

NEW DEAL LESSONS FOR THE AFFORDABLE CARE ACT: THE GENERAL WELFARE CLAUSE

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The questions put to our panel were: Is a constitutional crisis on the order of 1937 looming?² 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, derives from the spending power, not the commerce power, where most of the attention has been. More importantly, the controversy surrounding the Affordable Care Act, if a crisis at all, is political. With crisis comes opportunity. In this case, the controversy is an opportunity for us to carefully consider whether the predominantly private market approach to health care is the direction we want to continue. Alternatively, the 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 that something needs to be done to fix the U.S. health care system. But there is no similar

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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).

urgency for the Supreme Court to radically redefine the scope of federal power.

In conceiving a present-day constitutional crisis, one might view the New Deal as representing unprecedented expansion of federal power, and the Affordable Care Act litigation as inviting the Court to contract federal power. I maintain that the Affordable Care Act (“ACA”) minimum essential coverage provision,² or “individual mandate,” is constitutional under existing precedent.³ The issue, then, is whether the Court takes this opportunity to refine, or define new, limits on the commerce power. I also believe that the twenty-six states’ challenge to ACA’s Medicaid expansion⁴ as a violation of the Tenth Amendment is unsupported by precedent. But again, the issue is whether the Court will decide to elucidate existing limits on conditional spending power.⁵ Even framing the issues in those terms, the controversy is not driven by 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.

Taking the “even if” arguments one step further: Even if there is 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 some other privilege (federal student loans) or activity (accessing medical care), or could truly style the law as a federal tax, perhaps with a credit for obtaining insurance and redistribution under the spending power, essentially “Medicare for All.” Either alternative would be an exercise of constitutional congression-

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 <http://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 <http://www.nejm.org/doi/pdf/10.1056/NEJMp1113618>.

al power. Federal power would still be expanded at least as much as by the currently enacted individual mandate. The political process, but not the Constitution, blocked those or similar alternatives.

Consider Medicare for All: Accepting that as a constitutional alternative to the individual mandate,⁷ the real question before the Court, the real possibility for limiting federal power, is not the commerce power, but the spending power. On that point, the structural issues before the Court during the New Deal may provide 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 did so in two respects: First, by adopting a broad interpretation of the General Welfare Clause as a discrete 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. First, a pre-cursor decision in 1936, *United States v. Butler*,¹¹ although striking down President Roosevelt's Agricultural Adjustment Act on Tenth Amendment grounds (and under the Court's then-prevailing view that agricultural production is not "commerce"), also 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 A pair of companion cases in 1937 carried the *Butler* General Welfare Clause interpretation forward to expressly uphold the SSA. In *Helvering v. Davis*,¹⁴ the 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 Court held that both the taxing and spending provi-

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).

sions 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 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 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 conditional spending power. The federal government could achieve broad policy objectives, not by commandeering or directly regulating states, but by placing incentives on them to participate in enacting federal programs. The success of the SSA cooperative federalism strategy was soon evident. In 1930, before the New Deal, only one state (Wisconsin) had a state unemployment compensation program.²⁰ By 1937, after the SSA, 43 states had passed unemployment compensation laws.²¹

But where was health care in the New Deal? The Court's broad interpretation of the General Welfare Clause and constitutional approval of the SSA old-age pension and unemployment compensation provisions would similarly have supported a national health care program. President Roosevelt's 1944 State of the Union Address and aspirational "Second Bill of Rights" included: "The right to adequate medical care and the opportunity to achieve and enjoy good health."²² But the 1935 SSA had not achieved that goal 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 President Johnson's 1965 War on Poverty. Before the New Deal, federal funding for health care was limited to public health aims, including infectious disease control and immigration, with some assistance to pregnant women, infants, and disabled

15 *Id.* at 640.

16 *Id.* at 641–44.

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. & POL'Y 301, 308 (2011).

children.²⁴ The 1935 SSA extended limited public health funding to states,²⁵ and those provisions faced no constitutional challenge. Post-New Deal federal health care legislation was similarly modest and targeted to particular health care infrastructure needs or groups deemed especially deserving government assistance.²⁶ By and large, federal legislation over the past century has been to support private health insurance, especially the rise of employer-based health insurance.²⁷

The 1965 enactment of Medicare and Medicaid represents the high-water mark for federal health care legislation. President 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 perpetuates inequality just as much as direct discrimination. Congress addressed lack of access to medical care with three programs: Medicare Part A, Medicare Part B, and Medicaid.²⁹ Those 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 Social Security Act, and Congress's spending power authority under *Butler*, *Helvering*, and *Steward Machine* was never questioned. Indeed, since the New

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: Déjà Vu All Over Again*, HEALTH AFF., Nov./Dec. 2002, at 31, 34–35.

25 See STARR, *supra* note 23, at 270.

26 See STARR, *supra* note 23, 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 POL'Y 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 23, at 367; Fee & Brown, *supra* note 24, at 39.

29 See MARMOR, *supra* note 26, at 59–60 (describing the three parts of the legislation); STARR, *supra*, note 23, at 369 (similarly describing the “three-layered cake”).

Deal, the 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 with considerable concessions, including Part B itself, which added optional physician services to the Part A mandatory coverage for inpatient hospital care, and allowed balance billing by physicians.³² In addition, the programs maintained an active role for private insurers and providers, through reimbursement methodologies and claims administration.³³

The absence of comparable expansion of the federal welfare state since 1965 is not because such programs would be unconstitutional. Rather, federal health reform policy has maintained a commitment to private solutions, especially 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 that Bush-era program is conspicuously a “managed competition” model,³⁶ with a gaping 100%-self-pay “doughnut” hole.³⁷ Even within big govern-

³⁰ See Erwin Chemerinsky, *A Defense of the Constitutionality of the Individual Mandate*, 62 MERCER L. REV. 618, 618 (“Since 1937, the Supreme Court has struck down no major social program.”); COENEN, *supra* note 1, at 185 (“In the post-1936 period, the Court has upheld federal spending programs without exception.”).

³¹ See MARMOR, *supra* note 26, at 58; STARR, *supra* note 23, at 369; Field, *supra* note 23, at 313.

³² See MARMOR, *supra* note 26, at 60–61.

³³ See Field, *supra* note 23, at 313–14.

³⁴ See Leonard, *supra* note 27, 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. POL’Y & L. 187, 201–02 (2007).

³⁷ 42 U.S.C. § 1395w-102(b).

ment programs, the private market continues to dominate health care delivery.

Against that historical backdrop, the sleeper issue in the Affordable Care Act, and the real potential for contraction of federal authority, is the spending power. The Supreme Court's most surprising move thus far 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 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, pass the point of pressure and become unconstitutionally coercive. Acknowledging that the Medicaid program has been in place for over fifty years, with every state voluntarily agreeing to participate and many changes to the coverage and eligibility requirements over the life of the program,⁴¹ states nevertheless argue that the ACA's particular expansion of Medicaid now constitutes coercion. If the Court takes this opportunity to limit the spending power and to restrict 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. Arthur Miller, writing in 1958, quoted Woodrow Wilson in 1908, 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."⁴² But by the time Miller wrote fifty years later, he maintained "that question has largely been settled."⁴³ 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."⁴⁴ Going forward, Miller saw states as not

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 Arthur S. Miller, *The Constitutional Law of the "Security State"*, 10 STAN. L. REV. 620, 635–36 (1958).

⁴³ *Id.* at 636.

⁴⁴ *Id.* at 629.

much more than federal “housekeepers.”⁴⁵ 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.”⁴⁶

Consistent with Miller’s prescience, ACA derives from federal legislation but relies heavily on state cooperation to enact the 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.⁴⁷ Also, states were invited to assist the federal government in establishing stop-gap, high-risk insurance pools, almost as soon as ACA was enacted.⁴⁸ Recently, federal authorities passed on the task of defining a fundamental component of the private market health reforms, the “essential health benefits” package, to states.⁴⁹ Accordingly, the 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.

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*.⁵⁰ The question in *Douglas* was whether Medicaid beneficiaries or providers can sue states to enforce compliance with federal requirements. Precedent is clear that there is no individually enforceable statutory right to state compliance.⁵¹ Instead, the *Douglas* Petitioners challenged California’s Medicaid policies on supremacy (federal preemption) grounds.⁵² After granting review and hearing argument, the Court declined to answer the question because federal authorities in the meanwhile had

45 *Id.*

46 *Id.*

47 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 ALA. L. REV. 241, 284–93 (2010–2011) (describing the operation of exchanges).

48 42 U.S.C. § 18001 (Supp. IV 2010); News Release, U.S. Dep’t of Health & Human Servs., HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan (July 1, 2010), available at <http://www.hhs.gov/news/press/2010pres/07/20100701a.html>.

49 See News Release, U.S. Dep’t of Health & Human Servs., HHS to Give States More Flexibility to Implement Health Reform (Dec. 16, 2011), available at <http://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 <http://www.nejm.org/doi/pdf/10.1056/NEJMp1200693>.

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

51 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).

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

approved California's allegedly noncompliant Medicaid program.⁵³ Thus, the question remains unresolved. The possibility of Supremacy Clause challenges to state laws purporting to implement federal standards could radically affect administration of those cooperative programs. For example, if states agree, but then fail, to establish ACA-compliant exchanges, could individuals sue to force them to do so?⁵⁴ More generally, can individuals sue to prevent state misconduct under federal program rules and regulations?

Returning to the questions put to our panel: The current crisis, if any, is political, not constitutional. Assuming we agree that Congress could get at the health insurance coverage and health care access problems another way, through different exercises of commerce or spending power, then there is no "crisis" about the scope of federal power. Moreover, there is no pressing need to contract or expand federal power in order to address societal problems. There is nothing for which the law needs to find a way. The crisis—or more properly, opportunity—is political. Most Americans agree that 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.⁵⁵

To address those concerns, the one solution that made it through Congress—and one initially proposed by a conservative think-tank in response to Clinton health reform⁵⁶—was to require (most) everyone to purchase insurance before they think they need it and to give federal tax incentives and subsidies to help them 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, get there, and tackle all 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

⁵³ *Douglas v. Indep. Living Ctr. of S. Cal.*, 2012 WL 5555204 (U.S.).

⁵⁴ See Sara Rosenbaum, *Equal Access for Medicaid Beneficiaries—The Supreme Court and the Douglas Cases*, 365 NEW ENG. J. MED. 2245 (2011), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1111428> (discussing implications of private oversight of ACA implementation).

⁵⁵ See *Kaiser Health Tracking Poll: Public Opinion on Health Care Issues*, THE HENRY J. KAISER FAMILY FOUNDATION, at 6 (Sept. 2011), available at <http://www.kff.org/kaiserpolls/upload/8230-F.pdf>.

⁵⁶ 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.

around on their own.⁵⁷ The political opportunity in the Affordable Care Act litigation, however the Court rules on the individual mandate, is allowing the electorate to consider the alternative of a more comprehensive, welfare-state approach to health care by closely examining the private market alternative. Where that opportunity could derail into crisis is if the Court, for the first time in seventy-five years, substantially limits Congress's authority under the General Welfare Clause.

⁵⁷ 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 6, 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).