutes a sufficient intrusion indicates that these possibilities should be a sufficient intrusion to support a prima facie claim.430 The only three courts to have considered limits on abortion insurance coverage—the First, Third, and Eighth circuits—found a sufficient impingement to support a prima facie claim, and two of these struck the restrictions, albeit not under the current approach to abortion cases.431

430. See, e.g., Zablocki v. Redhail, 434 U.S. 374, 387 (1978) (invigorated scrutiny based on mere possibility that required certification of ability to support children as prerequisite to marriage license would chill certain individuals from marrying even if they could afford to pursue and would qualify for the certification).
B. Prima Facie Claims?

The prima facie due process and equal protection claims here are identical to those concerning context one, with two exceptions. First, the due process “life” or “liberty” involved is the right to purchase insurance so one can obtain an abortion if it becomes necessary. This not only covers the likely fundamental right to purchase insurance necessary to access care. It also includes (1) the fundamental right to be free of prohibitions on abortion prior to viability and abortion restrictions that put the woman’s life or health at risk and (2) in the context of limitations short of total prohibitions and not threatening a woman’s life or health, what appears to be but has not been labeled as such, a quasi-fundamental right to control one’s bodily integrity, self-definition, life and future, and reproductive decision-making by terminating a pregnancy. Second, the possible classification is between those seeking insurance for abortion and those seeking insurance for all other care, including pre-natal and birthing care. The Court might find, however, that these two groups are not similarly situated because abortion is distinct from other medical procedures in that it alone involves the death of a potential human being. The Court has thus far refused to recognize any classification in abortion cases, including a gender classification. That might suggest that it would be hesitant to recognize other classifications that might support an equal protection claim. Regardless, there is at least a prima facie due process claim.

This context poses decision-making difficulties because it involves a regulation on, and perhaps de facto prohibition of, purchasing insurance for future abortions. Many abortions will inevitably occur concerning a pool of insured women. On the other hand, any one or more of the women in that pool might never need or seek an abortion. Abortion regulations and prohibitions are usually judged by looking to the stage of pregnancy and the fluctuating weight of the government’s, and possibly the women’s, interests. It is interesting to analyze government going upstream and prohibiting purchase of abortion insurance because the Court has never decided such a case.

and remanding for determination whether the restrictions were irrational under the rational basis test). See Part V(D) infra regarding the Court’s current approach to abortion cases.

432. Gonzalez v. Carhart, 550 U.S. 124, 145, 156 (2007); Stenberg v. Carhart, 530 U.S. 914, 921 (2000); Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 847, 857, 877-79 (1992) (plurality opinion of Justices O’Connor, Kennedy, and Souter) (referring to fundamental liberty based on two lines of cases: (1) those protecting intimate decisions concerning intimate relationships, family, and whether or not to beget a child, and (2) those protecting the right to personal autonomy and bodily integrity in the context of refusal of medical treatment).

433. But see Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 928 (abortion implicates guarantees of gender equality); Mary Nagle, Abortion Post-Glucksberg and Post-Gonzales: Applying an Analysis that Demands Equality Under the Law for Women, 16 DUKE J. GEND. L. & POL’Y 293, 293-96 (2009) (the Court has only recognized a substantive due process right to abortion, which has been chipped away at and needs supplementation with notions of gender equality).

434. See text at notes 437-440.
Going upstream is more intrusive than restrictions that apply to planned abortions because it robs a subgroup of the vast majority of women who, given the legal restrictions that exist, are nevertheless allowed to purchase abortions. It robs both persons who cannot afford direct abortion services but who can afford insurance and persons who would have had access through their or their employer’s, spouse’s, or parents’ health care insurance program if these latter had not participated in an exchange. It also forces women to face a possibly agonizing decision—Would I ever obtain an abortion and therefore should I purchase (separate) abortion insurance?—that would never come up if they were already covered by an inclusive policy offered by an employer or already chosen by the employee. This is a significant psychic intrusion.

The government might argue, to the contrary, that the potential effect on yet-to-be identified women is too amorphous and remote to constitute legally recognized harm. However, this would allow the government to benefit from its premature assault on women’s rights. It would allow, and might encourage, the government to create uncertainty and thereby obtain an advantage. This is at odds with our law’s conception of equity.435

C. Is There a (Quasi-) Fundamental Right and If So, What Test Would Apply with What Result in the Abortion Context?

It has been established above that because there is probably a fundamental right to purchase health care insurance and a significant intrusion on that right, the compelling state interest test should be used in the health care insurance context.436 However, the analysis would probably differ insofar as the health care insurance sought covers abortions. It is beyond the scope of this article to survey all of the Court’s abortion opinions, and the history and nuances of the Court’s various standards of review, during the more than three and a half decades it has addressed the subject.437 I will observe that the “undue burden” element of the Court’s present decision-making approach has a tortured history and remains somewhat opaque.438 I will also summarize the Court’s decision-making approach or standard of review as it exists at the time I write these words.

438. Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 876 (1992) (plurality opinion of Justices O’Connor, Kennedy, and Souter) (“The concept of an undue burden has been utilized by the Court as well as individual members of the Court, including two of us, in ways that could be considered inconsistent.”); Catlin Borgmann, Abortion, the Undue Burden Standard, and the Evisceration of Women’s Privacy, 16 WM. & MARY J. WOMEN & L. 291 (2010). See generally Elizabeth A. Schneider, Comment, Workability of the Undue Burden Test, 66 TEMPLE L. REV. 1003, 1003-06 (1993).
First, the Court will, at least operationally, treat government prohibitions on abortion prior to viability unconstitutional per se. Similarly, restrictions on abortions that pose a threat to a woman’s life or health are per se invalid, and this is regardless of the stage of pregnancy or the government’s reason for acting.\footnote{See generally Roe v. Wade, 410 U.S. 113 (1973).} The Court has not used per se language, and another way to interpret the reference here to per se invalidity is that prohibiting abortions that are prior to viability or that threaten the woman’s life or health are per se undue burdens and therefore unconstitutional.

Second, as to government restrictions that do not threaten the woman’s life or health and do not seek to prohibit abortion before fetal viability, the Court uses the above-described “undue burden” intermediate test.\footnote{See supra text accompanying notes 307-314.} (Although not explicitly saying so, it seems to have demoted the right to make decisions concerning abortion, insofar as there is no prohibition before viability and the abortion does not threaten the woman’s life or health, to quasi-fundamental status, down from its pure Roe-era position as a fundamental right.)

The Court should, but might well not, accept the argument that a per se invalidity or strict scrutiny standard should apply across-the-board when the government does not attempt to regulate abortion but the very purchase of insurance that eventually would cover many abortions that obviously cannot be prohibited—or even regulated.

The Court probably would apply a per se invalidity rule if excluding women seeking abortion coverage from the exchanges or the requirement of separate accounts made it literally or virtually impossible for a significant group of women to obtain abortion coverage. Any future abortion has the potential to be necessary to save the woman’s life or health, and this is a reason for persons to seek abortion insurance. Moreover, there could be circumstances where the State, by the time future abortion might be chosen, has attempted to prohibit abortion prior to viability. Given that the government has not just regulated abortion but has reached upstream to restrict abortions, it has created a situation of uncertainty that should require it to bear the burden of that uncertainty concerning the circumstances within which particular insurance seekers will eventually seek abortion.\footnote{Segura v. United States, 468 U.S. 796, 837 (1984) (Stevens, J., dissenting) (“The risk of uncertainty as to what would have happened absent the illegal conduct posed by the facts of this case should be borne by the party that created that uncertainty, the Government. That is the teaching of our exclusionary rule cases.”). See Taylor v. Alabama, 457 U.S. 687, 690 (1982); Dunaway v. New York, 442 U.S. 200, 218 (1979); Brown v. Illinois, 422 U.S. 590, 604 (1975).} When dealing with large numbers, individual uncertainty is swamped by the dead certainty that some women want abortions and need insurance to pay for it. Since this may happen to any woman of childbearing age, the probability calculation applies to each of them individually. The way to implement this burden is to assume that all the abortions that the
restrictions on purchase of abortion coverage engender will be performed to protect the woman’s life or health or under other circumstances in which the state is not allowed to prohibit abortions. I will assume, only for purposes of extending the analysis, that the Court would not accept the per se invalidity or strict scrutiny argument and would judge the abortion insurance context with the same approach it has used otherwise.

It has been demonstrated above that the PPACA’s restrictions on purchase of abortion insurance might create a prohibitive effect on women’s access to abortions and that forcing them to purchase general policies that cover abortion or specific abortion policies if they are available outside the exchanges significantly intrudes on their rights to well-being and self definition. The argument above can be buttressed by adding that the federal government would have either created or required the creation of the exchanges and the overall health care system under the PPACA that led to literal or virtual prohibition whenever a state chose to exclude women seeking abortion coverage from the exchanges, or even when there were just requirements of separate accounts and paper work. It could be further explained that the woman only seeks to purchase abortion coverage without interference by the government, not to force the State to affirmatively supply an abortion for her.

On the other hand, invoking an analogy to the abortion funding cases, the Court conceivably might conclude that although the government would have strongly regulated the health care system, it still remained a largely private system in which the government would not be responsible for women’s inability to directly purchase abortions or purchase more expensive abortion coverage outside the exchanges. It could further conclude that, even if the exchanges and the overall health care system in effect constituted a public welfare program as to which the government would bear certain liabilities, the government has not intruded upon the right to choose whether to have an abortion because any inability still exists because of the woman’s lack of sufficient wealth to directly purchase an abortion or to purchase abortion coverage outside the exchanges in another State or a foreign jurisdiction.

I will assume that the Court would not accept this reasoning because it seems clear that the government is affirmatively interfering with women’s rights by not allowing them to access markets open to most other persons or forcing them to confront the abortion choice when otherwise such a choice might never have to be made. They are not asking for a subsidy as is true concerning the abortion funding cases. On the other hand, the Court did invoke the abortion funding cases in a context that could be argued to be similar to the present one. In Webster v. Reproductive Health Services, the Court upheld a state law that

442. See supra notes 437-40 and accompanying text.
prohibited the use of public facilities or public personnel in abortions. The Court said that insisting on access to public facilities or public personnel was constitutionally equivalent to demanding that the State pay for one’s abortion. If the woman is not able to access abortion services outside the public sphere, it is not the fault of the government; rather, it is caused by her lack of resources for which the government is not responsible.445 Similarly, the government might argue that it is not responsible if women can’t obtain abortions outside the “public” exchanges.

Access to exchanges can be distinguished from access to public facilities and personnel because although an exchange might be administered by the State or federal government, it can also be run, wholly or partially, by a private nonprofit entity.446 In any event it must become self-sufficient.447 Webster can also be distinguished because the abortion coverage does not come from any government facility or personnel; it comes from private insurance companies offering through the exchanges. Finally, the government’s intrusion is particularly potent because it reaches upstream and regulates purchase of abortion insurance as opposed to abortion itself. This could cause many women substantial anxiety or mental anguish even though they never turn out to seek an abortion. Other women will have lost or never gained insurance through an individual policy or their employer’s, spouse’s, or parents’ insurance offered through the exchanges. Thereby, many women will be forced to go without abortions they can’t afford out-of-pocket (unless they feel forced to take unsafe measures). Assuming that the Court would accept this latter line of reasoning and not treat this context as involving a disfavored positive claim to government supplied benefits, I will proceed with additional analysis.

If any prohibition or regulation, regardless of its purpose, posed a significant threat to women’s life or health, it would be invalid per se. Once again, the insurance that is not accessible to women will inevitably cover many abortions in which the woman’s life or health is at risk. The government might argue, to the contrary, that such future harm is too remote to constitute a substantial intrusion, and that abortion is not usually sought to protect the woman’s life or health. It might argue that prevention of purchase of insurance coverage is too remote as to all abortions, and that, at most, a rational basis test should be applied. This position is erroneous. Court precedent concerning sufficient intrusions indicates that preventing purchase of insurance would be enough to establish a prima facie claim.448 Once again, the only courts—the First, Third, and Eighth Circuit Courts of Appeal - to have addressed regulations and prohibitions concerning abortion

445. Id. at 508-11.
446. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 215 (“These Exchanges will be administered by a governmental agency or non-profit organization”).
447. Id. (“In establishing an Exchange under this section, a state must ensure that each Exchange is self-sustaining beginning on January 1, 2015.”).
448. See supra note 432 and accompanying text.

A more plausible approach for the government would be to argue that although Webster can be nominally distinguished and a prima facie case plausible, the present situation is sufficiently analogous to that in Webster to justify use of the rational basis test. I will assume the Court would still reject the government’s argument and apply the undue burden test.

\section*{D. More on the Undue Burden Test.}

The Court’s current description of the undue burden test can be found in \textit{Gonzalez v. Carhart},\footnote{Gonzalez v. Carhart, 550 U.S. 124 (2007).} where it stated:

\begin{quote}
[A State] … “may not impose upon this right [to choose to have an abortion] an undue burden, which exists if a regulation’s purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.” [citation] On the other hand, “[r]egulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman’s exercise of the right to choose.”\footnote{Id. at 146.}
\end{quote}

The PPACA’s restrictions discussed here must be analyzed under the two prongs of the undue burden test. First, it must be determined whether the government’s intent was to interfere with women’s right to choose to have an abortion. If there is improper intent, the government loses. Second, it must be established whether the impact of the restriction constitutes a “substantial obstacle to the woman’s exercise of the right to choose.”\footnote{Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992).}

Concerning intent, it would be difficult or impossible to show (although it might well be true) that the PPACA separate bookkeeping requirements or state prohibitions on purchase in exchanges were intended to create an obstacle for women seeking abortion. This is because, first, the separate policy and bookkeeping requirements have what the Court has said is a legitimate goal of, through the Hyde Amendment, preventing the use of federal monies for abortions. The abortion funding cases are wrong because they do not involve, as
the Court holds, women asking for government subsidies.\textsuperscript{453} To the contrary, they involve unconstitutional affirmative government attacks, in the form of symbolic and direct messages, on the integrity of women who seek abortions.\textsuperscript{454} However, the Court has held that the abortion funding cases involve government subsidies and a legitimate interest in protecting the sanctity of life, thus preserving the Hyde amendment.\textsuperscript{455}

State exclusions of abortion from the exchanges could, upon the close examination they should receive, be shown to be based on an illegitimate intent to interfere with abortions. The precedents, however, are conflicted regarding the rigor with which the intent prong of the undue burden test will be applied. This is a close and complex question which I intend to pursue in a subsequent article.

Turning to the effect of the restrictions at issue, as indicated above, three U.S. Courts of Appeal, the First, Third, and Eighth Circuits, have considered state laws that either required separate, supplemental policies ("riders") for abortions or prohibited municipal government employers from receiving compensation in the form of abortion coverage.\textsuperscript{456} Two of these precedents held the restrictions at issue were unconstitutional, but they antedated the Court's current undue burden test. Moreover, these cases were decided either before any articulation of the undue burden test\textsuperscript{457} or under an earlier, completely different, and inconsistent test that seems to have dictated strict scrutiny only if an undue burden were shown.\textsuperscript{458}

One of these precedents, however, is pertinent insofar as it quantifies the effect, at least in one venue and at one time, supplemental policy requirements might have on the costs of abortion coverage. In \textit{National Education Association of Rhode Island v. Garrahy},\textsuperscript{459} the court analyzed a statute that required separate insurance policies or riders for most abortions. It observed that the effect of the statute "would be to render comprehensive insurance, including abortion

\begin{itemize}
\item \textsuperscript{454} Michael Perry, \textit{Why the Supreme Court Was Clearly Wrong in the Hyde Amendment Case: A Brief Comment on Harris v. McRae}, 32 \textit{STAN. L. REV.} 1113 (1980) (the government’s action based on the view that abortion is immoral).
\item \textsuperscript{455} Id.
\item \textsuperscript{456} See \textit{supra} note 449 and accompanying text.
\item \textsuperscript{458} Coe v. Melahn, 958 F.2d 223 (8th Cir. 1992) (finding sufficient intrusion to require use of the then articulated undue burden test, finding no undue burden, and remanding for consideration under the rational basis test).
\end{itemize}
coverage, available at rates which prevailed prior to the statutory restriction — but nonetheless at a price higher than the one charged for a policy without abortion coverage."\textsuperscript{460} This statutory scheme apparently did not require separate accounts and bookkeeping, but it does suggest that the PPACA’s requirements concerning riders and separate accounts might not add significantly to insurer’s costs or deter them from offering abortion coverage in riders to their general policies. Therefore, the argument that there is an undue burden might fail in this respect.

The Garrahy case also found that the regulation requiring a specific form of abortion insurance policies could interfere with many women’s rights. First, the policies allowed employers to provide or not provide coverage, thus qualifying the woman’s right by the employer’s choice. Second, they allowed any enrollee in a non-employer group plan to object to abortion coverage for all enrollees. Women affected could only obtain coverage by leaving the plan and foregoing an employer subsidy or a group discount. Finally, single women enrolled in Blue Cross would have to transfer to another plan that did not follow Blue Cross’s policy of allowing insureds to choose their physicians and sites of care.\textsuperscript{461} Those are certainly within the magnitude of interferences I have argued substantially intrude on women’s rights.\textsuperscript{462} They call for application of the undue burden test if the State gets over the above argument that prohibitions of abortion coverage should be per se unconstitutional.\textsuperscript{463}

States’ exercise of their PPACA option to prohibit coverage in the exchanges could add a small cost for coverage outside the exchange if separate coverage were available there. On the other hand, it could significantly add to the cost of abortion coverage if the same were only available outside the exchanges along with a general policy. Recall that it is likely that policies will be less expensive if offered through an exchange. Further, the exclusion from the exchanges would constitute as de facto prohibition if no abortion coverage (of reasonable cost) were available outside the exchanges. It is likely, moreover, that the majority of insured persons will continue to have insurance through their employers. If an employer chooses not to cover abortions or goes through the exchange, as most probably will do because of cost,\textsuperscript{464} then all their employees will not be covered for abortions unless they can find a reasonably priced abortion-only insurance policy outside the exchange. If not viewed as per se invalid prohibitions, these effects should at least be found to constitute undue burdens, i.e., substantial obstacles to women’s exercise of their rights.

\textsuperscript{460} Id. at 1378.
\textsuperscript{461} Id. at 1378-79.
\textsuperscript{462} See supra note 434 and accompanying text.
\textsuperscript{463} See supra notes 442-45 and accompanying text.
\textsuperscript{464} See supra text accompanying notes 195-213.
Planned Parenthood of Southeastern Pennsylvania v. Casey[^465] is the case that articulated the current undue burden test[^466] There the Court, in a plurality opinion presented jointly by three Justices, upheld several restrictions on abortion, with the exception of a spousal notification requirement and a related demand that women provide their reasons that might justify not informing their spouses[^467] The Court upheld record keeping requirements that preserved the confidentiality of the patient’s identity and a parental consent requirement that had an escape clause[^468] It addressed several other limitations. First, it addressed whether the disputed law’s definition of emergency (pertaining to an exception to a generally required twenty-four-hour waiting requirement) “would constitute a threat to her health,”[^469] stating:

> [T]he Court of Appeals construed the phrase “serious risk” . . . . It stated: “[W]e read the medical emergency exception [allowing immediate abortions despite the general 24-hour waiting and other requirements] as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman . . . . We . . . conclude that, as construed by the Court of Appeals, the medical emergency definition imposes no undue burden on a woman’s abortion right.”[^470]

Having found the emergency exception to be sufficient to protect women’s life and health, the Court turned to other provisions. First it addressed the requirement that a physician provide the information required by the statute (concerning which, see immediately below), observing that “[s]ince there is no evidence on this record that requiring a doctor [as opposed to another health care provider] to give the [specific] information as provided by the statute would amount in practical terms to a substantial obstacle to a woman seeking an abortion, we conclude that it is not an undue burden.”[^471]

Next the Court addressed the requirement that a physician tell the woman the nature of the procedure, the health risks of childbirth and abortion, and “the probable gestational stage of the fetus” 24 hours before the abortion:

> These findings [that the 24-hour waiting period might subject women, who have to travel significant distances to obtain a provider, to delays of more than a day and therefore the necessity of two rather than one visit to the doctor; that this might make it harder to explain absence to husbands or employers; that it might subject women to greater risks of being harassed by abortion opponents; and that it falls the heaviest on

[^466]: Id. at 876.
[^467]: Id. at 887-98.
[^468]: Id. at 879-98.
[^469]: Id. at 880.
[^470]: Id.
those with few resources] are troubling in some respects, but they do not demonstrate that the waiting period constitutes an undue burden. We do not doubt that, as the District Court held, the waiting period has the effect of “increasing the cost and risk of delay of abortions,” but the District Court did not conclude that the increased costs and potential delays amount to substantial obstacles.472

The Court finally addressed the spousal notification requirement. It assumed that the overwhelming percentage of women would notify their husbands regardless of the statute, but nevertheless stated:

The spousal notification requirement is … likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle . . . . The analysis does not end with the one percent of women upon whom the statute operates; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects. For example, we would not say that a law which requires a newspaper to print a candidate’s reply to an unfavorable editorial is valid on its face because most newspapers would adopt the policy even absent the law. The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.473

The passages quoted above provide a few insights into the meaning of per se invalid provisions or those that comprise an undue burden. First, they indicate that regulations that make abortion more than “a little more” expensive or difficult are impermissible. The quoted language was in reference to the one extra visit to a doctor made necessary by the 24-hour waiting period. One extra visit to the doctor ($50 to $100) might not be an undue burden, but two extra visits (up to $200) is very significant to many women and might be held to be an undue burden. Similarly, the Court also stated that slight increases in costs ($50 to $100) are permissible, suggesting that substantial cost increases ($200?) constitute undue burdens.

Second, the Court reasons that there will be an undue burden if substantial numbers of women, not in absolute numbers but a proportion among those women who are in fear, are deterred by the provision at issue. When applying this to the spousal notification requirement, the Court explained that it does not matter that the vast number of married women inform their husbands; it is solely the perhaps one percent who would be deterred from seeking an abortion if they had to inform their husbands who must be considered. If a number of women among this small group were chilled, there would be an undue burden. Thus, by analogy, there only has to be a relatively small number of a possibly small group

472. Id. at 886.
473. Id. at 893-94.
of women who lose access to abortion insurance because of the PPACA’s abortion restrictions to establish an undue burden.

Third, the Court indicated, by accepting the lower court’s interpretation of the emergency exception, that it would not tolerate even regulations that would “in any way pose a significant threat to the life or health of the woman.” The words “in any way” obviously connote prohibition of regulations that even slightly increase the probability of harm to life or health. I interpret this as application of a per se test to such regulations.

Given all the above analyses, the federal and state restrictions on abortion coverage at issue here should be found to be either per se unconstitutional or to constitute undue burdens.

VI. APPLICATION TO CONTEXT THREE: EXCLUSION FROM STATE-CREATED PROGRAMS

A. The Nature of Context Three

Context three involves the PPACA’s permission to States to create programs involving provision of health care or health care insurance, both through contractors. Eligibility in these state created programs would be limited to state residents not eligible for Medicaid whose household incomes exceed 133 percent but do not exceed 200 percent of the federal poverty level, are not offered employer-provided coverage that meets the “affordable coverage” criteria of the tax laws, and are under age 65 as of the beginning of the plan year. If a state creates such a program, it is prohibited from allowing undocumented immigrants to enroll. This is true even though these programs can charge premiums or fees up to the amount of similar coverage in the exchanges and that undocumented immigrants are not eligible for health insurance premium assistance credits or cost-sharing reductions. In other words, undocumented immigrants are barred from these programs even though, if eligible, they would probably have to pay full market value for coverage.

If that were the case, context three should be treated virtually identical to context one. Both would involve a prohibition on the purchase of access to minimally acceptable care pursuant to coverage under a health plan or insurance policy. They would have to pay as much as any other subscriber, and much more than other similarly situated individuals who are alone eligible for premium assistance credits or cost-sharing reductions. This is my position, and groups that advocate for the interests of undocumented workers should be able to convince the Court that the two contexts are identical in all relevant aspects.

474. Id. at 880.
475. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 305 (premium assistance credit), 310 (cost-sharing reductions).
I will continue the analysis, however, by exploring whether the Court might treat this context as analogous to the prohibition on use of public facilities and personnel in *Webster v. Reproductive Services*.

It might do so whether or not coverage in these programs is offered at below market value. If there were no direct or indirect subsidy - to the overall program as opposed to premium assistance credits or cost-sharing reductions given to eligible documented residents - the Court could nevertheless characterize coverage in the programs as analogous to the situation in *Webster* if some public facilities and personnel were actually used. The Court might emphasize that these are State programs run under contracts with the State. Moreover, the Court might invoke Congress’s “plenary power” as analyzed in context one because it is a federal law that allows the states to create these programs and that stipulates criteria governing the financing and scope of care.

On the other hand, a more realistic approach would be to find that, in the absence of general subsidies, these programs involve persons purchasing coverage that will be provided by private insurers and health care providers. To the extent that these programs *might* involve use of some public facilities or health care providers who are employees of the government, a feasible less restrictive but also less than fair approach would be to allow undocumented immigrants to purchase coverage with the understanding that they are not only not eligible to receive premium or cost-sharing subsidies, but are also excluded from care provided in public facilities or by public employees.

I will assume only for purposes of continuing with the analysis that the bar of undocumented immigrants from the programs is (a) one against supplying those undocumented immigrants a bargain made possible by the state’s involvement in and contributions to the programs (i.e., a general subsidy), and (b) the equivalent of using state facilities or state personnel. (The Court conceivably could, but certainly should not, interpret context one as involving assumptions (a) and (b) immediately above. Context one should not be interpreted in this way because exchanges can involve private exchange personnel monitoring private insurers in an alleged “free market” (perhaps the largest or only one) not even containing a public option. If assumptions (a) and (b) were made concerning context one, the analysis below would apply to that context too.)

**B. Prima Facie Claims & Choice and Application of a Standard of Review**

Under the assumptions made for purposes of argument here, the PPACA’s prohibition on states serving undocumented immigrants in indigent health care programs (that can include an insurance component) they are allowed to create is more difficult to attack than the restrictions in contexts one and two. Although

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477. *See supra* text accompanying notes 335-45.
these state programs require payments by the enrollees, it is probable that the Court would find that there is no prima facie due process claim because there is no "life" or "liberty" right to receive, as assumed arguendo at this stage of the analysis, government-subsidized services. There is a long line of authority holding that the government does not have to supply even a measure of the necessities of life to anyone, let alone persons who are here illegally. Therefore, the government could not be held to have acted or intruded on any right in any relevant sense; it has simply, as it has the power to do, refused to supply benefits. One could reach this conclusion by finding no state action, no intrusion, no right, or none of the foregoing.

On the other hand, it is possible that, in light of the existence of substantial payments by the undocumented immigrants and the possibility of life itself being at risk, the Court would find that the government has intruded upon a right to "life." (Then the plaintiffs would have established (1) state action (2) intruding on (3) persons' (4) rights to "life.")

Undocumented immigrants possibly could make out a prima facie equal protection claim even if the Court refused to find a due process claim. Harris v. McRae illustrates the difference in equal protection and due process requirements. There the Court recognized a prima facie equal protection claim by applying the rational basis test to Medicaid's provision of child-birth related care and concomitant refusal to fund therapeutic and non-therapeutic abortions (other than those necessary to save the woman's life or for pregnancies resulting from promptly reported rape or incest). The Court found that the government’s action was "rationally related to the legitimate governmental objective of protecting potential life." However, no doubt relying on the strong presumption against affirmative governmental duties to provide even the necessities of life, the Court refused to find a prima facie due process claim because there was no intrusion on a life, liberty, or property right. The only way to logically explain this ruling is that although there was no right to "liberty" supporting a due process claim, there was a sufficient liberty interest, intrusion upon which created harm in fact and thus a prima facie equal protection case.

478. See Dandridge v. Williams, 397 U.S. 471 (1970) (no right to additional welfare benefits after parent has a specified number of children); Lindsey v. Normet, 405 U.S. 56 (1972) (no right to housing); San Antonio School Dist. v. Rodriguez, 411 U.S. 1, 18-37 (1973) (no right to education above that offered to students at different schools by government’s financing from property taxes); Maher v. Roe, 432 U.S. 464 (1977) (no right to non-therapeutic abortions); Harris v. McCrae, 448 U.S. 297 (1980) (no right to certain therapeutic abortions); DeShaney v. Winnebago County Dep’t of Soc. Serv., 489 U.S. 189, 196 (1989) (no right for young child to protection from catastrophic abuse by his father despite State social worker’s involvement and knowledge of facts suggesting that the child was at serious risk).

480. Id. at 321-26.
481. Id. at 316-17.
Even if undocumented immigrants could establish a prima facie equal protection claim, the federal government could probably meet the rational basis test by arguing that it wanted to preserve important and perhaps scarce resources for legal residents. It probably would not have to establish that there is actually a shortage of particular resources, that undocumented immigrants paying to participate in a state program would exacerbate any burden, or that its action would alleviate such a burden. Rather, the government could probably just assert that one can conceive of this goal being legitimate and actually being advanced.

On the other hand, given that life itself is at risk, that, if allowed to enroll, the undocumented immigrants would be paying a substantial amount of money greater than many other similarly situated persons because of their ineligibility for premium credits or cost-sharing reductions, and that, as argued in subsection IV.B.5.D, there might be proof that the government would save rather than lose money by allowing enrollment; the Court might strike the ban by applying the traditional rational basis test as it did in *United States Department of Agriculture v. Moreno*.482

There, food stamp recipients attacked the constitutionality of a statute that withheld that benefit from households containing an individual who was unrelated to any other household member. The purposes of the challenged legislation, according to the government’s Declaration of Policy, were to encourage development of the agricultural industry and provide persons with nutritionally adequate diets. These purposes were obviously not served by limiting recipients of food stamps. The government explicitly abandoned an argument that its action preserved morality and conceded that any interest in preventing “hippie communes” would be an illegitimate desire to harm a politically unpopular group.483 Thus, this was a rare case where the government worked itself into restating its defense of the law on a single stated purpose - preventing fraud. The Court explicitly applied the rational basis test and reasoned that, insofar as fraud was concerned, able bodied persons such as hippies could easily change their living arrangements and remain eligible despite the household restriction. The only persons who could not change their living arrangements would be “AFDC mothers who try to raise their standard of living by sharing housing.”484 Thus the Court concluded:

[T]he 1971 amendment excludes from participation in the food stamp program, not those persons who are “likely to abuse the program,” but, rather, only those persons who are so desperately in need of aid that

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484. *Id.* at 537-38.
they cannot even afford to alter their living arrangements so as to retain
their eligibility. Traditional equal protection analysis does not require
that every classification be drawn with precise “mathematical nicety.”
Dandridge v. Williams, 397 U.S., at 485. But the classification here in
issue is not only “imprecise,” it is wholly without any rational basis.485

Similarly, the Court could apply the intermediate test I described above as
having been used de facto in Cleburne, Romer, and Lawrence. That test, again,
involves finding that the government’s only actual purpose is an irrational
antipathy toward an identified group. This finding is reached because there is no
rational connection between any legitimate purpose and the state’s action.

Using either the Moreno or Cleburne/Romer/Lawrence approach, one can
argue that there is no legitimate purpose advanced by the exclusion of
undocumented immigrants. If saving of scarce resources were the government’s
purpose, it would not exclude undocumented immigrants from both the
exchanges and State low cost care programs. The exclusions leave a group of
millions of persons uninsured, which is antithetical to overriding rationale of the
PPACA to bring down per capita costs by insuring as many persons as possible
and providing these insureds with quality care, especially preventive care,
thereby minimizing expensive delayed or emergency care.486 This is irrational.
That should be enough under Moreno, but under Cleburne, Romer, and
Lawrence one would add that, because of all this, it is apparent that the
government’s purpose was simply to harm a politically unpopular group.

C. A Plyler v. Doe Argument

Undocumented immigrant children might be able to prevail by analogizing
themselves to the quasi-suspect classification of innocent undocumented
children in Plyler v. Doe and analogizing access to health care (through
insurance) to the quasi-fundamental right to education in Plyler. (Recall that the
Court did not directly use the quasi-suspect or quasi-fundamental language.)487
This argument would probably fail under the same analysis ventured above as to
Plyler and context one.488

If the Court were to reject the federal power as opposed to state power
distinction explained above and accept Plyler as relevant, the intermediate test
that would apply under that case, again, can be “described either as a unique
balancing test that weighs national and state interests as well as individual
interests against the state’s asserted interests or as a test that requires more than a
legitimate (‘substantial’) interest and proof of a close connection between the

485. Id. at 538.
486. See supra note 419 and accompanying text.
487. See supra notes 330-33 and accompanying text.
488. See supra notes 373-78 and accompanying text.
state’s interest(s) and its classification, or an ill-defined combination of both.” 489

The government interests that would be invoked here parallel those examined concerning context one: again, preserving medical resources for legal residents (who, in addition, might be more likely to stay in the U.S. and make contributions to our economy or culture), protecting societal integrity, garnering political support, and a siege (deterrence). As argued concerning context one, the interests in political support and a siege might be found illegitimate. 490

Under the Plyler analysis, however, the government would not have to show its actual interests. The government might nevertheless avoid any mention of political support or a siege out of concern that the Court might be offended by a government argument that it was interfering with children’s access to possible life-saving care to encourage them to leave and discourage others like them from coming to the U.S. The government would likely, however, assert these interests along with preserving medical resources and protecting social integrity and argue that if any of them is “substantial” or weightier than the undocumented children’s rights, it should prevail. If the Court applied the prong of Plyler that requires a close relationship between the government’s interest and its classification, the government would likely not be able to show that a significant amount of political support, siege, medical resources, or societal integrity would be lost by allowing undocumented immigrant children to have health care or insurance in voluntary state programs. In fact, overall, just the opposite might be true.

On the other hand, the government might be able to show that a large number of undocumented children would use the voluntary state programs, more than the number of undocumented immigrants who would purchase health care insurance. This might create or exacerbate a scarcity problem and be found substantial, real, cured by exclusion, and weightier than the children’s interests. This should not be dispositive, however, because undocumented immigrant children would still have to pay substantial premiums. It could also be argued that interests of legal residents outweigh those of persons illegally here. In Plyler, the Court found that the State did not show any sufficient burden it suffered in having to supply education to undocumented immigrant children. 491

Therefore, proof of a substantial burden posed by undocumented immigrant children would be crucial for the State to have a chance to prevail.

On the other hand, it is likely that the state could not meet this burden because there would probably be a net savings if undocumented immigrant children were allowed in the programs. Savings would occur if providing care to undocumented children were to protect the population generally (e.g., from

489. See Plyler v. Doe, 457 U.S. 202, 216 (1982); see also id. at 221 (substantial interest required); id. at 225 (balance must tip in favor of the state if it is to prevail); id. at 226 (the state bears burden to “demonstrate” its means are reasonably related to its ends).

490. See supra notes 388-406 and accompanying text.

communicable diseases) and prevent the children from becoming expensive late or emergency patients.

Recall, moreover, that many children of undocumented immigrants are citizens. Their parents might assume the children share the parents’ ineligibility. Similarly, the parents could fear applying for their children because doing so might lead to the parents’ deportation. This should be a sufficient intrusion on the children’s fundamental right to purchase health care insurance to justify use of the strict scrutiny analysis ventured as to context one. This would indicate that the exclusion from the State programs should be found unconstitutional insofar as citizen children are involved.

In summary, the Court should find that contexts one and three are analogous and involve restrictions that are unconstitutional under strict, intermediate, and even rational basis scrutiny. However, the Court might well distinguish the contexts, reasoning that context one involves a negative claim (let me buy insurance) and that context three involves a disfavored positive claim (let me purchase partially subsidized care). The Court might also find more force to the government’s asserted purposes in context three. The Court might or might not find a prima facie due process claim, but it would probably at least find an equal protection claim. If so, the Court could still apply the rational basis test and reason that the government has asserted legitimate interests that conceivably would be achieved by its actions. On the other hand, the Court might find, as in Moreno, literal irrationality here. Similarly, it might invoke the Cleburne/Romer/Lawrence test that looks to the government’s actual purpose as revealed by absence of means-ends fit regarding other interests. If so, it should find that the government’s actual purpose is to kowtow to an irrational hatred or fear of undocumented immigrants. In any event, citizen children of undocumented immigrants should receive the protection of strict, and certainly not less than intermediate scrutiny.

VII. APPLICATION TO CONTEXT FOUR: DUE PROCESS & EQUAL PROTECTION ATTACKS ON MANDATES

A. The Nature of Context Four

Context four involves the PPACA’s requirements that most individuals and some employers either purchase specified health insurance for themselves or their employees or pay “penalties” or “taxes.”\footnote{492 See supra note 11 and accompanying text.} There is no stigma attached to these penalties/taxes payments because the PPACA emphasizes that it does not aim to force any individual or employer to purchase insurance; it only seeks to
encourage purchase of insurance. Therefore, it is not reasonable to argue that there is any reputational interest at issue. This bears on a related issue as to whether the mandates can be justified as exercises of the government’s power to tax. During the campaign in favor of the PPACA, President Obama insisted that the mandates did not involve taxes. Now that several lawsuits have been launched against the PPACA and its mandates, government lawyers have argued that the charges associated with the mandates are in fact taxes, while their opponents have argued that they are unconstitutional penalties. As pointed out at the beginning of this article, one court has held actually that the individual mandate constitutes a penalty, not a tax. This article, however, generally does not address such government-power related issues. I will make two points relevant to the power question. First, the mandates do not besmirch anybody’s reputation, and, in that sense, seem to involve taxes and not civil penalties. Second, as one commentator has observed, the mandates can easily be viewed as either a tax on self-insurance or an income tax.

Some of the attorneys who have attacked the PPACA have alleged that, insofar as individuals are concerned, the mandates interfere with rights to medical decision-making and informational privacy. Recall, moreover, that certain individuals and employers are exempt or excluded from the mandates because of their relative poverty, limited size (for businesses), or religious objections.

493. CCH’s Explanation of the PPACA, supra note 9, at ¶ 220 (“the Act is not to be construed as restricting the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in a Health Insurance Exchange”).

494. This is especially true because the Court has held that one does not even have a constitutional right to reputation. Paul v. Davis, 424 U.S. 693, 713 (1976). But see Wisconsin v. Constantineau, 400 U.S. 433, 437 (1971) (“Where a person’s good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential.”).

495. See Robert Pear, Changing Stance, Administration Now Defends Insurance Mandate as a Tax, N.Y. TIMES, July 18, 2010, at A-14 (“Administration officials say the tax argument is a linchpin of their legal case in defense of the health care overhaul and its individual mandate. . . .” The President had earlier refused to characterize the penalty as a tax, apparently reluctant to support what might have been seen as a tax increase that could reach lower-income persons.); see also George Stephanopoulos, Obama: Mandate is Not a Tax, ABC NEWS, Sept. 20, 2009, http://blogs.abcnnews.com/george/2009/09/obama-mandate-is-not-a-tax.html. See text at note 2 supra regarding constitutional arguments and opinions for and against plaintiffs.


498. See supra note 138 and accompanying text.
B. Prima Facie Claims?

The individuals and employers would seem to have a prima facie due process claim because the mandates involve (1) government action (2) impinging on (3) persons’ (4) property or liberty (not to contract) rights. The Court has been willing to review taxes under the due process clause, and this indicates it believes there is at least a property right in the sums persons pay as taxes. The same would probably be found as to payments individuals and companies expend to purchase the required health care coverage.

Individuals and employers would also seem to have equal protection prima facie cases because they are (1) persons (2) to which government action (3) draws classifications which treat other persons (including certain employers) more favorably by not requiring them to purchase insurance or pay a fine and (4) this causes harm in fact to their liberty or property interests. There are multiple classifications that could be mentioned, but one example should suffice. As noted above, the law excludes certain persons at certain income levels and employers of a certain size, from the requirement to purchase health insurance, and it allows others to apply for a special exemption on the basis of hardship.

It is conceivable, but highly unlikely, that the Court might not find any “liberty” or “property rights,” a gesture toward complete withdrawal from review of taxes under the due process clause. It is equally possible that the Court would characterize individuals and employers exempt from the insurance mandate as not being sufficiently “similarly situated,” compared to those subject to the mandates, to create a classification for equal protection purposes. I will not dwell on these issues because it is clear that even if the Court recognizes any prima facie case, it will apply the rational basis test and uphold the mandates. Here there is no “life,” medical decision-making privacy, or medical informational privacy substantially at stake. (But see below regarding alleged rights to medical decision-making and informational privacy.)

C. Is There a (Quasi-) Fundamental Right or (Quasi-) Suspect Classification?

Many litigants have attacked the mandates as unprecedented intrusions on the rights of individuals and employers, especially individuals. They argue that the government has never had the temerity to force persons to buy health care or any other commodity. Presumably, the supposedly unprecedented nature of the intrusion not only shows Congress has exceeded its powers (such as the


500. See supra note 138 and accompanying text.

501. See infra text accompanying notes 503-519.

commerce power), but also demonstrates that it ipso facto targets a basic or special liberty. This is an exaggeration because government requires that persons purchase, for example, automobile insurance and necessities of life for their children.503 As to employers, it requires purchase or provision of worker’s compensation coverage as well as many items to comply with health, safety, and welfare requirements.

One might argue that the various mandates mentioned here involve state rather than federal laws. However, there are federal laws prohibiting child abuse that mandate parents purchase certain necessities (including medical care) as well as federal laws requiring expenditures to meet safety and health requirements. The 1792 Uniform Militia Act required all able-bodied free, white men to purchase muskets.504 One might further argue that at least the state laws are not good analogies because they are passed pursuant to the states’ broad police power rather than limited federal authority under provisions such as the commerce clause. However, that argument still leaves the federal law examples mentioned here which have stood the test of times, and the existence of federal power in the first instance is irrelevant to substantive due process’ and equal protection’s protection of individual rights that serve as affirmative checks on broad areas of state and federal power. Once again, this article does not analyze the extent of federal powers such as that granted by the commerce clause. It also does not directly address the extent of state powers in the absence of “delegation” of authority by the federal government.

The mandates do not involve any unique intrusion or special rights. Nevertheless, the most avid opponents of the PPACA insist that it perforce entails an intrusion on fundamental medical decision-making and informational privacy rights. As to medical decision-making privacy, the government does not intrude on it by levying a tax or by encouraging one to obtain health care

503. See, e.g., 21 DEL. CODE ANN. § 2118 (West 2011) (requirement of insurance for all motor vehicles required to be registered); ARIZ. REV. STAT. ANN. § 28-4135 (West 2011) (auto insurance); WASH. REV. CODE ANN. § 9A.42.020 (West 2011) (child care); ARIZ. REV. STAT. ANN. § 8-801 (child care).

insurance. Concerning medical informational privacy, the PPACA does not seem to increase the risk of disclosures concerning individual insureds beyond what existed before its enactment.

So that readers can draw their own conclusions, however, I will nevertheless paraphrase plaintiff Coons’ assertion of fundamental rights to medical decision-making and informational privacy in Coons v. Geithner filed August 12, 2010, in the United States District Court for the District of Arizona:

In Count I, plaintiff alleges that he has rights to control his body, create or refrain from establishing a doctor-patient relationship, to accept or refuse treatment, and make health care choices with the assistance of professionals. These interests combined constitute the “right to medical autonomy” based in the 5th and 9th Amendments. These rights are intruded upon by forcing plaintiff to use limited resources to purchase insurance he does not desire or otherwise pay a penalty, both which reduce the health treatments and doctor-patient relationships he can afford to choose. These rights are also invaded by forcing plaintiff to create or risk creating an intimate relationship concerning his health and medical care with millions of non-physician intermediaries employed by health insurers rather than directly with the physician of his choice. Depending on the plans available, plaintiff’s choice of physicians and/or medical services may be curtailed. These rights are also unduly burdened by imposing the threat of price controls and/or similar regulation (including the Independent Payment Advisory Board) that will limit his access to treatment, hospitals, drugs, and physicians.[506]

Insurers invariably ask for medical information and request a general HIPPA [Health Care Privacy And Portability Act] disclosure authorization needed for rate setting. They can, consistent with HIPPA and state privacy law, disclose plaintiff’s medical records to third parties for any legitimate business purpose, including marketing and data mining. Insurers share information through the Medical Information Bureau (“MIB”) and other entities that compile searchable databases. Approximately 600 insurers use MIB. Even without authorization, the Department of Health and Human Services (“HHS”) can access plaintiff’s medical records when pursuing a compliance investigation or review or an enforcement action. HIPPA also allows numerous disclosures without plaintiff’s consent if there are “reasonable safeguards” in place. These include disclosures for “medical treatment, payment and health care operations,” and for general public interest purposes such as national security activities.

506. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 1385.
Insurers’ business associates such as collection agencies, data storage and data sharing or mining companies may make any disclosures that the insurers are authorized to make. Millions of entities are authorized under HIPAA and Arizona law to access information obtained as part of the insurance application process. HIPAA does not require audit trails for all uses and disclosures, does not require encryption when records are not being transmitted, and does not require at least two-factor authentication for access to secure data systems. A study shows that in 2007 hackers could penetrate every medical data system maintained by 850 providers. There are numerous recorded abuses, including the infamous cases involving Britney Spears and Farrah Fawcett. Since 2003, HHS and affiliated agencies received over 50,989 complaints of HIPAA violations. Of 45,000 screened to date, at least 10,515 investigation and enforcement actions have been brought against health plans. In Arizona, if persons or entities who allegedly improperly disclosed records are in compliance with HIPAA, they are immune unless they furnish false information with malice or willful intent to injure any person. All the above concerns about loss of medical privacy are currently, and will continue to chill, plaintiff’s free and open communication with his doctors.

As to Count II, based on the same set of facts as Count I but instead resting the right to privacy on the 4th, 5th and 9th Amendments, plaintiff alleges that he is subject to an illegal search and seizure without consent, a search warrant, or an equivalent legal process subject to judicial review.507

The plaintiff’s assertions of interference with his medical decision-making because of having to spend money to comply with the PPACA’s individual mandate are fanciful. The mandate is analogous to a myriad of social and economic laws and regulations that limit individuals’ use of their monies.508 The remote and gossamer quality of plaintiff’s decision-making privacy is illustrated by the outrageous claim that there might be price controls at the behest of the IPAB. IPAB only makes formal recommendations concerning Medicare and IPAB is required to refrain from making recommendations that limit benefits.509 Plaintiff’s assertions regarding informational privacy are also weak.

508. Such as laws against gambling and other “vice” activities, requiring automobile insurance, levying excise taxes, and requiring helmets.
509. See CCH’s Explanation of the PPACA, supra note 9, at ¶ 1385 (explaining process whereby proposals of Independent Medicare Advisory Board “shall not include recommendations to ration health care, raise revenues or premiums, increase beneficiary cost-sharing, or restrict benefits, or modify eligibility criteria”).
The Court has ruled on indistinguishable facts as to both medical decision-making and informational privacy in *Whalen v. Roe*.510 There, patients and their physicians argued that New York’s requirement that all prescriptions for “dangerous drugs” be registered with a central government repository unconstitutionally trenched on their fundamental rights to decision-making and informational privacy.511

The Court assumed, but did not hold, that medical decision-making and informational privacy are fundamental rights.512 However, the Court applied the rational basis test because it determined that there were sufficient safeguards in place to make intrusions on privacy unlikely. These safeguards and the necessity of medical record-keeping despite the possibility of disclosure were described by the Court as follows:

The District Court found that about 100,000 Schedule II prescription forms are delivered to a receiving room at the Department of Health in Albany each month. They are sorted, coded, and logged and then taken to another room where the data on the forms is recorded on magnetic tapes for processing by a computer. Thereafter, the forms are returned to the receiving room to be retained in a vault for a five-year period and then destroyed as required by the statute. The receiving room is surrounded by a locked wire fence and protected by an alarm system. The computer tapes containing the prescription data are kept in a locked cabinet. When the tapes are used, the computer is run “off-line,” which means that no terminal outside of the computer room can read or record any information. Public disclosure of the identity of patients is expressly prohibited by the statute and by a Department of Health regulation. Willful violation of these prohibitions is a crime punishable by up to one year in prison and a $2,000 fine. At the time of trial there were 17 Department of Health employees with access to the files; in addition, there were 24 investigators with authority to investigate cases of overdispensing which might be identified by the computer. Twenty months after the effective date of the Act, the computerized data had only been used in two investigations involving alleged overuse by specific patients. . . . Even without public disclosure, it is, of course, true that private information must be disclosed to the authorized employees of the New York Department of Health. Such disclosures, however, are not significantly different from those that were required under the prior law. Nor are they meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with

511. *Id.* at 599.
512. *Id.* at 600 (the Court stated that the rights to informational and decision-making privacy were the second and third aspects of the fundamental privacy recognized by the Court and analyzed by Professor Kurland, but concluded: “We are persuaded, however, that the New York Program does not, on its face, pose a sufficiently grievous threat to either interest to establish a constitutional violation.”).
many facets of health care. Unquestionably, some individuals’ concern for their own privacy may lead them to avoid or to postpone needed medical attention. Nevertheless, disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient.513

Three of the five approaches discussed above concerning the identification of fundamental rights—the Glucksberg test, the intimate interests or relationships approach, and the expanded precedential analysis - seem to support a determination that a specific form of medical decision-making privacy (such as the right to access health care through the purchase of insurance developed here) and medical informational privacy are fundamental rights.514 However, here too the protections of HIPPA515 and state privacy laws516 are in place. They are much more elaborate than any measures described in Whalen. HIPPA provides for and is applied by an administrative apparatus that has adopted required detailed regulations as to privacy and security of medical information. It is beyond the scope of this article to review these detailed provisions, but I will observe that HIPPA provides for more elaborate privacy and security regulations and more severe penalties than those operational in Whalen. These include requirements that covered entities that possess medical information have internal personnel responsible for handling complaints and promulgating and enforcing policies and procedures to ensure the privacy and security of medical data as well as applying sanctions to company personnel who do not follow these protections. A second layer of monitoring compliance through accepting complaints and conducting investigations and enforcement actions exists at the federal level. Finally, HIPPA does not preempt any state laws that are even more protective of privacy.517 Therefore, even if the PPACA’s opponents could show that the PPACA touched their rights to medical decision-making and informational privacy, the risk/intrusion would, as in Whalen, only be sufficient to support application of the rational basis test.

Plaintiff Coons describes a reality that most educated people know about. With millions if not billions of medical disclosures, regimens of treatment, payment, administration, legal, and other transactions that occur on a daily basis, there will be some improper disclosures. Coons states that insurers require disclosure authorizations for rating, but the PPACA is designed generally to

513. Id. at 593-94, 602.
514. See supra notes 317-320 and accompanying text.
abolish rating.\footnote{518 See CCH’s Explanation of the PPACA, \textit{supra} note 9, at ¶¶ 170, 175.} Coons’ identification of complaints and actions might look substantial in raw numbers, but they are a tiny portion of all transactions. Coons alleges that hackers were able to invade the data of each of over 800 providers surveyed. If this is true, then Coons is doomed to an invasion of privacy in any event if he ever seeks out a health care provider. Once again, the point is that there is a ubiquitous risk of disclosure in all contexts. However, our huge health care system could not function without hard and electronic records. It is already very expensive to pursue privacy and confidentiality, and measures to virtually eliminate the risks of improper disclosures would be beyond our means. It is highly unlikely that the Court, or any court, would accept Coons’ allegations as sufficient to trigger any scrutiny beyond the rational basis test. I will assume this to be the case for purposes of further analysis. There is sufficient information about forms of strict and intermediate scrutiny here that a reader who disagrees with me can apply such scrutiny to Coons’ allegations.

The only rights or interests at sufficient risk to trigger the usual standard of review for the right or interest invaded because of the mandates - freedom of contract or property interests in sums paid for premiums or taxes/penalties - are not fundamental or quasi-fundamental under any of the five approaches set forth above. They are, at most, economic interests, and the Court consistently holds such interests to be ordinary at best.\footnote{519 See CONSTITUTIONAL LAW 392 (Kathleen M. Sullivan & Gerald Gunther eds., 17th ed. 2010) (“the minimum ‘rational basis’ standard that continues to the present to govern due process review of economic legislation”).} The rights or interests in not being forced to purchase insurance, or, more generally, in never being forced by government into any commercial transaction whatever are not fundamental to the survival of our nation or any institution within it. They are neither deeply rooted in our traditions nor such a central part of liberty that freedom could not be said to exist without them. They do not involve personal, intimate decisions or such decisions that affect important relationships, nor do they implicate the very ability to make such decisions. They do not have a nexus to other rights that have been found fundamental, have not been previously supported as special, and are not especially important.

As to suspect classifications, individuals and employers subject to the mandates meet none of the many criteria relevant to finding suspect or quasi-suspect classifications. They are not subject to negative stereotypes and stigma, they have not been thrust into a status they don’t deserve, they presumably do not wish to change their status as documented individuals or recognized companies, they are not politically powerless, they are neither insulated nor vulnerable, and they are not distinct minorities.
D. Application of the Rational Basis Test

The government could assert several conceivable interests that the mandates could serve. The mandates could help fund the new health care system and funding itself is a legitimate interest. The mandates could help bring health care insurance and health care to millions more U.S. residents. The mandates could make our health care system more efficient or more equitable. They could foster a sense of unity, solidarity, or empathy among members of our society. (This is not the above-referenced cynical manipulation or unseemly bargaining for votes for an overall program by sacrificing one’s principles and the interests of a vulnerable group.)

Even if the Court employed strict or intermediate scrutiny, the government interests just listed should be found in the top tier of a hierarchy of values. They are inextricably bound up with the fundamental right of access to and choice of care at one’s own expense. The government interests should be held “compelling.” Furthermore, overturning the mandates would strike at the PPACA’s heart. The mandates seem to be, moreover, the least restrictive alternative considering the more intrusive alternatives of a public option or a single-payer system. The most disputed part of applying heightened scrutiny if it were employed is whether the mandates will achieve any of the lofty goals just stated above. Will the government be able to show there is a substantial or close means-ends connection? Those questions could conceivably be, but, given the limited nature and magnitude of plaintiffs’ interests, should not be, deeply explored in the many cases that attack the PPACA all over the country. The same would be true as to additional litigation that might be portended by the fact that many States have passed or are in the process of considering legislation or state constitutional amendments that purport to nullify the PPACA.

Following existing doctrine, the Court should show constraint and refuse to become entangled with these policy and political disputes, saving its institutional energy and integrity to protect vulnerable groups unfairly singled out in an otherwise good-spirited and reasonably crafted Act.

520. See supra notes 384-95 and accompanying text.
521. See supra notes 2-4 and accompanying text.
522. Id.
I. INTRODUCTION

Not long after agreeing to take part in this symposium, one of the authors of this article had a conversation with a colleague in the hall of the law school. The author explained he was planning to write an article questioning the constitutionality of the mandate for individuals to purchase health care insurance and asked for his colleague’s opinion. The author asked if the Federal Government could compel citizens to purchase health care insurance and what the limits of that power were. Colleague replied that he took a “process view” of the matter. A mandate to buy a Buick would not follow a mandate to buy health insurance simply because members of Congress (“Except those from Michigan,” the author sniped) would not vote for it. In addition, Colleague could have added that this approach had the Supreme Court’s blessing when applied to the congressional power to extend general regulations of commerce to the states. Colleague’s view corresponds to what Randy Barnett calls the “law professor” pre-1995 understanding of congressional power under the Commerce and Necessary and Proper Clauses, where “the Supreme Court had so expanded the

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1. The Court has rejected earlier decisions giving the states structural protections against federal regulation in areas of traditional state function, saying instead that the states must rely on the federal political process to preserve their interests. See, e.g., Garcia v. San Antonio Metro. Transit Auth., 469 U.S. 528 (1985) (overruling Nat’l League of Cities v. Usery, 426 U.S. 833 (1976) and upholding the Fair Labor Standards Act as a general regulation that applied equally to public and private employees).

2. U.S. Const. art. I, § 8, cl. 3 (“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. 18 (“ . . . 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.”). The authors will frequently refer to this concept as the law professors’ understanding throughout this article.
scope of the commerce power of Congress that Congress could do anything it wanted, provided it was not violating some other constitutional constraint, such as the First Amendment.”

This article should begin with the proviso that the Supreme Court will sustain the constitutionality of the individual mandate to purchase health care insurance if it agrees with my colleague’s and the law professor’s understanding of both the Commerce and the Necessary and Proper Clauses. The constitutional defenses of this mandate derive from the logical extension of several holdings under well-established constitutional doctrines. Defenders of the mandate say that its constitutionality is based upon settled law. This is accurate, though, only in the sense that many movies and books claim that the stories they tell are based upon actual facts. This, of course, is not at all the same as saying that the stories they tell are actually true.

So, too, it is with the constitutionality of the individual mandate. The theory of the Federal Government’s power that underlies the law professor understanding is diametrically opposed to the limited government/enumerated powers view of the framers. One can easily state the scope of federal power under the law professor understanding—Congress can largely do what it wants. The founders’ theory, one consistent with a government of enumerated and limited powers, is more difficult to articulate. This is especially true with regard to legislative and constitutional novelties such as the individual mandate. Such a theory of congressional power must reflect the text of the constitution, the intent of the framers, important relevant precedent, and notions of federalism and individual rights. This theory is one that the authors support and seek to develop in this article.

Additionally, this article will question the constitutionality of the individual mandate by testing the mandate against an understanding of Congress’s limited commerce and implied powers. This understanding holds that Congress can regulate activities by appropriate means where the subject matter or purpose of the regulation is interstate commerce. A corollary of this understanding is that Congress may not commandeer states or individuals in order to carry out federal

4. See infra notes 30-53 and accompanying text.
5. See infra notes 30-53 and accompanying text.
6. This view is based partly on the observation that between 1937 and 1994, the Supreme Court did not strike down a single piece of legislation as a violation of Congress’s powers under the Commerce Clause. See Gregory W. Watts, Gonzales v. Raich: How to Fix a Mess of “Economic” Proportions, 40 Akron L. Rev. 545, 545 (2007) (citing Alex Kozinski, Introduction to Volume Nineteen, 19 Harv. J.L. & Pub. Pol’y 1, 5 (1996)).
7. See e.g., Randy E. Barnett, The Original Meaning of the Commerce Clause, 68 U. Chi. L. Rev. 101 (2001) (exploring the original intent of the framers with respect to the Commerce Clause).
8. Id.
regulatory schemes.\(^9\) In conducting this test, the authors will examine the nature and scope of Congress’s implied powers, the limitation of regulation to activity, and the notion of “commandeering the individual.” To set the stage, this article will first examine the constitutional attacks found in a suit the Commonwealth of Virginia brought against the statute and the mandate.

II. VIRGINIA V. SEBELIUS

A. The Commonwealth of Virginia’s Claim

One of the first cases challenging the constitutionality of § 1501 of the Patient Protection and Affordable Care Act (“PPACA”) is *Virginia v. Sebelius*.\(^10\) The PPACA provides that all Americans, unless expressly exempt, must maintain a minimum level of health insurance coverage, or be subject to a penalty.\(^11\) On March 23, 2010, the Commonwealth of Virginia filed a complaint for declaratory and injunctive relief alleging that the individual mandate, requiring citizens to purchase health insurance for themselves and their dependents, violates the United States Constitution.\(^12\) The Commonwealth had, in the 2010 Regular Session of the Virginia General Assembly, enacted a statute that would not require residents of Virginia to purchase health insurance under the federal plan except as required by a court or through the Department of Social Services.\(^13\) The Commonwealth maintained that the unconstitutionality of the PPACA dictated that it was not entitled to any deference under the Supremacy Clause, and thus the conflict with the Virginia statute was moot.\(^14\)

The Commonwealth’s arguments largely hinged on the novelty of the PPACA. First, the Commonwealth referenced the Congressional Research Service’s opinion of the individual mandate’s constitutionality.\(^15\) The Service stated that “[w]hether such a requirement would be constitutional under the Commerce Clause is perhaps the most challenging question posed by such a proposal, as it is a novel issue whether Congress may use this Clause to require an individual to purchase a good or service.”\(^16\) Second, the Commonwealth

\(^9\) See infra notes 111-122 and accompanying text.
\(^13\) VA. CODE ANN. § 38.2-3430.1:1 (West 2010).
\(^15\) Id. at 4.
\(^16\) Id. at 4 (quoting CONG. RESEARCH SERV., REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS 3 (2009)).
relied on *United States v. Lopez* and *United States v. Morrison*, where the Supreme Court concluded that the regulation of non-economic activities is beyond the limits of the Commerce Clause. The Commonwealth contended that “the Supreme Court has never extended the Commerce Clause beyond the regulation of (1) ‘use of the channels of interstate commerce;’ (2) ‘the instrumentalities of interstate commerce;’ and (3) ‘activities that substantially affect interstate commerce.’” The Commonwealth alleged that the status of being a Virginia resident “is not a channel of interstate commerce; nor a person or thing in interstate commerce; nor is it an activity arising out of or connected with a commercial transaction;” and that “the status arises from an absence of commerce.”

The Commonwealth, pulling on historical cases, in arguing that the PPACA’s novelty went too far to fall within constitutional parameters, made the point that also alleged “there is no tradition of using the Commerce Clause to require a citizen to purchase goods or services from another citizen.” Citing *Lochner v. New York*, the Commonwealth highlighted that prior to 1939, “this regime viewed the regulation of economic activity to be illegitimate unless that activity harmed or threatened to harm someone else.” Further, the Commonwealth asserted that it would be “inconceivable that the Commerce Clause prior to 1938 would have been deemed to reach and control a citizen’s decision not to engage in commercial activity.” Additionally, although the United States Supreme Court has not adopted a solid rule against “aggregating the effects of any non-economic activity in order to find Commerce Clause authority,” it also has never held that the Commerce Clause, combined with the Necessary and Proper Clause, can support Congress’s attempt to require a citizen to purchase goods or services.

The Commonwealth conceded that Congress may regulate non-economic activity under its Commerce Clause powers through the Necessary and Proper Clause.
Clause, but that the PPACA went too far. The Necessary and Proper Clause gives Congress authority to regulate only “when the means adopted to accomplish an enumerated power are ‘appropriate, are ‘plainly adapted’ to that end, and are ‘consistent with the letter and spirit of the constitution.’” The Commonwealth alleged that powers of Congress in the Commerce and Necessary and Proper Clauses do not support the constitutionality of the individual mandate. Further, the Commonwealth alleged that, because the individual mandate is an essential provision of the PPACA and cannot be severed from the Act, this renders the entire Act invalid.

B. The Government’s Response

The federal government, via Kathleen Sebelius acting in her capacity as Secretary of the Department of Health and Human Services, responded to the Commonwealth’s complaint by filing a motion to dismiss on May 24, 2010. In the motion, the Government alleged that the Commonwealth lacked standing to sue on behalf of its citizens. It argued that “[i]t cannot be conceded that a state, as parens patriae, may institute judicial proceedings to protect citizens of the United States from the operation of the statutes thereof,” and that “[i]t is no part of [a State’s] duty or power to enforce [its citizens’] rights in respect of their relations with the federal government.”

In addition, the Government also asserted that the mandate was a valid regulation of commercial and economic activity because the mandate “regulates economic decisions regarding the way in which health care services are paid for—decisions that, in the aggregate, have a direct and substantial effect on interstate commerce.” The Government also stated “Congress had far more than a rational basis to find the provision to be an essential element of the Act’s larger (and unchallenged) regulatory effort to regulate the interstate business of insurance.” The rational basis was that the provision did not allow health care market participants to shift “the costs of their care to third parties, and also

26. Complaint for Declaratory & Injunctive Relief, supra note 14, at 5 (citing Gonzales v. Raich, 545 U.S. 1, 39 (2005) (Scalia, J., concurring)). But cf. United States v. Comstock, 130 S. Ct. 1949, 1957 (2010) (holding that the word necessary does not mean “absolutely necessary” and that the Necessary and Proper Clause only requires a statute to constitute a means that is “rationally related to the implementation of a constitutionally enumerated power”).

27. Complaint for Declaratory & Injunctive Relief, supra note 14, at 5-6 (quoting McCulloch v. Maryland, 17 U.S. 316, 421 (1819)).


30. Memorandum In Support of Defendant’s Motion to Dismiss, Virginia v. Sebelius, 702 F.Supp. 2d 598 (E.D. Va. 2010) (No. 3:10CV188) [hereinafter Motion to Dismiss].

31. Id. at 1-2.

32. Id. at 12 (quoting Massachusetts v. Mellon, 262 U.S. 447, 485-86 (1923)).

33. Motion to Dismiss, supra note 30, at 19.

34. Motion to Dismiss, supra note 30, at 19.
prevents individuals from relying on the Act’s reforms . . . to delay the purchase of health insurance until illness strikes.”

Further, the Government argued that the PPACA “regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.” The Government supports its assertion by listing five reasons. First, allowing individuals to shop and compare health insurance options through Congress’s health insurance exchange will address inflated fees and premiums currently found in the insurance market. Second, the system creates a tax incentive for small businesses to purchase coverage for employees, while the system penalizes the large businesses that do not comply. Third, the program will subsidize coverage for many uninsured individuals by giving insurance tax credits and reduced cost-sharing for those between 133 and 400 percent of the federal poverty line. Fourth, the program will remove barriers to coverage, such as the refusal to cover individuals with pre-existing health issues. Finally, the program will impose a penalty on those individuals not exempt from the mandate, who do not maintain the required health insurance coverage. This, according to Congress is “an essential part of this larger regulation of economic activity.”

Further, the Government argued that Congress has the power to enact the individual mandate because the provisions addressing “minimum coverage” are necessary to accomplishing reform in the national health insurance market. Under the Necessary and Proper Clause, Congress is granted the authority to employ any means reasonable to accomplish an end supported by the Constitution. Interstate health insurance is an important part of commerce that Congress may regulate by reasonable means. Because the mandate is necessary

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35. Motion to Dismiss, supra note 30, at 19.
37. Motion to Dismiss, supra note 30, at 6-8.
38. Motion to Dismiss, supra note 30, at 6 (quoting H.R. REP. NO. 111-443, pt. II, at 976 (2010)).
39. Motion to Dismiss, supra note 30, at 7 (citing Patient Protection and Affordable Care Act, §§ 1421, 1513).
40. Motion to Dismiss, supra note 30, at 7 (citing Patient Protection and Affordable Care Act, §§ 1401-02).
41. Motion to Dismiss, supra note 30, at 7 (citing Patient Protection and Affordable Care Act, § 1201).
42. Motion to Dismiss, supra note 30, at 8 (quoting Patient Protection and Affordable Care Act, §§ 1501(a)(2)(H), 10106(a), 42 U.S.C.A. § 18091(a)(2)(J) (2011)).
43. Motion to Dismiss, supra note 30, at 34.
44. Motion to Dismiss, supra note 30, at 34 (quoting Hodel v. Va. Surface Mining & Reclamation Ass’n, 452 U.S. 264, 276 (1981)).
45. Motion to Dismiss, supra note 30, at 34.
for the remainder of the PPACA’s effectiveness, Congress’s regulation of individual health insurance is within the constitutional powers granted to Congress.46

Additionally, the Government argued that the grant of Commerce Clause authority is extremely broad.47 Relying on Gonzales v. Raich, the Government reiterated Congress may regulate activities that substantially affect interstate commerce.48 When Congress decides whether an activity substantially affects interstate commerce, Congress “may consider the aggregate effect of a particular form of conduct in deciding whether to exercise its Commerce Clause authority.”49 The question then becomes whether Congress had “a rational basis for concluding that the class of activities, ‘taken in the aggregate’ at least has some substantial effect on interstate commerce.”50 Thus the Government argued Congress only needed to establish a rational basis for its conclusion and that a court “may not second-guess the factual record upon which Congress relied.”51 Because Congress had a rational basis to conclude that participation in the health care market and the lack of doing so imposes “substantial costs on other participants in that market,” and that those decisions have a “substantial effect on the larger market for health care services,” the Government argued that Congress has the power to regulate the health care market.52

Although the Government argued that the Commonwealth’s interpretation of the individual mandate was incorrect and that the Commonwealth lacked standing, the United States District Court for the Eastern District of Virginia disagreed with the Government and denied their motion to dismiss.53

III. LIMITED GOVERNMENT AND THE NECESSARY AND PROPER CLAUSE

On its face, the debate over the constitutionality of the PPACA is about the scope of Congress’s commerce power.54 This debate intensified with the rise of the New Federalism in 1995 with the Supreme Court’s decision in United States
Since Lopez, the Supreme Court has pushed back against the law professor understanding of the breadth of federal power, and adopted a limited government view of the constitutional framers. In Lopez, Chief Justice Rehnquist began the substantive portion of the opinion by writing, “We start with first principles. The Constitution creates a Federal Government of enumerated powers.” Then, after discussing commerce precedent since John Marshall, he wrote, “[b]ut even these modern-era precedents which have expanded congressional power under the Commerce Clause confirm that this power is subject to outer limits.”

Rehnquist’s conclusion in Lopez might seem surprising to the reader that remembers him, quoting with approval just a few pages earlier, Marshall’s statement about the commerce power from Gibbons v. Ogden. This broad assertion of Congress’s commerce power seems to favor the law professor understanding more than the limited government view of the framers.60

Even so, the Necessary and Proper Clause combines with the Commerce Clause to limit Congressional commerce power. Consider the three-part definition of the commerce power that Rehnquist gives in Lopez:

[W]e have identified three broad categories of activity that Congress may regulate under its commerce power. First, Congress may regulate the use of the channels of interstate commerce. Second, Congress 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. Finally, Congress’ 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.61

Rehnquist’s three-part commerce power definition and Marshall’s assertion of the scope of congressional powers appears to support the broad notion of congressional power asserted in the Government’s motion to dismiss in Virginia
and not the enumerated powers, limited government view of the framers.\(^{63}\)

However, one important fact forestalls this conclusion. Rehnquist’s three-part commerce power definition does not solely derive from the nearly plenary Commerce Clause.\(^{64}\) The third part of the definition derives instead from the Necessary and Proper Clause.\(^{65}\) For the activities that substantially affect interstate commerce are not interstate commerce themselves and, thus, fall outside the scope of the Commerce Clause.\(^{66}\) Although these activities do not fall within Congress’s enumerated powers here, these activities may fall within Congress’s implied powers under the Necessary and Proper Clause.\(^{67}\) However, Congress’s implied power under the Necessary and Proper Clause is not as broad as the near plenary power possessed under Marshall’s assertion in their enumerated powers.\(^{68}\)

The breadth of this implied power under the Necessary and Proper Clause is the main issue in *Lopez*, *Sebelius* and most of the controversial commerce power decisions of the Court in the last fifteen years.\(^{69}\) In *Sebelius*, the Government advanced the position that, under the substantial effects test, there need be only a rational basis for the congressional conclusions regarding these effects.\(^{70}\) Once again, if this assertion is a correct statement of the law, the result is the law professor understanding of congressional power.

To sort this out, we must turn to Rehnquist’s three-part definition of the commerce power to understand the scope of implied congressional power under the Necessary and Proper Clause.\(^{71}\) Although each side has accepted this language as canonical,\(^{72}\) each side interprets the language differently, viewing it

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62. See *supra* notes 48-53 and accompanying text.
63. See *supra* notes 48-53 and accompanying text.
64. See *e.g.*, Randy Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional*, 5 N.Y.U. J.L. & Lib. 581, 592-93 (2010) (discussing the common law development of the commerce power and pointing out that the “substantial effects” doctrine concerns the application of the Necessary and Proper Clause in the context of the commerce power, rather than deriving from the Commerce Clause directly and arguing that cases applying the “substantial effects” doctrine are more properly referred to as “Necessary and Proper Clause cases” than “Commerce Clause cases”).
65. See *id*.
66. See *id*.
67. See *id*.
68. See *id*.
69. See *e.g.*, Gonzales v. Raich, 545 U.S. 1 (2005) (holding that Congress could regulate the intrastate cultivation and possession of marijuana under its Commerce Clause powers); United States v. Morrison, 529 U.S. 598 (2000) (holding that a federal violence against women statute to be beyond the Commerce Clause powers of Congress); United States v. Lopez, 514 U.S. 549 (1995) (holding that the Gun-Free School Zones Act of 1990, which made it illegal to possess a gun within a school zone, is beyond the commerce powers of Congress).
70. See *supra* notes 48-53 and accompanying text.
71. See *infra* note 74 and accompanying text.
72. See *supra* notes 44-47, 26-29 and accompanying text (illustrating the Government and Commonwealth acceptance, respectively).
through the lens of its own constitutional theory. Here the interpretation comes from Chief Justice John Marshall’s opinion in McCulloch v. Maryland:

Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.

Marshall “glossed” this language later by writing, “[S]hould [C]ongress, under the pretext of executing its powers, pass laws for the accomplishment of objects not [e]ntrusted to the government; it would become the painful duty of this tribunal, should a case requiring such a decision come before it, to say, that such an act was not the law of the land.”

Both the Commonwealth of Virginia and the Federal Government appealed to Marshall’s formulation of the Necessary and Proper power in their Sebelius motions, but in different ways; the Commonwealth argued that the individual mandate is not within Congressional power to enact and the Government argued that the mandate is “reasonably adapted” to an end permitted by the Constitution. The usual tests will not resolve this disagreement because both sides appeal to and claim to satisfy these tests. Because of the factual and constitutional novelty of the individual mandate, the analysis must force a return to constitutional basics.

Our analysis begins in 1791 with the congressional debate over the first national bank, one of the early occasions questioning the breadth of implied power afforded to Congress under the Necessary and Proper Clause. James Madison, the Father of the Constitution, categorically asserted, “Whatever meaning this clause may have, none can be admitted, that would give unlimited power to Congress.” More recently, Chief Justice Rehnquist repeated this principle in the Lopez case. This maxim, on one level, is little more than another way of stating the truism that the Constitution creates a Federal Government in general, and a Congress in particular, which possesses only limited and enumerated powers. Yet this maxim has teeth in the individual mandate dispute, for it is not clear how the Government’s theory of the federal commerce power is capable of any principled limitation.

73. See supra notes 44-47, 26-29 and accompanying text (illustrating the Government and Commonwealth acceptance, respectively).
75. Id. at 423.
76. See supra notes 44-47, 26-29 and accompanying text (illustrating the Government and Commonwealth acceptance, respectively).
77. See supra notes 26-29 and accompanying text.
78. See supra notes 44-47 and accompanying text.
79. 2 ANNALS OF CONG. 1898 (1791).
80. Id.
81. See supra notes 57-58 and accompanying text.
82. See supra note 79-81 and accompanying text.
For, like the question posed to the colleague in the hall, if Congress can mandate that individuals buy health insurance because health care insurance decisions affect interstate commerce, what are the constitutional limits of the federal commerce power? This problem is particularly severe under the rational basis test that the Government argued for in Sebelius and the Supreme Court adopted in the recent United States v. Comstock case. As Justice Kennedy noted in his concurrence in Comstock, this “mere conceivable rational relation” test, drawn from Due Process rather than Commerce or Necessary and Proper sources, runs the risk of not calling for a close enough means-ends relation between statute and enumerated end. This risk leads to the greater danger of unlimited congressional power.

Another constitutional worry arises from the unprecedented nature of the individual mandate. In 1994, the last time that Congress attempted health care reform, the Congressional Budget Office published a memorandum asserting that, “[a] mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States.” Michael Dorf, a supporter of the current individual mandate, has countered that the individual mandate is not, in fact, unique. He lists as other mandate examples jury service, military draft, and vaccination (as well as

83. See Randy Barnett, Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional, 5 N.Y.U. J.L. & Lib. 581, 634 (2010) (discussing the dangerous slippery slope introduced once Congress is able to mandate that citizens buy goods or services). See also David B. Rivkin et al., A Healthy Debate: The Constitutionality of an Individual Mandate, 158 U. Pa. L. Rev. PENNUMBRA 93, 99 (2009) (“If Congress can mandate the purchase of health care insurance, it can similarly impose, under the Commerce Clause guise, an infinite array of other mandates, ranging from health club memberships to a requirement to consume a given quantity of fruits and vegetables annually.”).

84. See United States v. Comstock, 130 S. Ct. 1949, 1956 (2010) (“[I]n determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power.”). See e.g., Illya Somimm, Taking Stock of Comstock: The Necessary and Proper Clause and the Limits of Federal Power, 2010 CATO SUP. CT. REV. 239 (discussing, inter alia, the implications of Comstock for the future as it relates to the health care bill).

85. See Comstock, 130 S. Ct. at 1966-67 (Kennedy, J., concurring) (arguing that the any notion of a rational basis test under the Necessary and Proper Clause should be at least as demanding as it has been in Commerce Clause cases, which require a tangible, empirically verifiable link, as opposed to an abstract link between Congress’ means and end).

86. See id.


88. See id.

the state mandate of compulsory school attendance).\textsuperscript{90} Dorf’s examples here are correct, but one can also readily distinguish them from the individual mandate.\textsuperscript{91} Mandates have been the rare exception in American life and legislation.\textsuperscript{92} These mandates either arise out of civic duties owed as citizens of their state and nation (i.e. jury service, the draft and even compulsory school attendance) or public health necessity (i.e. the case of vaccination).\textsuperscript{93} However, Congress’ commerce power does not serve as the constitutional basis for any of these mandates.\textsuperscript{94} And unlike the individual mandate, these mandates do not require citizens to buy goods or services from private individuals.\textsuperscript{95} Dorf’s examples do not add up to a general congressional power to establish individual mandates of any kind.\textsuperscript{96}

The strongest constitutional objections to the individual mandate, however, do not arise out of the standard tests or of maxims of the Framers. Because of the novelty of the mandate, the strongest constitutional objections arise out of the innovative features that the mandate contains.\textsuperscript{97} One cannot, for example, readily apply the economic activity limitation of the \textit{Morrison} case\textsuperscript{98} to the individual mandate. One reason is that the decision to buy health insurance is not clearly economic or noneconomic.\textsuperscript{99} But a more salient reason is that the decision or failure to consider this purchase is not an activity at all.\textsuperscript{100} It is inactivity.\textsuperscript{101} This raises a serious problem for the individual mandate because the commerce power itself is premised on the regulation of activity.\textsuperscript{102}

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\item[90.] Id.
\item[92.] See Randy Barnett, \textit{Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional}, 5 N.Y.U. J.L. & Lib. 581, 606-07 (2010) (stating that “apart from registering for the draft, serving on a jury, submitting a tax return, and responding to the census, none of us can think of any such personal mandates.”).
\item[93.] Id. at 629-34.
\item[94.] See id. (arguing that none of the duties the federal government has imposed on the people (e.g. to register for the draft, to sit on a jury, to fill out a census form, or file a tax return) have been imposed via Congress’ power to regulate economic activity. Instead, they have all been considered fundamental duties owed to the government by virtue of citizenship or residency).
\item[95.] See id.
\item[96.] See id.
\item[97.] See id.
\item[98.] United States v. Morrison, 529 U.S. 598, 613 (2000) (“[T]hus far in our Nations’ history our cases have upheld Commerce Clause regulation of intrastate activity only where the activity is economic in nature.”).
\item[100.] See id. at 605-06 (arguing that calling decision-making activity would destroy the long-made distinction between acts and omissions, which have been historically treated differently).
\item[101.] See id.
\item[102.] Id. at 604-05 (“the first thing to notice about all of the substantial effects cases . . . is that each concerns the regulation of . . . activities, not inactivity”).
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Commerce is an activity and all the tests the Supreme Court has developed for the regulation of commerce speak in terms of activity.\footnote{103}

The Government in \textit{Sebelius} attempted to maneuver past this by asserting that the individual mandate is a regulation of health care payment decisions,\footnote{104} but this evasive technique is doomed to fail. First, the individual mandate regulates more than decisions; it regulates all failures to purchase health insurance whether deliberate or unintentional.\footnote{105} But more importantly, a decision, standing alone, is not an action.\footnote{106} A decision is a purely mental event, while an action contains a physical component.\footnote{107} Just as none of the commerce power tests and definitions includes inactivity, none include decisions rather than activities.\footnote{108} This derives from the concept that regulation is of activity, not inactivity.\footnote{109} The individual mandate is constitutionally and historically outside all definitions of the commerce power since the birth of the Constitution.\footnote{110}

Instead, the individual mandate amounts to what Randy Barnett calls “a commandeering of the people.”\footnote{111} The constitutional prohibition of commandeering arose, of course, in the context of federal regulation of the states

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\item \textsuperscript{104} See supra note 34 and accompanying text.
\item \textsuperscript{106} See supra note 100-01 and accompanying text. See also David B. Rivkin et al, \textit{A Healthy Debate: The Constitutionality of an Individual Mandate}, 158 U. Pa. L. Rev. PENNUMBRA 93, 99 (2009) (alleging that the individual mandate does not regulate activity at all, but rather features an affirmative command to engage in a particular activity, which applies not because anyone has engaged in activity but rather simply because they exist).
\item \textsuperscript{107} See Rivkin, supra note 106, at 99.
\item \textsuperscript{108} See supra note 99-101 and accompanying text.
\item \textsuperscript{109} See Gregory W. Watts, \textit{Gonzales v. Raich: How to Fix a Mess of “Economic Proportions}, 40 AKRON L. REV. 545, 575-76 (2007) (discussing the meaning of “To Regulate” and arguing that “‘[to regulate’ unmistakably refers to the enactment of rules for the purpose of controlling an activity . . . .”).
\item \textsuperscript{110} See, e.g., Randy Barnett, \textit{Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional}, 5 N.Y.U. J.L. & Lib. 581, 634 (2010) (“[The individual mandate] crosses an important line between limited and unlimited government power.”); David B. Rivkin et al, \textit{A Healthy Debate: The Constitutionality of an Individual Mandate}, 158 U. Pa. L. Rev. PENNUMBRA 93, 99 (2009) (“what Congress is contemplating with regard to the health care mandate is even less defensible under a Commerce Clause analysis than what it sought to do in the Gun-Free School Zones Act of 1990 or the Violence Against Women Act of 1994, both of which, after all, purported to regulate noneconomic activities that were nevertheless freely engaged by individuals”).
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rather than of individuals. Nevertheless, the concept is relevant and compelling in the individual context as well. Under the commandeering doctrine, Congress may offer incentives for state action, but Congress may not coerce state action. In Printz v. United States, the Court put this federal disability directly in terms of the Necessary and Proper Clause:

> When a “Law . . . for carrying into Execution” the Commerce Clause violates the principle of state sovereignty . . . it is not a “Law . . . proper for carrying into Execution the Commerce Clause,” and is thus, in the words of The Federalist, “merely [an] act of usurpation” which “deserves to be treated as such.”

While most discussions of the Necessary and Proper Clause focus on the necessity of federal laws, this commandeering discussion instead asserts that the propriety of the law is a separate and independent requirement. Thus, a statute may be necessary in the sense that it has the required means-ends relation to an enumerated power, but may still be unconstitutional because the statute is improper.

The impropriety of commandeering the state arises out of the Tenth Amendment and involves a violation of state sovereignty. Since the Tenth Amendment reserves powers to the individual as well as to the states, an analogous constitutional impropriety occurs when Congress exceeds its delegated powers and violates individual rights and autonomy by ordering individual action. As in the state commandeering, Congress can provide encouragement for individuals to purchase health insurance through subsidy, tax credit or deduction, for example, but cannot coerce individuals through a

112. See, e.g., New York v. United States, 505 U.S. 144 (1992) (holding that Congress may not compel states to enact or enforce a federal regulatory program but may incentivize its adoption).

113. Id. at 166 (“This is not to say that Congress lacks the ability to encourage a state to regulate in a particular way, or that Congress may not hold out incentives to the States as a method of influencing a State’s policy choices.”).

114. Id. at 162 (“[T]he Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress’ instructions.”).


116. See id.


118. U.S. Const. amend. X (“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.”).

119. See Randy Barnett, Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional, 5 N.Y.U. J.L. & Lib. 581, 622-23 (2010) (discussing several Court decisions which have addressed statutes alleged to have improperly commandeered legislatures).

120. See id. at 627-31 (arguing that the text of the Tenth Amendment permits this analogy as it recognizes popular sovereignty in addition to state sovereignty).
mandate or penalty. As Alexander Hamilton wrote, “The propriety of a law in a constitutional light, must always be determined by the nature of the powers upon which it is founded.”

IV. CONCLUSION

Almost 200 years ago, Chief Justice John Marshall, writing of federal power, predicted that “the question respecting the extent of the powers actually granted . . . will probably continue to arise, so long as our system shall exist.” The debate over the individual mandate in the country at large, and in this symposium in particular, demonstrates the accuracy of Marshall’s prediction. In this article, the authors have argued that Marshall and other important historical constitutional sources should serve to resolve these disagreements. The limited government notions Marshall and the framers espoused should lead the Court in resolving this question and invalidating the individual mandate.

121. See New York v. United States, 505 U.S. 144, 166 (1992) (explaining that Congress may not commandeer state legislatures but may encourage states to regulate in a particular way).