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The past, present, and future of universal healthcare

Andrew Walter Parr

The Past, Present, and Future of Universal Healthcare

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FACULTY COMMITTEE:

Project Advisor: Philip, Frana, Ph.D.
Associate Dean and Associate Professor of Interdisciplinary Liberal Studies

Reader: Philip, Frana, Ph.D.
Associate Dean and Associate Professor of Interdisciplinary Liberal Studies

Reader: Matthew, Chamberlin, Ph.D.,
Director, Independent Scholars Program; Faculty Member

HONORS COLLEGE APPROVAL:

Bradley R. Newcomer, Ph.D.,
Dean, Honors College

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To my Parents. Without whom I would be nothing. Literally.

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Abstract

Since the dawn of the twentieth century, the demand for universal healthcare has been growing in the United States. Our health outcomes are poor, yet American healthcare is some of the most expensive in the world. Many proponents of a universal healthcare system assert that it could fix these problems. However, their opponents contend that it would bankrupt the nation and leave our healthcare woes unchanged. In this paper, I do not take a stance on that issue. Rather, I seek to explore the development of the U.S. healthcare system and understand its current state. I then examine and compare current proposals to "fix" the U.S. healthcare system. This paper concludes by postulating what a Supreme Court case containing a constitutional challenge of one such proposal might look like. I seek to answer the question: Is universal healthcare constitutional? Based on the current state of the law in the United States the answer is most likely no.

I. The History of Healthcare

Although nations such as Germany, Austria, Hungary, Norway, Britain, and Russia began to create social insurance programs in the late eighteenth and early nineteenth centuries, The United States abstained[1]. These programs were created in order to protect workers from unemployment, the cost of medical bills, and wages lost due to sick leave. Progressive reformers in the United States were not as interested in reforming health insurance in the U.S. as reformers in Europe were. In the early 1900s progressives advocated for health insurance to protect lower class workers from increased medical bill costs; however, most of this support was directed towards private insurance rather than government socialized insurance. The railroad industry led the way in terms of providing private health insurance for its workers.[2]

As medicine modernized hospitals quickly became more "high tech". Rather than simply housing and feeding sick patients they were able to provide antiseptics and treatments to reduce pain. The American Hospital Association (AHA) was formed in 1898 and worked to provide education for health care leaders and was a source of information on health care issues and trends. In 1901 the American Medical Association (AMA) established regional chapters and by 1910 it had increased its membership tenfold.[3] It continued to grow and eventually included almost half the physicians in the United States. During this period surgery became common practice and the power of doctors grew substantially. As medicine became more advanced physicians gained more power. They were no longer quacks performing pseudo-surgeries and

[1] Physicians For a National Health Program. "A Brief History: Universal Health Care Efforts in the US." PNHP, n.d. https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/.
[2] PBS. "Healthcare Crisis: Healthcare Timeline." PBS Healthcare. Public Broadcasting Service, n.d. https://www.pbs.org/healthcarecrisis/history.htm.
[3] *Ibid.*

dismemberments. As the AMA became more powerful, physicians began demanding greater payment for their services.

The American Association of Labor Legislation (AALL) began demanding reform for social insurance in the nineteen teens.[4] They held conferences on and began to lobby legislators to create social insurance programs in the United States. At first, the AMA was supportive of the AALL's mission to transform American healthcare. However, the AALL and the AMA could not agree on what physicians were to be paid. The AMA would not tolerate a reduction in doctors' salaries under a system of socialized medicine. The AMA and AHA both opposed this effort. They eventually came to deny that they had ever supported the AALL's proposal.[5]

However, among the American people social insurance and social medicine began to become more popular. The American Federation of Labor (AFL) also opposed the AALL's proposal. The AFL believed that compulsory health insurance would limit the power of labor unions to negotiate wages and benefits with workers. The AALL proposed a system of social insurance that would have ensured families, that made under $1200 a year, would not have to bear the burden for funeral costs.[6] A substantial portion of the private insurance industry business in the early twentieth century was lower income funeral policies. The fear that socialized insurance would eliminate this business led the private insurance industry to also oppose the AALL plan. WWI, and the rise of Anti-German propaganda that denounced German socialism, eventually turned the public against the AALL proposal too. For a time, this killed the prospect of social insurance in the United States.

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[4] Starr, Paul. "Transformation in Defeat: The Changing Objectives of National Health Insurance 1915-1980." American Journal of Public Health 72, no. 1 (January 1982): 78.
[5] Physicians For a National Health Program. "A Brief History: Universal Health Care Efforts in the US."
[6] *Ibid*.

However, healthcare costs continued to rise. In the 1920s General Motors began the push for employer-based insurance when they insured 180,000 of their workers against healthcare related costs. The advent of the Great Depression brought about the necessary motivation for reform. In 1933 Isidore Falk and Edgar Sydenstricker were enlisted by President Franklin Roosevelt to draft a public healthcare program that was to be included in the Social Security Act.[7] The social health insurance program portion of the bill was condemned by the American Medical Association and, in order to pass a social security type program at all, the health insurance portion had to be scrapped. The AMA, AHA, and other lobbies threatened to pressure vulnerable members of Congress to vote against the bill in its entirety.[8] President Roosevelt was under immense pressure to ensure that social security legislation was passed so the healthcare portion of the bill was removed.

In the 1940s Blue Cross began offering private insurance coverage for hospital services across the United States.[9] Private corporations took after General Motors' lead and began offering employees insurance in order to abide by the wage controls implemented during WWII. Also, at this time, twenty years after its discovery, penicillin began being used by physicians to treat bacterial infections.[10] As a result, physicians gained even more power. In the late 1940s President Truman displayed vigorous support for a compulsory national health insurance system that would be mandatory for all Americans. This was the first time that health insurance had been proposed that would cover those that were well off. However, Republicans in Congress denounced Truman's plan as a communistic agenda. They refused to debate a Truman-like

[7] PBS. "Healthcare Crisis: Healthcare Timeline." PBS Healthcare. Public Broadcasting Service, n.d.
[8] Physicians For a National Health Program. "A Brief History: Universal Health Care Efforts in the US."
[9] PBS. "Healthcare Crisis: Healthcare Timeline." PBS Healthcare.
[10] Physicians For a National Health Program. "A Brief History: Universal Health Care Efforts in the US."

proposal.[11] The AMA and other powerful lobbies continued to oppose any sort of national health insurance program during this time. American voluntarism, however, was at an all-time high, and many hospitals and physicians gave charity care to those that could not afford it.

Throughout the 1950s national calls for health insurance became taboo as the Cold War heated up. Any suggestion at socializing medicine was seen as communist propaganda. Moreover, in the early 1960s, Democratic Congressmen began to propose legislation that once again focused on social insurance. The AMA, seeing that their power once again might potentially be reduced, countered social insurance legislation with a proposed system of benefits for the elderly.[12] These benefits were deemed "eldercare" and were devised to accompany the Social Security Act. Republican Congressmen countered with a two-part Medicare A and B plan that covered health insurance and supported an optional primary care insurance fund. Medicaid was also included in this proposal.[13] As part of his Great Society program President Lyndon Johnson signed Medicare and Medicaid into law in 1965.

In the 1970s employer sponsored health insurance had become widespread. However, by 1974 healthcare costs had risen twenty percent, twenty-five million Americans were uninsured, and forty percent of Americans' insurance plans did not cover doctoral visits.[14] As a result of the unprecedent condition of healthcare in the United States, President Richard Nixon, a Republican, introduced a Comprehensive Health Insurance Plan (CHIP) to Congress in 1974. Nixon was a reformer; he had previously signed the National Cancer Act in 1971 and he sought drastic

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[11] Physicians For a National Health Program. "A Brief History: Universal Health Care Efforts in the US."
[12] HealthMarkets Insurance Agency. "American Healthcare History: A Glimpse Back & a Big Step Forward." HealthMarkets, n.d. https://www.healthmarkets.com/content/american-healthcare-history.
[13] *Ibid.*
[14] Seervai, S., & Blumenthal, D. (2017, November 2). Lessons on Universal Coverage from an Unexpected Advocate: Richard Nixon. Retrieved from https://www.commonwealthfund.org/blog/2017/lessons-universal-coverage-unexpected-advocate-richard-nixon

change.[15] Nixon wanted health insurance to be available to all Americans; he believed he could do this without raising taxes. To accomplish this, he sought to enact an employer mandate that compelled all employers to offer private health insurance to permanent employees. However, to decrease the burden on employers, employees would be required to share the cost up to a certain extent. Nixon's CHIP program would not have required the raising of taxes.[16] However, once again the quest for social health insurance was met with opposition from all sides. Republicans generally opposed this program, and CHIP was met with staunch opposition from Ted Kennedy in the Senate. Kennedy was a key Democratic leader, and he favored a single payer system. Democrats believed the CHIP program didn't go far enough. Kennedy and Nixon almost agreed on a plan just before The Watergate Scandal derailed Nixon's presidency.[17] The Watergate Scandal intervened just in time to kill socialized health insurance once again.

In the 1980's, President Ronald Reagan began trying to cut the costs of existing social programs. Medicare payment was shifted from a procedure and treatment-based approach to the Diagnosis Related Group scale. Under the DRG plan Medicare reimbursement was fulfilled by the condition that patients had rather than by the treatment they received. This was done to incentivize providers to engage in the cheapest treatments possible. Private providers began to switch to this system as well to cut the cost of private insurance. However, during this time healthcare costs continued to rise and did so at almost double the normal inflation rate.

[15] Seervai, S., & Blumenthal, D. (2017, November 2). Lessons on Universal Coverage from an Unexpected Advocate: Richard Nixon.
[16] Freed, G. (2015, July 13). Nixoncare vs. Obamacare: U-M team compares the rhetoric & reality of two health plans | Institute for Healthcare Policy & Innovation. Retrieved from https://ihpi.umich.edu/news/nixoncare-vs-obamacare-u-m-team-compares-rhetoric-reality-two-health-plans
[17] Stockman, F. (2012, June 23). Recalling the Nixon-Kennedy health plan. The Boston Globe. Retrieved from https://www.bostonglobe.com/opinion/2012/06/22/stockman/bvg57mguQxOVpZMmB1Mg2N/story.html

By 1990 almost twenty percent of Americans were uninsured.[18] At this time, support for a nationalized healthcare system had grown substantially. The cost of health services and treatments in the early 1900's was problematic for the poor. However, by the 1990's treatments had become so complex that the middle class began to struggle to pay for services that were commonplace. Healthcare was now a middle-class issue; as a result, support for socialized care was at an all-time high. It was a solution that politicians could easily propose without a necessity for too many details. President Bill Clinton had campaigned on a platform of health policy reform; during his Presidency he proposed his own nationalized healthcare program that sought to insure all Americans either through their employers or directly through the government.[19] However, both Republicans and Democrats again criticized the plan from both sides of the aisle. Republicans stated that the plan was too complex and overly invasive in peoples' lives.[20] Many Democrats either introduced plans of their own because they believed the Clinton Plan did not go far enough.

[18] HealthMarkets Insurance Agency. "American Healthcare History: A Glimpse Back & a Big Step Forward."
[19] Skocpol, Theda. "The Rise and Resounding Demise of the Clinton Health Security Plan." In The Problem That Won't Go Away: Reforming U.S. Health Care Financing, edited by Henry J. Aaron, 34–54.
[20] *Ibid.*

II. The History of The Commerce Clause

While healthcare in the United States was developing, a separate phenomenon was occurring. The power of Congress was growing substantially through the expansion of the Commerce Clause. The Constitution of the United States gives Congress the power to regulate interstate commerce. This power is in Article I section 8; from our nation's founding it has given Congress impressive power.[21] Over the years, the Supreme Court has, some would argue, expanded that power. There is still a debate over whether the Court has expanded the powers of the Commerce Clause, or if they have simply discovered this expansive power in the initial Constitution. Because of the mandate of power that this clause gives to Congress, it is no surprise that they often use it as a justification for some of the United States' most inventive and expansive statutes. In *McCulloch v. Maryland* (1819) for example, Congress's authority to create a national bank was challenged when the State of Maryland booted the Second Bank of the United States from its shores.[22] The bank manager sued the state, and Maryland argued that the suit did not have standing because Congress should have no authority to incorporate a bank in the first place.

The Supreme Court; however, found that Congress can incorporate a bank because it is "necessary and proper" to certain powers such as the regulation of commerce.[23] The Court decided that the Commerce Clause must be interpreted in such a way that anything be permissible if "the ends 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

[21] US Constitution, art. 1, sec. 8, cl. 3.
[22] *McCulloch v. Maryland*, 17 U.S. 316 (1819)
[23] *Id.*

consist with the letter and spirit of the constitution are constitutional."[24] In other words, if something is not directly prohibited and it helps Congress accomplish something that goes along with the interpreted meaning of the Constitution, then Congress can operate under the authority of the Commerce Clause. This gave Congress a grant of power to accomplish objectives, that are not directly under the purview of the explicit meaning of the Constitution, so long as they fit the spirit and essence of the document. One such essence is that Congress can create new interstate commerce.

Another important evolution of the Commerce Clause came in *Gibbons v. Ogden* (1824).[25] This case reinforced the earlier principle, of the original Marshall court, and held that the Constitution, and particularly the Commerce Clause, must be interpreted broadly so as to allow Congress to have an unconfused sole authority over disputes of interstate transactions. However, In *Gibbons v. Ogden* the Court improved upon this and found that since commerce, in most circumstances, is neither purely interstate or purely intrastate, then Congress should also have sole authority in regulating intrastate commerce too. Intrastate is synonymous with local commerce or transactions that occur purely within a state. This ruling was the first to establish the Commerce Clause as one that is virtually plenary i.e. limitless or independent.[26] Congress does not have to use the Necessary and Proper Clause in order to regulate commerce for specific reasons. It can do so for any reason or in any way that it pleases. Chief Justice John Marshall, the Chief Justice during these two rulings, held that the people, and the not the Court, should be the sole restraint on legislative overstepping. The votes of citizens for certain legislators over others should be the check on the Constitutionality of legislation.

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[24] *Id.*
[25] *Gibbons v. Ogden*, 22 U.S. 1 (1824)
[26] *Id.*

In *Champion v. Ames (1903),* Congress's power to regulate commerce was once again called into question and then subsequently expanded.[27] The Legislature had banned lotteries in the United States, on grounds that they were a moral cancer. A man, who had been arrested for selling lottery tickets, sued Congress as a result. The suit charged Congress with overstepping its power to regulate commerce. Regulation, according to the challenger's argument in this case, did not include prohibition outright. However, the Court once again ruled in favor of Congress and found that the power of regulation is parallel to the power of prohibition; the Act was upheld.[28]

In *Unites States v. Darby* (1940), Congress's power to regulate commerce was expanded once more when the Court found that Congress could regulate labor conditions so long the as the labor resulted in interstate commerce.[29] Finally, in *Wickard v. Filburn* 1942 the Court established that Congress could regulate people's behavior, independent of transactions, so long as that behavior related to interstate commerce. The Court also held that this behavior could be regulated, even if it did not substantially affect commerce, so long as it would do so if scaled so that everybody was engaging in this behavior.[30] Thus, the Court decided that if many people engaging in an action could affect commerce, then the government could prohibit an individual from performing that action. This has come to be known as the aggregation principle.

In 1935, Congress passed the initial Agricultural Adjustment Act which, among other things, limited the amount of wheat that individual farmers could grow. Roscoe Filburn had been growing wheat, not to sell, but to feed to his livestock. He was charged with violating the

[27] *Champion v. Ames*, 188 U.S. 321 (1903)
[28] *Id.*
[29] *United States v. Darby Lumber Co.*, 312 U.S. 100 (1941)
[30] *Wickard v. Filburn*, 317 U.S. 111 (1942)

Agricultural Adjustment Act.[31] Congress justified the AA Act under the invocation of the Commerce Clause. Filburn argued that because he was not selling the wheat that he was producing, he was not involved in commerce; therefore, Congress could not regulate his wheat production under this clause. The Court ruled in favor of Congress yet again and found that Congress could stop someone from producing if it affected how much commerce they would normally engage in; although this would not affect commerce by itself, if done by a multitude it would.[32]

The Court stated that if Filburn was not growing extra wheat for his cattle, he would have to purchase more wheat from the open market to do so. If every farmer decided to grow extra wheat instead of purchasing more from the market then this would, the court argued, have a substantial effect on commerce. This is the application of the aggregation principle.[33] This decision once again referred to Marshall's earlier statements about letting Congress broadly interpret the Commerce Clause, and giving the people the power, through their vote, to decide what is Constitutionally permissible.

[31] Schwartz, David. S.1. "An Error and an Evil: The Strange History of Implied Commerce Powers." American University Law Review 68, no. 3 (February 2019): 927–1014.
[32] *Wickard*, 317 U.S. at 111
[33] Schwartz, David. S.1. "An Error and an Evil: The Strange History of Implied Commerce Powers." American University Law Review 68, no. 3 (February 2019): 927–1014.

III. The Affordable Care Act

There was a pattern among the decisions of the Court with regards to Congress's ability to regulate interstate commerce. The Court seemed to have, no matter the period, given deference to Congress's ability to decide for itself what powers it has under the Commerce Clause. Although this was a long-standing Judicial tradition, Congress's progress in this area was halted in *National Federation of Independent Business v. Sebelius* (2012).[34] This was the case that decided the constitutionality of the Patient Protection and Affordable Care Act of 2010 or what is commonly known as the Affordable Care Act i.e. Obamacare. This enormous statute attempted to, among other things, create a market in which Americans that did not have health insurance could enroll and acquire insurance through exchanges set up by the state governments.[35] This massive statute also expanded Medicaid coverage and tried to make private insurance more affordable and customer friendly. One such way in which the Affordable Care Act attempted to do this was the mandating of coverage of children under the plan of their parents until age 26.[36]

Through these actions, Congress was attempting to reduce the uninsured population in the United States. One piece of the ACA that was critical to this goal was what has come to be called the individual mandate. This mandate is a collection of provisions within a variety of sections of the ACA that say that someone must pay a penalty if they do not have one of the three types of insurance mentioned above.[37] In ensures that young healthy individuals are

[34] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012)
[35] "Health Insurance Rights & Protections." HealthCare.gov, n.d. https://www.healthcare.gov/health-care-law-protections/.
[36] *Ibid.*
[37] Levitt, Larry, Gary Claxton, Anthony Damico, and Cynthia Cox. "Assessing ACA Marketplace Enrollment." The Henry J. Kaiser Family Foundation, June 9, 2016. https://www.kff.org/health-reform/issue-brief/assessing-aca-marketplace-enrollment/.

entered into the risk pool for insurance. The mandate was critical to the success of the Affordable Care Act due to the nature of insurance. The ACA required that everyone have insurance or pay a penalty to opt out, because individuals that often forego having insurance are usually young, healthy, and the least likely to incur an illness.[38] Insurance, health insurance specifically, only works if those that are actuarially the least likely to incur risk buy into the insurance as well. This can work in two ways: community rating and experience rating.

In community rating premiums, not only is risk distributed among the insured, but everyone pays the same price. However, with experience rating premiums, those that cost less, and thus that incur less risk, pay less than those that incur more risk.[39] This analysis results in a system in which young healthy people often don't purchase insurance. Firstly, because it is expensive and secondly because the cost of insurance is actuarially not worth the low amount of risk they would incur without insurance. These people ending up choosing to opt out of health insurance makes insurance more expensive in turn for those that do choose to buy it, because the pool of insured people is largely made up of those that are of a higher actuarial risk. These individuals cost more to insure because they use up more services and have a higher chance of acquiring illnesses and ailments.[40]

Congress enacted the ACA, and specifically the sections that make up the Individual Mandate, under the authority of the Commerce Clause. This authority was challenged in *National Federation of Independent Business v. Sebelius* (2012). In *Sebelius*, the NFIB argued that despite previous rulings that expanded the Commerce Clause, Congress did not have the

[38] *Ibid.*
[39] Kaminski, Janet L. "COMMUNITY VERSUS EXPERIENCE RATING HEALTH INSURANCE." OLR Research Report, July 3, 2008. https://cga.ct.gov/2008/rpt/2008-R-0377.htm.
[40] Follmann, J. F. "Experience Rating vs. Community Rating." The Journal of Insurance 29, no. 3 (1962): 403-15.

power to compel someone to engage in commerce. The court had previously ruled that Congress had the powers to use it to create Commerce, regulate purely intrastate commerce, and even prohibit Commerce; however, the NFIB stated that upholding the power to create commerce would be an unprecedented and dangerous expansion of Congress' powers under the Commerce Clause. The NFIB argued that Congress was defining a market (healthcare) and requiring people, who would not otherwise, to engage in that market. The NFIB also stated that they believed that upholding the ACA under the Commerce clause would give Congress unlimited power under the Commerce clause.[41] Members of the Court expressed similar worries.

However, defenders of the ACA argued that people engage in the commerce of healthcare throughout their life at some point. They held that because all people will eventually use health services, the ACA does not compel people into a market that they would not normally engage in. They will engage in it at some point in their life, the ACA will simply change the time of the engagement, so that rather than occurring at the point of sale, the engaging in commerce will occur when people purchase insurance. Those that defended the ACA claimed that perhaps someone living off the grid might never use health services; however, it is supremely unlikely. They claimed that an ordinary American could not claim that the they would never use healthcare. The defense went on to postulate that changing the point of sale is akin to a regulation, and that the defense claiming that commerce was being compelled was an exaggeration.[42]

Still, some of the more conservative members of the court feared that letting the Affordable Care Act stand under the Commerce Clause would give Congress unlimited power

[41] *Sebelius*, 567 U.S. at 519
[42] *Id.*

under the Commerce Clause. Justice Scalia for example, thought that Congress using the commerce clause to regulate the affordable care act would give Congress the power to define a market and choose to regulate it however they want.[43] In this case that market was healthcare; the regulation was compulsory enrollment in health insurance.

Justice Scalia asked to what end does this power of the commerce clause go. He thought that the ACA's advocates didn't understand the scope of the power that they were arguing for. Justice Scalia pointed out that although the ACA only forced people to buy health insurance, next time it could force individuals to engage in physical activity. He states, eventually the government could decide "everybody has to exercise, because there's no doubt that lack of exercise causes illness, and that causes health care costs to go up"[44]. The first half of this statement is important because it addresses the government's argument that the ACA is justified in order to improve health. It also points out that, if public health is proper justification for such a great expansion of power, then public health could be used as justification to compel people to engage in physical activity. Justice Scalia asserted that public health could be used as a reason to in effect engage in any behavior that it deemed necessary to ensure the health of the public. The second half of his statement is also important. The government used a motivation of trying to decrease healthcare costs as its reasoning to force individuals to engage in commerce and buy health insurance. However, he also asserts, that if the Court approved such a reason, then Congress could conceivably use any reason to force people to engage in unwanted commerce.

[43] "National Federation of Independent Business v. Sebelius." Oyez, www.oyez.org/cases/2011/11-393. Accessed 10 January. 2020.
[44] "National Federation of Independent Business v. Sebelius.", The Affordable Care Act Cases Oral Argument - March 27, 2012. Oyez, www.oyez.org/cases/2011/11-393. Accessed 10 January. 2020.

The government insisted that they were not trying to force people to exercise; however, members of the court felt that setting this precedent of compulsory commerce was of great concern. Justice Scalia insisted that to establish this coercive power without limitation would allow future lawmakers to coerce people to engage in any behavior so long as it affected commerce i.e. public health. He felt that nothing could bind the lawmakers other than their own "arbitrary judgement".[45]

The Solicitor General, Donald Verrilli, argued for the government. He did not address this complaint of Scalia's directly; however, he responded by stating that the Affordable Care Act is not forcing commerce but altering the point at which it occurs. Commerce is a market of transactions. Verrilli argued that since everyone, at some point in their lives, uses some form of health services, healthcare "is an interstate market in which everybody participates".[46] Because of the complexity and uniqueness of the healthcare market, Congress had to change the timing of the transaction and according to Verrilli, they had the authority to do so under the Necessary and Proper Clause. When healthcare is purchased as needed it is unaffordable; therefore, Congress had to enforce the already occurring transaction to transpire ahead of time by way of the Individual Mandate.

The government's argument can best be qualified in the following response given by Solicitor General Donald Verrilli. Verrilli states that "[w]hen Congress is regulating -- is enacting a comprehensive scheme that it has the authority to enact that the Necessary and Proper Clause gives it the authority to include regulation, including a regulation of this kind, if it is necessary to counteract risks attributable to the scheme itself that people engage in economic

[45] *Ibid.*
[46] *Ibid.*

activity that would undercut the scheme. It's like…it's very much like *Wickard* in that respect…With respect to the…considering the Commerce Clause alone and not embedded in the comprehensive scheme, our position is that Congress can regulate the method of payment by imposing an insurance requirement in advance of the time in which the -- the service is consumed when the class to which that requirement applies either is or virtually is most certain to be in that market when the timing of one's entry into that market and what you will need when you enter that market is uncertain and when -- when you will get the care in that market, whether you can afford to pay for it or not and shift costs to other market participants."[47]

Verrilli is invoking a few key principles here. Firstly, he is asserting that *Wickard v. Filburn's* aggregation principle applies here.[48] Although he does not directly state it, his invoking of *Wickard* is to try to point out the similarity between it and this case. Verrilli's logic is such: just as the Court in *Wickard* asserted that an aggregate of many farmers' actions can be harmful enough that it can be regulated, here too they must assert that an aggregate of individuals foregoing health insurance can be harmful enough to be regulated.

Secondarily, Verrilli is arguing that the government is not compelling individuals to engage in commerce. According to the Solicitor General, everyone already engages in this commerce at some point in their life; however, people are often not ready to engage in that commerce when they need to unless they have some form of insurance to protect them against the high cost of health services. Therefore, he says that Congress is regulating "the timing of one's entry into the market"[49]. Because of this discrepancy, the government believed that it was

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[47] *Ibid.*
[48] *Wickard*, 317 U.S. at 111

[49] "National Federation of Independent Business v. Sebelius.", The Affordable Care Act Cases Oral Argument - March 27, 2012. Oyez, www.oyez.org/cases/2011/11-393. Accessed 10 January. 2020.

not forcing people to engage in commerce but rather amending the exact moment that they engage in commerce. This, Verrilli argued, was perfectly legal. However, the majority of the court did not see the individual mandate in this light.

During the hearings of the Supreme Court, Justices who favor one argument over another will often try to assist the lawyer making that case.[50] This practice occurred numerous times during *Sebelius* and perhaps saved the ACA by changing the government's stance over just what the Individual Mandate was. Justice Ginsburg suggested to Solicitor General Verrilli that the ACA could use the taxing power to uphold the individual mandate rather than the Commerce Clause. Instead of compelling people to engage in commerce by forcing them to buy insurance, the Individual Mandate could be taxing those that refuse to engage in certain practices and then redistributing that tax money like any other excise. The other Justices were quick to rebut by stating that the legislation did not claim to be a tax. However, the Solicitor General was quick to seize on this opportunity and was ready with precedent. Verrilli referenced the *License Tax Case*s (1866)[51] during which business licenses were "denominated a fee and nontax, and the Court upheld it as an exercise of the taxing power, in a situation in which the structure of the law was very much like the structure of this law, in that there was a separate stand-alone provision[s] that set the predicate and then a separate provision in posing the fees"[52].

Verrilli then pointed out that members of Congress had spoken on the Senate floor about the PPACA being an exercise of their taxing power. He stated of the Affordable Care Act that "the legislative history is replete with members of Congress explaining that this law is

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[50] Liptak, Adam. "When the Justices Ask Questions, Be Prepared to Lose the Case." The New York Times, May 25, 2009. https://www.nytimes.com/2009/05/26/us/26bar.html.
[51] *License Tax Cases*, 72 U.S. 462 (1866)
[52] "National Federation of Independent Business v. Sebelius.", The Affordable Care Act Cases Oral Argument - March 27, 2012. Oyez, www.oyez.org/cases/2011/11-393. Accessed 10 January. 2020.

constitutional as an exercise of the taxing power."[53] He was referring to a particular 60 to 39 Senate vote that denoted PPACA as a tax.[54]

This logic would inevitably win out and the Court ultimately upheld the ACA under the authority of Congress's taxing power; however, an important distinction was made. Congress could not compel someone to engage in commerce. The Legislature could regulate a market; they could exaggerate a market, but they could not create one. Justice Roberts wrote the majority opinion for the Court in the *NFIB v. Sebelius case*. He explicitly rejected the use of the Commerce Clause to uphold the ACA. He states that "[c]onstruing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority".[55] In his decision, Justice Roberts first establishes that the power that the government is requesting has not existed before this moment. He goes on "[t]he Framers knew the difference between doing something and doing nothing"[56]. Roberts mentions that although the Commerce Clause does give Congress the power to regulate commerce, it does not specifically grant the power to compel it. Roberts contends that the power to compel individuals to do something is so great that the Framers certainly would have explicitly stated it. The Constitution's enumerated powers can imply lesser and coordinate powers; however, one cannot draw more intense power from lesser forms. He concludes that the power to compel cannot be found within the Commerce Clause and thus the Individual Mandate cannot be upheld by it.

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[53] *Ibid.*
[54] Pear, Robert. "Senate Passes Health Care Overhaul on Party-Line Vote." *The New York Times*, December 24, 2009. https://www.nytimes.com/2009/12/25/health/policy/25health.html.
[55] *Sebelius*, 567 U.S. at 519
[56] *Id.*

Justice Roberts goes on to address the secondary proposal that the Commerce Clause claim can be strengthened by the additional citing of the Necessary and Proper Clause. Justice Roberts subsequently denies this claim as well. Roberts holds that past incitements of the Necessary and Proper Clause have been used to enhance enumerated powers or powers that have already been drawn from enumerated powers. He states that "[e]ach of this Court's prior cases upholding laws under that Clause involved exercises of authority derivative of, and in service to, a granted power"[57]. The Necessary and Proper Clause, he explains, cannot grant new powers.

Justice Roberts goes on to cite *Hooper v. California* (1895) when he declares that "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality,"[58]. This reasoning is not an example of case law, rather, it is a system of judicial activism used by some past and present members of the Court in which a justice actively attempts to uphold legislation. Using this method, Justice Roberts stated that the Affordable Care Act must be read as a tax in order for it to remain. Although the Chief Justice recognized that the Individual Mandate labels itself as a penalty rather than a tax, this does not, he states "control whether an exaction is within Congress's power to tax"[59]. In essence, a bill's distinction as a tax or non-tax does not establish its actual legality as being a tax or non-tax. The Chief Justice found suitable evidence in the nature of the language ACA and in the conditions of its inception that it could indeed be classified as a tax. It was upheld.

However, lawyers and court reporters alike were stunned by Roberts' decision. A conservative Justice, Roberts, had single-handedly upheld one of the most progressive pieces of legislation in American history. Justice Roberts is a pledge judicial conservative; his theory of

[57] *Id.*
[58] *Hooper v. California*, 155 U.S. 648 (1895)
[59] *Sebelius*, 567 U.S. at 519

the law requires that he intervene in law-making as little as possible. He described his decision as an instance of this ideology. However, some court reporters have theorized that Roberts made the decision in order to not affect the election results in 2012.[60] He knew that universal healthcare had become a popular topic amongst most Americans and did not want to damage Republicans in the polls by striking the ACA down.

[60] Roy, Avik. "The Inside Story on How Roberts Changed His Supreme Court Vote on Obamacare." Forbes. Forbes Magazine, August 13, 2014. https://www.forbes.com/sites/theapothecary/2012/07/01/the-supreme-courts-john-roberts-changed-his-obamacare-vote-in-may/#34e1d7fbd701.

IV. The State of Universal Healthcare

The Affordable Care Act has been the closest that America has gotten to universal healthcare legislation. Although there have been previous attempts to attempt to nationalize healthcare in the United States, none of these attempts have emerged from Congress successfully. And even though the Affordable Care Act did not insure every American, it did greatly expand coverage. However, ten years after the passage of the ACA, there are once again calls to reform healthcare. Many Americans are calling for the government to nationalize the healthcare industry. According to a recent CBS poll two-thirds of American favor a nationalized healthcare system over our current health system.[61] However, recent studies have suggested that most Americans do not even know what a nationalized healthcare system would entail.[62]

Although there are a variety of health systems used throughout the world there are three major models of Universal Healthcare that most systems fit into. The first is the Beveridge Model. In this model care, rather than insurance, is provided and financed directly by the government. The system is financed by taxation of the public. This system usually involves total government ownership of health services. Physicians, nurses, and health administrators are often government employees and clinics and hospitals are government run. Great Britain's National Health Service is an example of this model.[63]

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[61] Backus, Fred, and Jennifer De Pinto. "CBS News Poll: Most Americans Favor a National Health Plan." CBS News. CBS Interactive, October 15, 2019. https://www.cbsnews.com/news/2020-polls-national-health-care-plan-favored-by-most-americans-cbs-news-poll-finds/.

[62] Lalley, Colin. "Americans Still Aren't on Board with Universal Health Insurance." Policygenius Magazine. Policygenius Magazine, December 5, 2017. https://www.policygenius.com/blog/survey-americans-dont-favor-single-payer-health-insurance/.

[63] Chung, Mimi. "Health Care Reform: Learning From Other Major Health Care Systems | Princeton Public Health Review." Princeton University. The Trustees of Princeton University, December 2, 2017. https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/.

The Second is the Bismarck Model. In this health system, insurance is provided by employers and employees by way of payroll deduction.[64] This payroll deduction is used to fund private insurance agencies called sickness funds. These sickness funds are required to insure all residents and are not permitted to make a profit. Under this system coverage is mandated by, but not run by, the national government. Costs are tightly controlled by the central government. Germany is the foremost example of this type of plan.[65]

The last category of health system that guarantees universal coverage is the National Health Insurance Model. Although health providers are often privately owned in this system, insurance is often financed through taxes as the government is the primary payer. All citizens pay into a national health fund which is then used to pay health costs. Pharmaceutical costs are negotiated by the government. This system is used by Canada and most current plans in the U.S. resemble this model.[66]

When Americans call for Congress to institute a national healthcare system, what are they really asking for? Another way to look at what universal healthcare in the United States might look like in the future is to investigate plans that are currently up for debate in the House and Senate. One such bill is the Medicare for All Act of 2019 (S. 1129).[67] This plan, which was proposed by Senator Sanders, falls under the national health insurance model of coverage. All U.S residents would be eligible to enroll in this scheme; some non-residents might also be eligible.[68]

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[64] PNHP. "Health Care Systems - Four Basic Models." Health Care Systems - Four Basic Models | Physicians for a National Health Program. Physicians for a National Health Program, n.d. https://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php.
[65] Chung, Mimi. "Health Care Reform: Learning From Other Major Health Care Systems | Princeton Public Health Review."
[66] *Ibid.*
[67] Medicare For All Act of 2019, S. 1129, 116th Cong. (2019).
[68] Medicare For All Act of 2019, S. 1129, 116th Cong. §102(a) (2019).

This plan replaces most current sources of coverage. It also abolishes private insurance not including supplementary coverage; however, providers cannot sell coverage of items covered under the plan.[69] The Veterans Administration health program as well as the Indian Health Service would be kept separate. Vision, dental, and long-term care services would be covered under this model.[70] There are proposals in the House and the Senate to pass accompanying bills that would provide transitional support to insurance workers that will lose their jobs as a result of the resultant termination private coverage.[71]

Under this system there would be no premiums; however, there will be some cost sharing for pharmaceuticals.[72] Most of this coverage would be paid for by rises in taxes across all income levels.[73] The tax raise would be proportional to income. The current Medicare, Medicaid and Federal employee's health Benefits program would be terminated and absorbed into this new system. This system states that it would expand primary care but does not say how it plans to do so.[74]

This program would gradually be implemented over a four-year transitional period. At the passage of the bill into law, Americans ages 55-64 would be eligible to buy into all Medicare options. During this period younger age groups would be synthesized into the buy in process. This plan would use existing PPACA marketplaces in order to register residents for Medicare.

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[69] Medicare For All Act of 2019, S. 1129, 116th Cong. §107(a) (2019).
[70] Medicare For All Act of 2019, S. 1129, 116th Cong. §1013(a&b) (2019).
[71] Abelson, Reed, and Margaret Margot Sanger-Katz. "Medicare for All Would Abolish Private Insurance. 'There's No Precedent in American History.'" The New York Times, March 23, 2019. https://www.nytimes.com/2019/03/23/health/private-health-insurance-medicare-for-all-bernie-sanders.html.
[72] Medicare For All Act of 2019, S. 1129, 116th Cong. §202(a&b) (2019).
[73] Kliff, Sarah. "Bernie Sanders's Medicare-for-All Plan, Explained." Vox. Vox, April 10, 2019. https://www.vox.com/2019/4/10/18304448/bernie-sanders-medicare-for-all.
[74] Medicare For All Act of 2019, S. 1129, 116th Cong. §613(b) (2019).

Existing Medicare rates would remain in place. Subsequent descriptions of this plan have stated that providers must participate in this new Medicare for all option.

There are three other plans that resemble Senator Sanders' plan. These are: the Medicare for All Act of 2019 (H.R. 1384), the Expanded and Improved Medicare for All Act (H.R. 676), Medicare for America Act of 2018 (H.R. 7339). These plans all share the same basic characteristics; they differ merely in implementation time and specific funding sources.

Another bill that was recently proposed is the State Public Option Act (S. 489, H.R. 1277). This plan would allow states to open up Medicaid eligibility to everyone living within their borders. Residents would enroll in either state or federal marketplaces similar to the those created by the ACA. Premiums and cost-sharing would be necessary for all individuals enrolled in this insurance option except those with incomes under four hundred percent of the federal poverty level. State spending on costs that weren't covered by individuals would be matched by federal funding. This bill would also match state funding for normal Medicaid expansion for the first 3 years after adoption.[75]

Any resident of a state that elects to enact this schema would be eligible for coverage; however, individuals who buy into this option will pay cost-sharing payments and premiums. Under this plan the individual states would be responsible for setting Medicaid premium rates. However, regardless of how the program is funded reimbursement must meet at least those rates provided for by Medicare.[76]

As of the Spring of 2020, Senator Sanders is the frontrunner in the Democratic Party Primaries. Not only this, but young Americans seem to be infatuated by his policies. The anti-

[75] Medicare For All Act of 2019, S. 1129, 116th Cong. §1002(c) (2019).
[76] Medicare For All Act of 2019, S. 1129, 116th Cong. §1002(d) (2019).

socialist attitudes that characterized the twentieth century seem to have gone by the wayside. If America's youth are impressed by the policies of Senator Sanders, then perhaps these policies will be the way of the future. If The Medicare For All Act being proposed by Senator Sanders was enacted, then it would go into effect on January 1st, of the fourth year after its enactment. Therefore, 4 years after the enactment of this bill it would be "unlawful for… a private health insurer to sell health insurance coverage that duplicates the benefits provided… under this Act; or… an employer to provide benefits for an employee, former employee, or the dependents of an employee or former employee that duplicate the benefits provided under this Act"[77]. As of 2017 private insurance and employer provided insurance are, when combined, the most common type of insurance in the United States. However, after the passage of this Act these forms will be virtually abolished. Employer provided insurance is often purchased through a private insurance company. Although private insurance can exist after this act, private insurers would not be able to sell duplicate insurance.

Private insurers would be allowed to sell non-duplicate coverage. As the Bill states "[n]othing in this Act shall be… construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act including additional benefits that an employer may provide… to employees or their dependents, or to former employees… or their dependents."[78] Because, most traditional services are covered under this act, insurers would effectively be forced out of the market. Private insurers would be reduced to fringe companies that sell supplementary coverage for randomly selected albeit rare procedures. Countries such as Canada possess similar features that allow private insurers to sell supplementary insurance.

[77] Medicare For All Act of 2019, S. 1129, 116th Cong. §107(a) (2019).
[78]Medicare For All Act of 2019, S. 1129, 116th Cong. §107(b) (2019).

However, Canada's public health benefits' package is much less comprehensive. Canadian basic insurance does not cover vision or dental procedures and services.[79] This allows niche markets for private insurers to cover vision services for example.

This specific feature of Medicare For All has been addressed before. As this paper previously highlighted, in *Champion v. Ames* the Court established that Congress has the power, through the Commerce Clause, to prohibit commerce. Congress does not need a substantial interest to do so because the Commerce Clause "is plenary, is complete in itself, and is subject to no limitations except such as may be found in the Constitution"[80]. Thus, this element of Medicare For All would not be challenged on Constitutional grounds.

Medicare and Medicaid are optional for health service providers. Providers can choose to accept or deny patients that use these programs as their primary form of insurance.[81] Medicaid is run by arms of the state governments called single state agencies. If a provider chooses to accept Medicaid, they must enter into an agreement with their single state agency that they will accept all Medicaid patients and subsequent reimbursements. If a provider chooses to accept Medicare, they must enter into an agreement with the Center for Medicare Services (CMS). In Medicare agreements, providers have the option to accept reimbursements and fees for some procedures and services but not others.[82]

The Sanders plan eliminates this choice in practice but not in name. Subsections 8-17 of Title III of Senator Sanders' Medicare For All bill describe how this plan does so without antagonizing the history of the Commerce Clause. These Subsections state that a provider is

[79] Kliff, Sarah. "Bernie Sanders's Medicare-for-All Plan, Explained."
[80] *Champion v. Ames*, 188 U.S. at 321
[81] U.S. Centers for Medicare & Medicaid Services. "Lower Costs with Assignment." Medicare.gov, n.d. https://www.medicare.gov/your-medicare-costs/part-a-costs/lower-costs-with-assignment.
[82] *Ibid.*

only eligible to participate in Medicare For All if they enter into a Medicare like arrangement with the Federal DHS Secretary. They state that "[a]n individual or other entity furnishing any covered service under this Act is not a qualified provider unless the individual or entity—is a qualified provider of the services under… section 302; has filed with the Secretary a participation…agreement described in subsection (b); and… meets, as applicable, such other qualifications and conditions with respect to a provider of… services under title XVIII of the Social Security Act"[83]. Thus, as is the case with both Medicare and Medicaid, participation in is voluntary. Health providers can technically not participate in Medicare For All… at all; however, this plan also prohibits private insurers from covering procedures that are covered by an enacted Medicare For All. As previously stated, because most conventional services are covered by Medicare For All, this bill effectively eliminates private insurance. Therefore, the bill, in practice, forces any provider who wishes to stay in practice to participate in Medicare For All. This detail would be unimportant had the Affordable Care Act been preserved under the authority of the Commerce Clause. However, Chief Justice Roberts specifically stated that the Commerce Clause could not support the weight of the Affordable Care Act. Although the authority that the Commerce Clause possesses has been expanded over the course of the history of the Court. The Chief Justice's assertions in *Sebelius* specifically discontinued that expansion. The authority that the Commerce Clause grants Congress cannot be used to compel people to engage in commerce. Under the precedent set by Roberts' decision, would eliminating private insurance and thus effectively leave them with no other choice than to opt into Medicare reimbursement count as compelling providers to engage in commerce?

[83] Medicare For All Act of 2019, S. 1129, 116th Cong. §302(a&b) (2019).

This paper will seek to establish an answer to this question. The remainder of this paper will use the precedent outlined in the previous sections to predict what a possible case against The Medicare For All Act might look like. Due to their contribution to the history and development of healthcare in the United States and their more involvement in lobbying, I believe the American Medical Association would be the most likely suitor to step in and challenge Medicare For All. I also believe, as the facts have dictated in this paper, that their most likely challenge to Medicare For All would be on the basis of the compulsion of doctors to participate in Medicare. The following section contains three remaining subsections. The first describes a simulated argument for the AMA; the second describes a simulated argument for the government. The third and final section is a simulation of what the current Court might decide if this hypothetical case were to make it all the way to The Supreme Court of the United States.

V. American Medical Association v. The United States

IN THE SUPREME COURT OF THE UNITED STATES

No. 2020-2021

American Medical Association v. The United States

American Medical Association, Petitioner

Vs.

The United States, Respondent

Brief for the Petitioner

Question Presented

Whether eliminating the private insurance agency forces physicians to become reimbursed solely by Medicare and is doing so a violation of the Commerce Clause.

Summary of the Argument

The Court should reverse the lower court opinion and ensure that Americans are not unconstitutionally forced to engage in commerce. As per the standard set in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), Congress cannot under the authority of the Commerce Clause compel an individual to engage in commerce against their will. Secondly this Act violates the Fifth Amendment. U.S. Const. amend. V, § 1.

Compulsion is defined as being "the action or state of forcing or being forced to do something: consisting of a quality of constraint"[84]. The second clause of this sentence is critical. Constraint can cause compulsion through the restriction of choice. The statute before the Court, S.1129 - Medicare for All Act of 2019 (Medicare For All Act or Act) invokes the Commerce Clause in order to establish a national health care system. This national healthcare system seeks to provide comprehensive healthcare to every American; however, the government has stated that in order for this system to function as intended, private insurance that provides for duplicate coverage cannot exist. Most traditional coverage is provided by the statute; thus, the law in question would effectively eliminate nearly all private insurance. Moreover, even dental and vision coverage would be provided by this Act[85], and the private insurance of these health services consequently eliminated[86]. Even the systems that this Bill seeks to emulate do not

[84] *Compulsion*, Lexico (Oxford. n.d).
[85] Medicare For All Act of 2019, S. 1129, 116th Cong. §107(a) (2019).
[86] Medicare For All Act of 2019, S. 1129, 116th Cong. §1013(a&b) (2019).

wholly restrict private insurance in such a way. Canada's healthcare model still allows private dental and vision insurance[87]. The effects of such an overhaul of the system would be unknowable. The step that the government is taking is dangerous and unconstitutional leap of faith.

The Constitution clearly states that Congress has the power "to regulate commerce with foreign nations, and among the several states". Const. art. I, § 3, cl. 8. The Court has since interpreted that the power to regulate is akin to the power to prevent. Congress may invoke the Commerce Clause in order to prevent transactions from occurring. *Champion v. Ames*, 188 U.S. 321 (1903). The Commerce Clause can be used to prevent unwanted behavior. This power has since been established as plenary. Thus, the government requires no reason to regulate and edit Commerce as it sees fit. The Court has been clear and consistent on this basis.

That being said, the Court recently has also established a limit on the government's ability to control commerce. Although the government may regulate commerce as it sees fit, the power to compel does not fall under the power to regulate. *Sebelius*, 567 U.S. at. 519. These powers are not adjacent. The history of interpretation of this court has allowed subservient and sometimes adjacent powers to be drawn out from those expressed in the Constitution. However, the court has been clear that they cannot draw greater powers from lesser ones. The power to compel is greater than the power to regulate.

The Fifth Amendment dictates that a citizen "private property [cannot] be taken for public use, without just compensation". U.S. Const. amend. V, § 1. The statute in question would seize the private services of doctors without giving them such compensation. Physicians receive on average twice as much reimbursement from commercial insurance as they do from

[87] Kliff, Sarah. "Bernie Sanders's Medicare-for-All Plan, Explained." Vox.

Medicare reimbursement.[88] Thus, compelling Physicians to perform services for half as much as they would receive otherwise cannot be compatible with the Fifth Amendment. This country's liberal founding established one's individual right to resist compulsion by establishing a necessary quality of consent. The Third Amendment to the Constitution states that "No Soldier shall, in time of peace be quartered in any house, without the consent of the Owner, nor in time of war, but in a manner to be prescribed by law.". U.S. Const. amend. III, § 1. The government claims that the United States is currently in a state-of-war to better public health. It claims that the death, illness, and poverty being experienced by the United States suggests that we are at war with ourselves; however, even if this was the case, the Third Amendment implies that the simple existence of war does not give the government unlimited power. Here, the Constitution acknowledges war and states that even in war, the government is limited in what actions it can take against private citizens without their consent. The Fifth Amendment continues in the same vein; it states that "nor shall [any citizen] be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation. U.S. Const. amend. V, § 1. Physicians receive almost double the payment from private insurance that they do from Medicare reimbursement. Restricting them to strictly be reimbursed by Medicare is an unjust reduction in their salaries by half. The government cannot seize an individual's property and pay them half of what they are owed. An action such as this would not fit the founders' conception of "just compensation". U.S. Const. amend. V, § 1.

[88] Masterson, Les. "CBO Reports Show Private Insurers Pay Physicians, Hospitals Far More than Medicare." Healthcare Dive, June 27, 2017. https://www.healthcaredive.com/news/cbo-reports-show-private-insurers-pay-physicians-hospitals-far-more-than-m/445949/.

It is primarily for this lack of consent tightly coupled with the Court's previous rejection of compulsion that the Medicare for All Act is unconstitutional. Through the abolition of duplicate coverage, the government has effectively eliminated competition in the market of health insurance. Insurance providers, in our current model of healthcare, in effect employ doctors. Employers pay the salaries of their employees. Insurance agencies reimburse physicians for their services. Although this relationship is not an exactly normal employer-employee relationship, payment of physicians is clearly provided by these organizations. Insurance providers are in effect the employers of private physicians. Even those "employed" by hospitals still receive payment from insurance-based reimbursement. Although in *Helvering v. Davis,* the Court held that Congress could tax employers, the Court did not state that the Court could abolish employers *301* U.S. 619 (1937). Insurance, as a method of payment, allows Americans who would otherwise not be able to afford physician services to see a doctor. This relationship is beneficial to all parties involved. However, it is clear that this relationship is not beneficial to those who are uninsured.

The government has sought to remedy those disaffected by this relationship through the establishment of an insurance for all system that enacts the government as the de facto single employer of physicians. Because most Americans are not able to afford insurance through individual payment, this severely constrains the choice of medical professionals to receive payment. Medical professionals must choose to accept Medicare reimbursement or only operate on funding provided by those who can afford to pay medical services out of pocket.

This constraint of choice has in effect compelled physicians to engage in commerce. Physicians did not consent to this constriction of their method of payment. They are private citizens being drafted to perform their ordinary job for a public entity. It has been established

that the government may not have the power to seize production in cases of national emergency for any period of permanence. *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579 (1952). This "dire" situation of the state of American healthcare is no worse than the Second World War under which *Youngstown* was decided. *Youngstown*, 343 U.S. at 579. Congress, and the President may not seize the means of production merely by claiming emergency powers because of a crisis.

Under the current format of the statute in question, physicians would not be able to supplement their income through private practice. There are over one million doctors in the United States.[89] If this statute stood, the number of individuals who could devote a reasonable portion of their income to paying for medical services would be in the few thousands.[90] A few thousand customers could not support a cohort of a million physicians; thus, physicians would be forced to accept Medicare reimbursement. Medicare reimbursement pays only eighty-seven cents for every dollar that providers pay to treat patients.[91] Medicare reimbursement is often not cost efficient for doctors and health providers to take. Thus, if the statute stands, health service professionals would be forced to engage in commerce that loses them money. They would effectively pay to treat patients. Doctors cannot sustain their income from receiving payment in this way. Individual providers would have two options: find patients that can afford to pay out of pocket or accept Medicare Reimbursement and engage in an occupation that would be a net negative.

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[89] Kaiser Family Foundation. "Professionally Active Physicians." The Henry J. Kaiser Family Foundation, March 8, 2019. https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel={"colId":"Location","sort":"asc"}.

[90] Healthcare Leadership Council. "More Physicians No Longer Seeing Medicare Patients." Healthcare Leadership Council, n.d. https://www.hlc.org/news/more-physicians-no-longer-seeing-medicare-patients/.

[91] American Hospital Association. "Underpayment by Medicare and Medicaid Fact Sheet." American Hospital Association, December 2017. https://www.aha.org/factsheet/2018-01-03-underpayment-medicare-and-medicaid-fact-sheet-december-2017-update.

The first of these options is unrealistic. Physicians simply could not operate under this model of payment; therefore, almost all providers would be forced to accept Medicare. This limitation of choice, constraint, is compulsion. The right of the individual to make free choice has been held up in precedent as nearly untouchable by the government. This court established that the power to compel individuals to engage in commerce that they do not consent to cannot be drawn from the Constitution without amendment to it. *Sebelius*, 567 U.S. at 519. The government seeks to compel individuals' physicians to accept Medicare financing under the current form and understanding of the Constitution. The provision that eliminates duplicate insurance must be thrown out by the court under *Stare Decisis*.

The question then remains of the severability of the provision of the elimination of private insurance from the Act. Medicare For All Act, S. 1129, 116th Cong. § 107 (2019). This Court established in *Alaska Airlines, Inc, v. Brock,* that elements of law can be separated from the body of the statute as long as the intent of legislature is still upheld. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987). In order to determine the severability of the duplicate coverage provision, this statute's intent must be determined. This statute is ultimately about equality. Numerous legislators are on record stating that the nature of the law is to insert an element of equity into the health market. Representative Primila Jayapal asserted that "if you make $500,000 or you make $50,000 you should have access to the same health care"[92]. She continues by stating that "Congress members shouldn't have better health care access than workers"[93]. Congresswoman Jayapal further asserts that "CEOs should not have better health care access

[92] Kliff, Sarah. "Pramila Jayapal Thinks We Can Get to Medicare-for-All Fast." Vox. Vox, February 28, 2019. https://www.vox.com/2019/2/28/18244547/jayapal-medicare-for-all-ezra-klein-show.
[93] *Ibid.*

than the average American."[94] Representative Jayapal's words imply that Americans of wealthier status should not be able go out and purchase alternative coverage. Doing so, according to Mrs. Jayapal would allow for an inequity in the market. This is in opposition to the very spirit of the law. The provision that eliminates duplicate coverage is an essential part of the statute and cannot be separated thereof. Medicare For All Act, S. 1129, 116th Cong. § 107 (2019). The constitutionality of the statute must then be determined with the inclusion of the compelling element. Because of the inability to strip this provision from the law, the Medicare For All Act of 2019 must be unconstitutional.

[94] *Ibid.*

Brief for Respondent

Question Presented

Whether enlisting physicians under the authority of the Medicare for All Act of 2019 in order to provide for the "general welfare" of the citizens of the United States is authorized under the present authority of the Taxing and Spending Clause (Article I, Section 8, Clause 1) and the power of Congress to "raise and draft armies" (Article I, Section 8, Clause 12).

Summary of the Argument

In 1936, the Agricultural Adjustment Act of 1933 (Agricultural Adjustment Act or Act), was challenged in *United States v. Butler*, 297 U.S. 1 (1936). Under the Agricultural Adjustment Act taxes were levied on farmers in order to control the price of crops. During the Great Depression America was in a dire state. Food prices were rising rapidly, and the unemployment rate skyrocketed. Congress had described the situation as an "economic emergency" that because of the skyrocketing prices of food farmers' continued production "affected transactions in agricultural commodities with a national public interest and burdened and obstructed the normal currents of commerce, calling for the enactment of legislation". *Id.*

In *Butler*, the Court upheld the tax that would "establish and maintain such balance between the production and consumption of agricultural commodities". *Id*. So too, now Congress has sought to tax wealthy Americans in order to maintain the balance between production and consumption. The price of health services has skyrocketed in the twenty-first century. Healthcare spending in the United States is growing at a rate of almost five percent a year. Twenty percent of America's gross domestic product is now spent on healthcare.[95]

[95] U.S. Centers for Medicare & Medicaid Services. "Historical." CMS, December 17, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

Congress, therefore, has implemented the Medicare For All Act in order to solve these issues. The Medicare for All Act would implement a tax on wealthy Americans in order to finance a reshaped healthcare system that would solve these issues and guarantee Americans a right to healthcare. In this way, the Medicare for All Act is comparable to the Agricultural Adjustment Act and it should be held up under the taxing power.

The Petitioner may assert that Congress does not have broad powers to tax individuals in order to provide for Universal healthcare. However, in *Butler* the Court asserted that the "taxing power of Congress is not limited to the very specific powers that are granted in the Constitution". *United States v. Butler*, 297 U.S. 1 (1936). They further stated that "Congress has very broad power to spend for the 'general welfare'". *Id.* These two provisions are crucial to determining the Constitutionality of the present statute. Congress may tax broadly "one group for the benefit of another". *Id*. The government asserts that Congress has the power to establish a national health care system in which the wealthy are taxed in order to provide for the "general welfare" of those who are less fortunate. In this case that provision would be a universal healthcare system that provides services for all Americans. *Butler* established that Congress has broad authority to provide for the "general welfare". The Court has upheld that the determination of what is included in the "general welfare" may change from time to time. In this case, the hundreds of thousands of Americans, who cite medical bills as a source of bankruptcy every year, need Congress's welfare.

In 1936 the Social Security Act of 1935, (Social Security Act or Act) was also challenged in *Helvering v. Davis* by a corporation seeking to destroy legislation that ensured elderly Americans would not be cast to the wayside and forced to live unsupported. 301 U.S. 619 (1937). The structure of family life had changed such that elderly individuals could no longer

count on their children to support them as they aged. As the United States changed, Congress responded by enacting legislation that sought to save Americans from living in destitution. Congress pledged to "provide for the general welfare" of all Americans by invoking the taxing power in order to collect money from employers to distribute this money to employees later in their lives. *Id.*

In *Helvering* the Court held that the "enjoyment of common rights, such as the right to employ labor, may constitutionally be taxed". *Id.* The Court established that Congress can tax one's right to employ labor. If the ability to tax employers is a power of Congress, then it follows that Congress also has the power to tax the right of employees to work. They are both common rights of citizens and residents of the United States. In the case of the Social Security Act, that tax was then distributed to elderly Americans in order that they may be supported in their old age. The Medicare for All Act mimics, and was made in the image, of the Social Security Act; this case should also be decided in the image of *Helvering*. The Medicare for All Act was drafted and implemented to put an end to an emergency in the United States. Lastly, the Court asserted that "unemployment is an ill not particular, but general, which may be checked". *Id.* Here too, the ill of a deficient healthcare system may be checked. Doctors are no longer grossly misinformed. Medical personnel can heal the citizens of this nation, but only if they are paid accordingly.

In *Arver*, the government cited laws from thirty-five different nations in order to uphold the Selective Service Act of 1917 (Selective Service Act or Act). 245 U.S. 366 (1918). The Court held that the deficiency of a Selective Service in the United States would be an issue of national security. The government in this case cites two laws of fellow nations that also hold to the English Common Law tradition. The first is The Canada Health Act (R.S.C., 1985, c. C-6),

hereby known as the Canada Health Act. The Canada Health Act ensures that "health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners". The second foreign law is the British National Health Service Act, which states that "services [that are] so provided shall be free of charge".[96] The Medicare for All Act seeks to operate in the same vein that our fellow Common Law Tradition neighbors do. That is, to provide insurance to all Americans in such a way that medical services will now be free. In *Arver* the Court held that the precedent of other nations sometimes must compel the United States to react accordingly. The six-hundred thousand bankruptcies in the United States that involve medical bills each year are an issue of national security. Medical Bankruptcy can cast Americans into poverty. Poorer Americans have a much higher crime victimization rate and crime rate than those who are not poor.[97] A poorer, more crime ridden America is not one that can defend herself.

Also, in *Arver,* The Court found that compelled military service is "neither repugnant to a free government nor in conflict with the constitutional guaranties of individual liberty". *Id.* The Court established that compelled military service is necessary "in case of need". *Id.* The facts of this case dictate that the United States is need of physicians to practice under the system that Medicare For All will establish. A universal healthcare system can only work if private insurance that offers duplicate coverage is eliminated. Congress would be unable to control the costs of the system if private insurers were allowed to continue to offer duplicate coverage. The

[96] Socialist Health Association. "National Health Service Act, 1946." Socialist Health Association, March 8, 2016. https://www.sochealth.co.uk/national-health-service/health-law/national-health-service-act-1946/.
[97] Harrell, Erika, Lynn Lanton, Marcus Berzofsky, Lance Couzens, and Hope Smiley-McDonald. "Household Poverty and Nonfatal Violent Victimization, 2008-2012." Bureau of Justice Statistics (BJS). Office of Justice Programs, November 18, 2014. https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5137.

elimination of private insurance would render the Medicare For All Act completely inadequate to its purposes. Therefore, the government asks that the provision that calls for the elimination of private insurance, not be removed from the Medicare for All Act and that the statute be weighed as a whole entity. Medicare For All Act, S. 1129, 116th Cong. § 107 (2019).

The Respondent asks that the Court uphold the decision of the Seventh Circuit Court of Appeals and allow the continued benefit of Americans under the Medicare For All Act. The Medicare For All Act is Constitutional under Congress's powers granted in Article I, Section 8, Clause 1 and Article I, Section 8, Clause 12 of the Constitution.

The Opinion of the Court

This Court now seeks to determine the Constitutionality of the Medicare For All Act of 2019. There are two questions to be answered at present. This legislation seeks to resolve apparent disparities in the healthcare system of the United States. The Medicare For All Act pledges to do so by setting up a "comprehensive protection against the costs of health care and health-related services". This Act's constitutionality has been challenged by the Petitioner on two grounds. They are as follows:

1. Does the Constitutional authority of Congress to "provide for the general welfare" subsequently give Congress the authority to establish a national healthcare system?
2. Does this interpretation fit with this Court's current interpretation of the Commerce Clause?

The answer to the first question is undoubtedly yes. Congress's ability to enact Statutes that enable broad sweeping social programs was established in *Helvering v. Davis* 301 U.S. 619 (1937). The Court concluded that to "provide for the general welfare" is a seemingly unlimitable power of Congress. The *Helvering* decision further qualified this statement that asserting that the limits of that power are expressed in the Constitution and its amendments. In accordance with *Helvering* only the Constitution itself may limit Congress's discretion. The question here is if the Third and Fifth Amendments limit Congress's discretion in this case. We conclude that they do not.

The Fifth Amendment dictates that a citizen's "private property [cannot] be taken for public use, without just compensation". U.S. Const. amend. V, § 1.

Although the market is often used to dictate "just compensation", in the present case it is widely agreed upon that the market is broken. *Helvering*, 301 U.S. at 619. Health authorities assert that the health market is not a reliable method for determining the true value of health

services. This is a widely agreed upon feature of the system. The nature of health services is such that they tend to appear more valuable than they actually are due to the inflexibility of need for them.[98] As a result, we cannot, rightly conclude that physicians offered a lesser value for their service, than the market warrants, is a violation of the Third and Fifth Amendments.

In order to answer the second question, it must first be determined whether the statute at hand affects interstate commerce. The Medicare For All Act does state that "nothing in this act shall prohibit individual States from setting additional standards… consistent with the purposes of this Act"[99]. It dictates any unspecified details to the individual states themselves; however, this is not in opposition to the idea that the Medicare For All Act has an effect on commerce among the states. Moreover, physicians are licensed by the individual states themselves. By way of their intrastate licensure physicians are agents of intrastate commerce. In *Gibbons v. Ogden* it was asserted that commerce is rarely, if ever, purely intrastate or interstate. 22 U.S. 1 (1824). It is often a combination of the two. Although physicians are licensed inside of states, they are in certain circumstances allowed to operate outside of the state in which they are licensed.[100] Physicians are the interstate-intrastate operators described in *Gibbons v. Ogden*. This Statute's affectation of physicians designates this to be a matter of interstate commerce. The Statute in question must be evaluated in light of the Commerce Clause. The Petitioner claims that Medicare for all "invokes the Commerce Clause"; we find that our own analysis concurs with this assessment. (Brief for the Petitioner).

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[98] Fodeman, Jason, and Robert A Book. "'Bending the Curve': What Really Drives Health Care Spending." *The Wall Street Journal*. February 19, 2010. https://www.wsj.com/articles/SB10001424052748703787304575075843971534082.

[99] Medicare For All Act of 2019, S. 1129, 116th Cong. §107(b) (2019).

[100] Kocher, Robert. "Doctors Without State Borders: Practicing Across State Lines." Doctors Without State Borders: Practicing Across State Lines | Health Affairs. Health Affairs, February 18, 2014. https://www.healthaffairs.org/do/10.1377/hblog20140218.036973/full/.

The government asserts that the Medicare For All Act is a mirror of the Social Security Act. (Brief for the Respondent). However, the situation presently before us is not identical to the one that was presented to this nation in 1935. The Social Security Act managed to solve the problems of unemployment and the deficiency of elderly care. Whether the statute before us can alleviate the problems present in the healthcare industry is unclear. Even if that answer was clearly knowable, the solving of the healthcare crisis is not a duty of this Court or its subsidiaries. That being said, it is the duty of this Court to uphold the Constitution of the United States by correctly interpreting its clauses in light of the times at hand. Although *Butler* established that the interpretation of the "general welfare", present in Article I, Section 8 of our Founding Document, is subject to the times in which it is interpreted, that interpretation must not exceed the limits of the words transcribed on the page. *United States v. Butler*, 297 U.S. 1 (1936). Although the defense asserts that the Medicare For All Act can be upheld on an authority other than that of the Commerce Clause, we hold that the statute's affectation of interstate commerce undoubtedly necessitates the need for its invocation and analysis. The section in question reads as follows:

"IN GENERAL.—Beginning on the effective date described in section 106(a), it shall be unlawful for—a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or an employer to provide benefits for an employee, former employee, or the dependents of an employee or former employee that duplicate the benefits provided under this Act."[101]

[101] Medicare For All Act of 2019, S. 1129, 116th Cong. §107(a) (2019).

Neither the Petitioner nor the Respondent deny that this section drafts physicians into the service of their Country. The Petitioner asserts that "in our current model of healthcare, in effect employ doctors". (Brief for the Petitioner). The Petitioner believes insurers to be the effectual employers of physicians; the logical end of this claim is that destruction of private insurance compels physicians to work for Medicare against their will. We do not concur with the description of insurance providers as employers; however, the compulsion of physicians is clearly apparent. Moreover, the claim that a doctor who refuses to work for Medicare would not be able to make a wage comparable to their previous salary is factual. The removal of the private insurance industry does indeed compel doctors to engage in unwanted commerce that they may not have engaged in otherwise. Given the choice, a doctor may take only private insurance rather than accept Medicare. The elimination of that choice cannot be reconciled with the understanding of the Commerce Clause presented in *Sebelius*, 567 U.S. at 519. *Sebelius* has been settled law for ten years now. *Id.* Although from time to time, the position of the Court will change, this day is not one of those times. An uprooting of settled law brings with it ramifications that this Court wishes to forego. We have found no issue with the principles outlined in *Sebelius*. This Court chooses, today, not to reconsider the issues presented in *Sebelius*. We have concluded that *Stare Decisis* this section of Medicare For All is unconstitutional.

Because the Section in question is unconstitutional, and the government has petitioned the Court not to consider the question of separation, it follows that the Medicare For All Act is not in line with our understanding of the Constitution and its tenets. The Decision of the Seventh Circuit Court of Appeals is hereby reversed.

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