



New Deal Lessons for the Affordable Care Act: The General Welfare Clause

BY ASSOCIATE PROFESSOR ELIZABETH WEEKS LEONARD (J.D.'99)

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Last winter, I participated in a panel of law professors brought together to consider the recently enacted federal health care law, the Patient Protection and Affordable Care Act of 2010 (ACA).

The Potential for Constitutional Crisis

The questions put to our panel were these: Is a

constitutional crisis on the order of 1937 looming? Are there structural similarities between the present period and the New Deal period?

My short answer to the first question is: No, there is not a constitutional crisis.

My longer answer to both questions is that any crisis, or constitutionally significant structural similarity, concerns the spending power, not the commerce power, where most of the public attention has focused.

More importantly, the controversy surrounding the ACA, if a crisis at all, is political, not constitutional.

With crisis comes opportunity. In this case, the controversy provides an opportunity for us to carefully consider whether

the United States' traditional, predominantly private-market approach to health care is an approach we want to continue to employ.

Put another way, the now-raging debate may lead us to recognize that expansion of the federal welfare state toward a universal "Medicare for All" approach is not only plausible but preferable.

First, why I say that no constitutional crisis is looming: The economic conditions and abject nationwide suffering beginning with the crash of 1929 compelled the law to find a way to address societal needs. Individual liberties came to encompass freedom from want and demand for affirmative government intervention.¹

In 2012, there is no similarly compelling, nationwide crisis, demanding government response. Ever-increasing health care costs, consuming an ever-increasing share of gross domestic product and rising numbers of uninsured, while serious national concerns, are not comparable to the Great Depression.

Most Americans agree something needs to be done to fix the U.S. health care system. But there is no similar urgency for the U.S. Supreme Court to radically redefine the scope of individual rights and governmental power.

The Great Depression forced our nation to rethink across the board the relationship of citizens and government.

The current health care "crisis" does not involve concepts as looming or stakes as large.

Depression photos courtesy of the Franklin D. Roosevelt Library website, version date 2009. This page, 1932; page 5, 1935. Photo top right by Samuel Perry, Shutterstock. Photo page 5 bottom right by John Churchman, Getty Images



“... the structural issues before the Supreme Court during the New Deal may indeed provide useful lessons for the current period.”

It was the political process, not the Constitution, that blocked these approaches.

Consider the possibility of Medicare for All: Accepting a government health care program (whether administered entirely by the federal government or in cooperation with states, i.e., Medicaid for All) as a constitutional alternative to the individual mandate,⁷ the real question before the Supreme Court, the real possibility for limiting federal power, does not concern the commerce power but rather the spending power.

In conceiving a present-day constitutional crisis, one might view the New Deal as representing unprecedented expansion of federal power, and the constitutional challenges to the Affordable Care Act as inviting the Supreme Court to contract federal power.

I maintain that the ACA’s minimum essential coverage provision,² or “individual mandate,” is constitutional under existing precedent.³

The issue, then, is whether the Supreme Court takes this opportunity to set forth new limits on the commerce power.

I also believe the 26 states’ challenge to ACA’s Medicaid expansion⁴ is unsupported by precedent.

But again, the issue is whether the Supreme Court will decide to impose new limits on the conditional spending power.⁵

Even framing the issues in these terms, the current controversy simply is not driven by an overwhelming public demand to decrease federal power in response to societal needs or wants, similar to the demand to expand federal power during the New Deal.

Let me take these points one step further: Even if there were a legitimate question whether the individual mandate, in particular, exceeds the commerce power, the objection is to the form, not the substance, of expanded federal power.

Congress could get to the same result in other ways, which similarly depend on broad federal power.⁶

For example, Congress could condition the requirement to obtain health insurance on taking advantage of some privilege (for example, securing federal student loans) or engaging in some activity (including accessing medical care) or it could truly style the law as a federal tax, with a credit for obtaining insurance and redistribution under the spending power, essentially “Medicare for All.”

Any of these alternatives would quite clearly pass constitutional muster, but federal power would still be expanded at least as much as by the currently enacted individual mandate.

New Deal Decisions

Viewing the current controversy through this lens, the structural issues before the Supreme Court during the New Deal may indeed provide useful lessons for the current period.

The most important work of New Deal cases with respect to health care policy was not the expansion of commerce power⁸ or the demise of economic liberties,⁹ but the establishment of the federal welfare state under the spending power.

The New Deal cases affected this outcome in two respects: first, by adopting a broad interpretation of the “General Welfare Clause” as a freestanding source of congressional authority; and, second, by endorsing a cooperative federalism approach to addressing social problems.

Especially important for health care were the New Deal cases upholding the Social Security Act (SSA),¹⁰ the statute that now includes two core government health care programs, Medicare and Medicaid.





The 1935 SSA extended very limited public health funding to states,²⁵ and those provisions faced no constitutional challenge.

Post-New Deal Health Care Legislation

Post-New Deal federal health care legislation was similarly modest and targeted particular health care infrastructure needs or groups, including the very elderly, deemed especially deserving of government assistance.²⁶

By and large, federal legislation over the past century has been centered on supporting access to private health insurance, especially through tax-based subsidization of employer-based health insurance programs.²⁷

The 1965 enactment of Medicare and Medicaid represents the high-water mark of direct federal involvement in providing and paying for health care.

Johnson's Great Society programs did not arise out of the same nationwide economic depression as the New Deal but in many ways took up the unfinished business of Roosevelt's social policy agenda.²⁸

In the civil rights era, there was a sense that lack of access to essential social services perpetuated inequality just as much as direct discrimination.

Congress addressed lack of access to medical care with three programs: Medicare Part A, covering inpatient hospital care; Medicare Part B, covering physician services; and Medicaid, providing government health insurance to the "deserving" poor.²⁹

These programs established a nationwide single-payer health care system, albeit limited to the elderly, disabled and certain poor Americans.

The programs were enacted as amendments to the SSA, and Congress' spending power authority to establish them under *Butler*, *Helvering* and *Steward Machine* was never questioned. Indeed, since the New Deal, the Supreme Court has struck down no federal program as exceeding the spending power.³⁰

The only significant political objection to Medicare and Medicaid came from the physician community, which feared government control of the practice of medicine and intrusion on the physician-patient relationship.³¹

Those concerns were addressed by giving considerable concessions to doctors, including the addition of Part B itself,

Three cases were of pivotal importance. First, a pre-cursor decision in 1936, *United States v. Butler*,¹¹ although striking down President Franklin Delano Roosevelt's Agricultural Adjustment Act on 10th Amendment grounds (and under the Supreme Court's then-prevailing view that agricultural production was not "commerce"), endorsed a broad Hamiltonian interpretation of spending power as not merely ancillary to the other enumerated powers.¹² As long as Congress was addressing a general, not merely a specific, concern, the spending power could reach it.¹³

Second, a pair of companion cases in 1937 carried the *Butler* General Welfare Clause interpretation forward to uphold the SSA.

In *Helvering v. Davis*,¹⁴ the Supreme Court validated both Title VIII, imposing mandatory payroll taxes on employers, and the separate Title II, authorizing payment of government pensions to old-age workers. The Supreme Court held that both the taxing and spending provisions of the SSA fell within the General Welfare Clause,¹⁵ recognizing that the problem of the elderly in need of support was clearly nationwide.¹⁶

In *Steward Machine Co. v. Davis*,¹⁷ the Supreme Court likewise upheld the federal unemployment compensation tax on employers. Under the SSA, employers received a credit against the federal tax for any amount paid to a state unemployment compensation program.¹⁸ The Supreme Court rejected claims that the provision was an unconstitutional tax, or that it invaded states' reserved powers or otherwise coerced states.¹⁹

Steward Machine, accordingly, established the constitutional basis for the conditional spending power. The federal government could achieve broad policy objectives, not by commandeering or directly regulating states, but by incentivizing with secured funds states' participation in federal programs.

The success of the SSA cooperative federalism strategy soon became evident. In 1930, before the New Deal, only one state (Wisconsin) had a state unemployment compensation program.²⁰ By 1937, after enactment of the SSA, 43 states had passed unemployment compensation laws.²¹

But where was health care in the New Deal?

The Supreme Court's broad interpretation of the General Welfare Clause and constitutional approval of the SSA old-age pension and unemployment compensation provisions seemingly would similarly have supported a national health care program.

Roosevelt's 1944 State of the Union Address and aspirational "Second Bill of Rights" included "[t]he right to adequate medical care and the opportunity to achieve and enjoy good health."²²

But the framers of the 1935 SSA put that goal to one side due to political objections, including widespread fear of socialized medicine and fragile political support for the act itself.²³

Health care would not be added to the SSA until 30 years later as part of President Lyndon B. Johnson's War on Poverty.

Before the New Deal, federal funding for health care was limited to public health aims, including infectious disease control focused on the immigrant population, with some assistance to pregnant women, infants and disabled children.²⁴

covering physician and outpatient services, along with the originally proposed Part A coverage for inpatient hospital care. The law also allowed physicians to bill patients directly for the cost of care not covered by Medicare.³²

Medicare and Medicaid also maintained active roles for private insurers and providers as government contractors to administer the programs and process claims.³³ Private insurance companies, including Blue Cross and Blue Shield, some of the earliest insurance companies, which were founded by associations of hospitals and physicians, have long served as Medicare and Medicaid contractors.

The absence of any comparable expansion of the federal welfare state since 1965 is not because such programs would be unconstitutional. Rather, federal health reform policy has been driven by a deep commitment to private solutions, especially by shoring up the now-dominant employer-based system, through which the majority of insured Americans receive their coverage.³⁴

In terms of federal health care legislation, the 2003 enactment of Medicare Part D, an optional outpatient prescription drug benefit, was as dramatic as it has gotten.³⁵ And this George W. Bush-era program reflects a conspicuously private-market “managed competition” model,³⁶ complete with a gaping 100%-self-pay “doughnut hole.”³⁷

The federal government pays a portion of beneficiaries’ routine, low-cost prescription drugs, and an even larger portion of catastrophic, high-cost drugs but provides no assistance for drug costs between those two extremes.

By design, private “pharmacy benefit managers” compete to enroll Medicare beneficiaries in their Part D prescription drug plans.

It is clear that even within big government programs, the private market continues to dominate health care delivery.

The Patient Protection and Affordable Care Act

Against that historical backdrop, the sleeper issue in the Affordable Care Act litigation that provides the real potential for contraction of federal authority concerns the scope of the spending power.

Before the three days of oral arguments in March, which offered their own surprises, the Supreme Court’s most unlikely move was granting certiorari to the states’ Medicaid challenge in the Florida lawsuit.

No circuit court had ruled in the states’ favor on that question, and similar challenges to even broader, more sweeping expansions of Medicaid in the past have not succeeded.³⁸

The states’ argument rests on a suggestion in *Steward*

Machine,³⁹ revived in *South Dakota v. Dole*,⁴⁰ that federal conditions on funding to states could, at some as-yet-unidentified point, become so coercive as to violate the anti-commandeering limit on the commerce power.

Acknowledging that the Medicaid program has been in place for more than 50 years, with every state voluntarily agreeing to go along with both it and many changes to federal requirements over the life of the program,⁴¹ a discontented group of states argued that the ACA’s particular expansion of Medicaid has “pass[ed] the point at which ‘pressure turns into compulsion.’”⁴²

If the Supreme Court takes this opportunity to limit the spending power and restrict the congressional amendment of existing cooperative programs, that decision could have significant implications that could give rise to a constitutional crisis.

The New Deal established a firm foundation for cooperative federalism, on which Medicaid and so many other programs are built.

Writing in 1958, Arthur Miller quoted President Woodrow Wilson, opining, at the turn of the century, that “the question of the relation of the States to the federal government is the cardinal question of our constitutional system.”⁴³ But by the time Miller wrote, 50 years later, he maintained “that question has largely been settled.”⁴⁴

To Miller, *Helvering* and *Steward Machine*, upholding the SSA, “gave final constitutional approval to the outlines of cooperative federalism. Once breached, the dam has never been repaired; the trickle became a stream and then a flood.”⁴⁵

Going forward, Miller envisioned states as not much more than federal “housekeepers.”⁴⁶ By and large, any new, important activities of state governments are federally funded: “When new problems arise, eyes swivel to Washington, not to the state capitol.”⁴⁷

Consistent with Miller’s prescience, ACA derives from federal legislation but relies heavily on state cooperation to put in place comprehensive reforms.

That expectation is not limited to Medicaid. State-based health insurance exchanges are intended to be the central pillars of the reformed private market for individual and small-group health insurance.⁴⁸

Also, states were invited to assist the federal government in establishing stop-gap, high-risk insurance pools, almost as soon as ACA was enacted.⁴⁹

Recently, federal authorities passed on the task of defining a fundamental component of the private market health reforms, the “essential health benefits” package, to the states.⁵⁰

Accordingly, the Supreme Court’s ruling on Medicaid expansion would have implications for the operation of those provisions of ACA, as well as a host of other long-standing cooperative federal-state programs.

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“The crisis – or more properly,
the opportunity – is political.”

The implications of Supreme Court review of the conditional spending power were highlighted in a different case this term, *Douglas v. Independent Living Center of Southern California*.⁵¹

The question in *Douglas* was whether Medicaid beneficiaries or providers could sue states to force compliance with federal statutory requirements.

Precedent is clear that there is no individually enforceable statutory right to state compliance with a federal conditional spending program under 42 U.S.C. § 1983.⁵²

The *Douglas* petitioners, however, sought to overturn California’s Medicaid policies, not by way of Section 1983, but simply as state laws that are preempted by federal Medicaid laws.⁵³

After granting review and hearing argument, the Supreme Court declined to answer the question because federal authorities had, after the filing of the cert petition, approved California’s allegedly noncompliant Medicaid program.⁵⁴ Thus, the question remains unresolved.

The possibility of Supremacy Clause challenges to state laws purporting to implement federal standards could radically affect the administration of cooperative programs on which foundation many of ACA’s provisions rest.

For example, if states agree, but then fail, to establish ACA-compliant health insurance exchanges, could individuals sue to force them to do so?⁵⁵ More generally, can individuals sue to prevent systematic state misconduct under federal programs?

Is There a Constitutional Crisis?

Returning to the questions put to our panel: The current crisis, if any, is political, not constitutional.

Assuming that we agree Congress could get at the health insurance coverage and health care access problems another way, through different exercises of the commerce and spending powers, then there is no “crisis” about the scope of federal authority.

Moreover, there is no pressing need to contract or expand federal power in order to address major and novel societal problems. There is nothing for which the law needs to find a new way.

The crisis – or more properly, the opportunity – is political.

Most Americans agree we need to do something about the health care system. And most people are deeply troubled by many commercial insurance practices, including the manner in which insurers currently exclude individuals and price health insurance policies for those who arguably need coverage the most.⁵⁶

To address those concerns, the one solution that made it through Congress – a solution initially proposed by a conservative think-tank in response to Clinton’s health reforms⁵⁷ – was to require most everyone to purchase insurance before they think they need it and to put in place federal tax incentives and subsidies to help individuals comply.

Politically, that approach reveals that we remain more comfortable with a private, competitive market for health care, rather than Medicare for All.

So either we get comfortable with Medicare for All and tackle all of the challenges of a single-payer system or we continue to put incentives, subsidies and nudges in place, perhaps even excising the individual mandate from ACA, and see if people come around on their own.⁵⁸

The political opportunity in the ACA litigation, however the Supreme Court rules on the individual mandate, lies in highlighting to the electorate the alternative of a more comprehensive, general welfare approach to health care.

Where that opportunity could derail into crisis is if the Supreme Court, for the first time in 75 years, substantially limits Congress’ authority to enact or administer new federal or cooperative federal-state health care programs.

Endnotes

¹ See DAN T. COENEN, CONSTITUTIONAL LAW: THE COMMERCE CLAUSE 44 (2004) (describing social and economic context out of which seminal Supreme Court precedent arose).

² 26 U.S.C. § 5000A(a) (Supp. IV 2010) (requiring that every U.S. citizen, other than those falling within specified exceptions, maintain a minimum level of health insurance coverage for each month beginning in 2014); see also *id.* § 5000A(b) (imposing a federal tax penalty for noncompliance).

³ See *Gonzales v. Raich*, 545 U.S. 1 (2005); *Wickard v. Filburn*, 317 U.S. 111 (1942).

⁴ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2010) (extending Medicaid eligibility to adults under age 65 (who are not pregnant and not already covered) with incomes up to 133% of the federal poverty level).

⁵ See *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (“Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns to compulsion.’”) (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)).

⁶ See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-11-392R, PRIVATE HEALTH INSURANCE COVERAGE: EXPERT VIEWS ON APPROACHES TO ENCOURAGE VOLUNTARY ENROLLMENT (2011) [hereinafter GAO Report], available at www.gao.gov/assets/100/97317.pdf; Einer Elhauge, *The Irrelevance of the Broccoli Argument against the Insurance Mandate*, NEW ENG. J. MED., Dec. 21, 2011, available at www.nejm.org/doi/pdf/10.1056/NEJMp1113618.

⁷ Even some of the strongest proponents of the view that the individual mandate is unconstitutional agree that Medicare for All is constitutional. See *AALS Hot Topic Panel Question and Answer Session*, 62 MERCER L. REV. 650, 660 (2011) (quoting remark by Professor Randy Barnett: “I just want to say, and maybe we’ll end on a point of agreement here, that if Medicare is constitutional, then Medicare for everyone is constitutional.”).

⁸ See *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937).

⁹ See *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937).

¹⁰ Pub. L. No. 74-271, 49 Stat.

620 (1935).

¹¹ 297 U.S. 1.

¹² *Id.* at 66.

¹³ *Id.* at 66-67.

¹⁴ 301 U.S. 619 (1937).

¹⁵ *Id.* at 909.

¹⁶ *Id.* at 909-10.

¹⁷ 301 U.S. 548 (1937).

¹⁸ *Id.* at 574.

¹⁹ *Id.* at 585-87.

²⁰ *Id.* at 587.

²¹ *Id.* at 587-88.

²² President’s Message to Congress on the State of the Union, 12 PUB. PAPERS 41 (Jan. 11, 1944).

²³ See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 266-69 (1982); Robert I. Field,

Regulation, Reform and the Creation of Free Market Health Care, 32 HAMLINE J. PUB. L. & POLY 301, 308 (2011).

²⁴ See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 155-61 (2d ed. 2008); STARR, *supra* note 23, at 240-42; Elizabeth Fee & Theodore M. Brown, *The Unfulfilled Promise of Public Health: Dejà Vu All Over Again*, HEALTH AFF., Nov./Dec. 2002, at 31, 34-35.

²⁵ See STARR, *supra* note 24, at 270.

²⁶ See STARR, *supra* note 24, at 270-71 (describing limited government health care programs, including poor farmer subsidies); see, e.g., Federal Food, Drug & Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938) (expanding FDA’s regulatory role); Hospital Survey & Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (funding new hospital construction and expansion); Kerr-Mills Act, Pub. L. No. 86-778, 74 Stat. 924 (1960) (providing federal assistance to the very poor elderly); see also THEODORE R. MARMOR, THE POLITICS OF MEDICARE 27-30 (2d ed. 2000) (describing limited government assistance under Kerr-Mills Act).

²⁷ See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POLY L. & ETHICS 23, 25-26 (2001) (discussing the historical rise of employment-based coverage, including wage and price controls, tax code incentives, and union pressure); Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 760-61 (2011) (describing historical events that gave rise to employer-based health insurance).

²⁸ See STARR, *supra* note 24, at 367; Fee & Brown, *supra* note 25, at 39.

²⁹ See MARMOR, *supra* note 27, at 59-60 (describing the three parts of the legislation); STARR, *supra* note 24, at 369 (similarly describing the “three-layered cake”).

³⁰ Erwin Chemerinsky, *A Defense of the Constitutionality of the Individual Mandate*, in Brad Joondorph, *Our Pending National Debate: Is Health Care Reform Constitutional?* 62 MERCER L. REV. 605, 618 (2011) (“Since 1937, the Supreme Court has struck down no major social program.”); COENEN, *supra* note 2, at 185 (“In the post-1936 period, the Court has upheld federal spending programs without exception.”).

³¹ See MARMOR, *supra* note 27, at 58; STARR, *supra* note 24, at 369; Field, *supra* note 24, at 313.

³² See MARMOR, *supra* note 27, at 60-61.

³³ See Field, *supra* note 24, at 313-14.

³⁴ See Leonard, *supra* note 28, at 760 (noting that 61% of the non-elderly population obtains health insurance from an employer plan); see, e.g., Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (providing grants to employers for adding HMOs to health plans); Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (creating extensive federal regulation of employee benefit plans, including health plans); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (allowing employees to maintain employer-based health insurance after termination for certain qualifying events); Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (allowing employees to change jobs without being excluded from health plans for pre-existing conditions).

³⁵ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

³⁶ See Jonathan Oberlander, *Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act*, 32 J. HEALTH POL. POLY & L. 187, 201-02 (2007).

³⁷ 42 U.S.C. § 1395w-102(b).

³⁸ See *Florida v. HHS*, 648 F.3d 1235, 1265 (2011) (citing cases).

³⁹ 301 U.S. at 589-90.

⁴⁰ 483 U.S. at 211

⁴¹ See Brief of Amici Curiae Health Law & Policy Scholars and Prescription Policy Choices in Support of Respondents on the Constitutional Validity of the Medicaid Expansion at 1-13, *Florida v. HHS*, No. 11-400 (U.S. Feb. 17, 2012) available at <http://aca-litigation.wikispaces.com/file/view/Health+Law+%26+Policy+Scholars+amicus+%2811-400+Medicaid%29.pdf> (describing Medicaid program expansions).

⁴² *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 589-90).

⁴³ Arthur S. Miller, *The Constitutional Law of the “Security State”*, 10 STAN. L. REV. 620, 635-36 (1958).

⁴⁴ *Id.* at 636.

⁴⁵ *Id.* at 629.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ 42 U.S.C. § 18031 (Supp. IV 2010). See also Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice under the Affordable Care Act*, 74 ALB. L. REV. 241, 284-93 (2010-2011) (describing the operation of exchanges).

⁴⁹ 42 U.S.C. § 18001 (Supp. IV 2010); News Release, U.S. Dept. of Health & Human Servs., HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan (July 1, 2010), available at www.hhs.gov/news/press/2010pres/07/20100701a.html.

⁵⁰ See News Release, U.S. Dept. of Health & Human Servs., HHS to Give States More Flexibility to Implement Health Reform (Dec. 16, 2011), available at www.hhs.gov/news/press/2011pres/12/20111216c.html. See also Alan Weil, *The Value of Federalism in Defining Essential Health Benefits*, 366 NEW ENG. J. MED. 679, 679 (2012), available at www.nejm.org/doi/pdf/10.1056/NEJMp1200693.

⁵¹ Nos. 09-958, 09-1158 & 10-283 (U.S. 2011) (consolidated).

⁵² See *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002); *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (applying *Gonzaga* in Medicaid context).

⁵³ *Douglas v. Indep. Living Ctr. of S. Cal.*, No. 09-958 (U.S. 2011), available at www.supremecourt.gov/qp/09-00958qp.pdf (questions presented).

⁵⁴ *Douglas v. Indep. Living Ctr. of S. Cal.*, -- S.Ct. --, 2012 WL 555204 (U.S.).

⁵⁵ See Sara Rosenbaum, *Equal Access for Medicaid Beneficiaries — The Supreme Court and the Douglas Cases*, 365 NEW ENG. J. MED. 2245 (2011), available at www.nejm.org/doi/pdf/10.1056/NEJMp1111428 (discussing implications of private oversight of ACA implementation).

⁵⁶ See *Kaiser Health Tracking Poll: Public Opinion on Health Care Issues*, THE HENRY J. KAISER FAMILY FOUNDATION, at 6 (Sept. 2011), available at www.kff.org/kaiserpolls/upload/8230-F.pdf.

⁵⁷ See Stuart M. Butler, *Assuring Affordable Health Care for All Americans*, THE HERITAGE FOUNDATION, at 6 (1989), available at http://healthcarereform.procon.org/sourcefiles/1989_assuring_affordable_health_care_for_all_americans.pdf.

⁵⁸ At least some studies suggest that most uninsured people actually want health insurance but simply cannot afford it and that other ACA provisions may make it affordable enough for most. See GAO Report, *supra* note 7, at 14 (noting experts’ conclusions that most people would prefer to purchase health insurance but that high cost is a barrier); John F. Sheils & Randall Haught, *Without The Individual Mandate, The Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted*, HEALTH AFF., Nov. 2011, at 1 (summarizing Lewin group study findings that 23 million people would still get coverage, only 7.8 million fewer than with the mandate).