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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: A CONSTITUTIONAL ANALYSIS

I. INTRODUCTION

Perhaps only taking a back seat to the economy, the Patient Protection and Affordable Care Act ("Affordable Care Act")[1] stood front and center in the 2012 United States presidential election.[2] But the Affordable Care Act's prominence in the American political landscape has been evident since its inception. In March 2010, despite Democratic control of Congress, H.R. 3590—which would later become the Affordable Care Act—barely mustered the requisite number of votes needed for enactment.[3] Formal congressional debate ended when President Barack Obama signed the resolution into law on March 23, 2010;[4] however, debate amongst the American populace persisted and polarized the nation on the issue of healthcare reform.

Healthcare reform in the United States can be traced back to the early twentieth-century.[5] At its roots, the social movement could best be described as strictly a "government-sponsored program of health insurance."[6] This initial, or "progressive," era of history saw the introduction of health insurance "as a program of income maintenance for wage earners[,] . . . disease prevention[,] and increased national efficiency."[7] Although some elements of reform caught on, namely through private business, results fell short of the compulsory system that most progressives envisioned.[8]

Societal changes also changed the view of healthcare reform from one of income maintenance to "a program primarily of medical care financing" that sought to increase access through the use of a risk allocation based system.[9] Reformers made efforts to become part of FDR's New Deal.[10] But those efforts proved to be unsuccessful. Nevertheless, reformers trudged ahead, gaining some traction during the 1940s with the Wagner-Murray-Dingell bill and President Truman's 1945 health program.[11] Ultimately, the reformer's efforts did not pay off until the passage of Medicare and Medicaid in 1965—well short of their early goals of a truly universal program.[12]

The third era of reform most resembles what people think of today. Healthcare reform evolved, once again; only this time, the focus became cost control, institutional reform, and universal coverage.[13] Much like the earlier eras, reformers here met continued resistance. During the 1970s, headway—the Nixon plan—seemed a sure thing.[14] The plan "would have mandated coverage by private employers—a regulatory approach to expanding health insurance that relied on copayments and other benefit limitations to control expenditures."[15] But it too failed, this time falling victim to political scandal.[16] Attempts at reform continued but did not make much of a political splash until the Clintons advanced proposals in the 1990s.[17] As ex-

pected, these proposals ended in the same manner that many before them had. Until the Affordable Care Act, never before had Americans seen such sweeping reforms implemented, at least in modern history.

These attempts at reform show that even in today's parlance, healthcare reform is hardly a novel concept.[18] Through the three eras, lawmakers and policy analysts have attempted to address our country's staggering health care costs.[19] Because cost represented only one of the three sides of the healthcare industry's "iron triangle," it was only a matter of time before any discussion on the topic raised competing issues with access and quality.[20] Essentially, this iron triangle was at the crux of every debate over healthcare reform in the United States and abroad.[21] Both sides of the American political aisle often agreed about the state of the healthcare system but disagreed, on a fundamental level, about how to address all the deficiencies.

The conservative argument centers on traditional notions of less government, including less regulation.[22] This free market approach grounds itself in two major premises: first, individuals must be responsible for their own health care;[23] and second, a truly free market can accomplish goals that a government-run system cannot.[24]

Naturally, the liberal argument represents the other side of the coin. This perspective generally sees health care as a fundamental right, much like the right to vote, to free speech, and to marry.[25] With this in mind, many liberals see the government as duty-bound to facilitate healthcare for all citizens, using a hands-on approach.[26]

Previous attempts to enact sweeping healthcare reforms have failed, but with the enactment of the Affordable Care Act, the liberal perspective would be put to a constitutional test. And the test came immediately. On the same day President Obama signed the Affordable Care Act into law, opponents filed numerous suits that challenged the law's constitutionality.[27]

II. OVERVIEW OF THE ACT

To better understand these challenges to the Affordable Care Act, a basic overview of the entire piece of legislation is useful. As enacted, the Affordable Care Act contains ten titles: (I) Quality, Affordable Health Care for All Americans; (II) Role of Public Programs; (III) Improving the Quality and Efficiency of Health Care; (IV) Prevention of Chronic Disease and Improving Public Health; (V) Health Care Workforce; (VI) Transparency and Program Integrity; (VII) Improving Access to Innovative Medical Therapies; (VIII) Class Act; (IX) Revenue Provisions; and (X) Strengthening Quality, Affordable Health Care for All Americans.[28]

Title I of the Affordable Care Act contains most of the widely known and discussed provisions. For instance, the "individual mandate" provision,[29] regarded as the legislation's lynchpin,[30] is located there. It requires most citizens to obtain minimum essential coverage beginning in 2014.[31]

Title I also requires certain employers to provide coverage to employees.[32] Other significant provisions in Title I establish the minimum coverage insurers must offer,[33] create insurance exchanges that allow consumers to shop for coverage with relative ease,[34] "limit[] insurers' ability to deny, rescind, and non-renew coverage,"[35] restrict the ability to apply lifetime caps on coverage,[36] and require insurers to provide preventative care without any additional out of pocket costs to the insured.[37]

Title II of the Affordable Care Act expands eligibility for Medicaid.[38] "In 2014, Americans earning less than 138% of the poverty line will be eligible for Medicaid."[39] This expansion has been predicted to capture approximately fifty million uninsured Americans.[40] Additionally, Title II simplifies individual enrollment options for Medicaid and the Children's Health Insurance Program (CHIP) by offering a web-based interface similar to the state-based exchanges commissioned by Title I.[41]

Title III attempts to reduce Medicare costs by restructuring and streamlining payment systems.[42] The legislation seeks to link payment to quality outcomes and incentivizes third-party oversight organizations to take responsibility for health care costs and quality.[43]

The Affordable Care Act, through Title IV, seeks to improve public health by creating a new interagency prevention council.[44] This council will focus on preventative care by increasing patient access and supporting public health innovation through research.[45]

Title V of the Affordable Care Act strives to improve quality of healthcare through workforce enhancement.[46] Anticipated changes here mirror front-end efforts, to some extent, that various states have already been implementing. Focusing on primary care, the Affordable Care Act seeks to offer financial incentives for physicians to enter into family medicine, general practice, and pediatrics.[47]

Title VI aims "to combat fraud and abuse in public and private programs."[48] The primary focus of these protective provisions is on Medicare and Medicaid, nursing homes, long-term care facilities, and other similar care providers.[49]

Unlike the previous provisions, Title VII focuses strictly on pharmaceuticals.[50] Essentially, the Affordable Care Act establishes a process by which the Food and Drug Administration (FDA) can readily approve and license a similar, generic version of an existing pharmaceutical product, resulting in more price competition and innovation.[51]

Title VIII authorizes the establishment of a "national voluntary insurance program for purchasing community living assistance services and support."[52] This is known as the CLASS program.[53] However, the current administration chose not to implement the program when it determined that adverse selections would make insurance premiums unaffordable.[54]

Title IX and X do not contain any substantive health care provisions. Title IX of the Affordable Care Act is the revenue or funding provision that

helps fund the health care expansion.[55] Title X is the manager's amendments legislation that amends previous sections of the United States Code to give effect to the Affordable Care Act's new legislation.[56]

III. LOWER COURT CHALLENGES

Affordable Care Act opponents filed numerous legal challenges on the very day President Obama signed the legislation into law.[57] Although more than twenty separate challenges were made,[58] a case before the Eleventh Circuit Court of Appeals became the challenge that ultimately gave rise to the Supreme Court of the United States's ruling on the constitutionality of the Affordable Care Act.[59] In *National Federation of Independent Business v. Sebelius* ("*NFIB v. Sebelius*"), twenty-six states, several individuals, and the National Federation of Independent Business joined together as plaintiffs to challenge certain provisions of the Affordable Care Act.[60] From this case, two provisions of the Affordable Care Act reached the Supreme Court for review: the individual mandate and the Medicaid expansion.[61]

In the original complaint filed in the United States District Court for the Northern District of Florida, the plaintiffs alleged six different ways in which the Affordable Care Act violated the Constitution.[62] Most of these claims were based on alleged violations of the Ninth and Tenth Amendments, but the plaintiffs also challenged parts of the Affordable Care Act under the Commerce Clause, the Fifth Amendment Substantive Due Process Clause, and Article I.[63] The specific statutory provisions at the heart of those violations included the individual mandate and concomitant penalty.[64] Additionally, the plaintiffs alleged that the Medicaid expansion and health benefit exchange provision proved too coercive to withstand constitutional challenge.[65] With respect to the individual mandate, the plaintiffs also made alternative arguments: if the mandate was considered a tax, it was an "unconstitutional unapportioned capitation or direct tax."[66]

On cross motions for summary judgment, Judge Vinson of the United States District Court for the Northern District of Florida ruled that the Affordable Care Act's expansion of Medicaid did not "violate the Spending Clause and principles of federalism protected under the Ninth and Tenth Amendments."[67] After summarily concluding that the Affordable Care Act passed muster under a *South Dakota v. Dole*[68] analysis, the court rejected the plaintiffs' argument that using Medicaid funding as a carrot to coax states' compliance was impermissibly coercive, finding that at a fundamental level, the decision to participate in the Medicaid program is completely voluntary.[69]

Despite upholding the constitutionality of the Medicaid expansion, the district court also ruled that the Affordable Care Act's individual mandate found in Title I violated the Commerce Clause.[70] Specifically, the court was concerned as to whether Congress had the authority to regulate activities

substantially affecting interstate commerce.[71] Noting that "[i]t would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause,"[72] the court resolved its concern by finding "that the individual mandate seeks to regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress's commerce power, as it is understood, defined, and applied in the existing Supreme Court case law."[73]

Continuing on, the court suggested that the individual mandate could not "be otherwise authorized by an assertion of power under the Necessary and Proper Clause."[74] Despite agreeing with the defendants' assertion "that the individual mandate is absolutely 'necessary' and 'essential' for the [Affordable Care Act] to operate as it was intended by Congress, . . . [it] falls outside the boundary of Congress' Commerce Clause authority and cannot be reconciled with a limited government of enumerated powers. By definition, it cannot be 'proper.'"[75] As such, the individual mandate could not survive by virtue of Congress's power through the Necessary and Proper Clause.

Because the mandate had no constitutional authority to rest upon and since it was "inextricably bound together in purpose" with the Affordable Care Act's remaining provisions, the court ruled that the mandate was not severable.[76] Consequently, the entire Affordable Care Act had to fall as a single unit.[77]

On appeal, the Eleventh Circuit affirmed many of the lower court's rulings, including the Medicaid expansion ruling,[78] the individual mandate-Commerce Clause ruling,[79] and the ruling that the mandate could not be upheld as a tax,[80] which was somewhat understated in the district court's opinion.[81] Despite affirming the district court's rulings on the three previous points, the Eleventh Circuit reversed the severability ruling.[82] The stage was set for the Supreme Court to grant certiorari.

IV. THE SUPREME COURT OPINION

After the Eleventh Circuit rendered its opinion, the Federal Department of Health and Human Services petitioned for writ of certiorari.[83] The Supreme Court of the United States granted the government's petition on three questions[84]: "whether the Affordable Care Act must be invalidated in its entirety because it is non-severable from the individual mandate that exceeds Congress' limited and enumerated powers under the Constitution;"[85] "[w]hether Congress had the power under Article I of the Constitution to enact the minimum coverage provision;"[86] "[w]hether the suit brought by respondents to challenge the minimum coverage provisions of the [Affordable Care Act] is barred by the Anti-Injunction Act [(AIA)];"[87] and "[d]oes Congress exceed its enumerated powers and violate basic principles of fed-

eralism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power . . . no longer apply?"[88] In March 2012, the Supreme Court sat for three days of oral argument on the issues presented in *NFIB v. Sebelius*.[89] The Court rendered its opinion on the last day of the October 2011 term.[90] Penned by the Chief Justice, the majority opinion affirmed and reversed, in part, the Eleventh Circuit's opinion.[91]

Preliminarily, Roberts, along with Justices Ginsburg, Breyer, Sotomayor, and Kagan, dismissed the notion that the AIA did not preclude review of the suit.[92] The AIA requires individuals subject to a tax to pay it and then sue to get a refund, if they were entitled; this is in lieu of challenging the tax in court before paying it first.[93] As it relates to the Affordable Care Act, the question here was whether challenging the individual mandate amounted to challenging a tax before paying it.[94] Noting that Congress referred to the individual mandate as a penalty rather than a tax, Roberts held that at least for the purposes of the AIA, the individual mandate was not a tax.[95] Foreshadowing later portions of his opinion, Roberts distinguished the tax analysis for AIA from the analysis that should be made for constitutional purposes: "It is true that Congress cannot change whether an exaction is a tax or a penalty for *constitutional* purposes simply by describing it as one or the other."[96]

Next, the Chief Justice, writing only for himself, held that Congress lacked the authority to enact the individual mandate under both the Commerce and the Necessary and Proper Clauses.[97] Congress's power under the Commerce Clause clearly permits regulation of commercial activity; although failing to purchase a product will certainly have an effect on interstate commerce, Roberts thought that compelling individuals to take some affirmative action to mitigate that effect falls outside the bounds of Congress's Commerce Clause power.[98] And permitting Congress to use their power in that manner would effectively expand its authority to a level without limitation.[99] Reaching a similar result under Congress's power from the Necessary and Proper Clause, Roberts held that unlike laws previously upheld, which "involved exercise of authority derivative of, and in service to, a granted power[,] . . . [t]he individual mandate . . . vests Congress with the extraordinary ability to create the necessary predicate to the exercise of an enumerated power."[100] That type of bootstrapping fell outside the scope of the Necessary and Proper Clause.[101]

Chief Justice Roberts, again only writing for himself, began paving the way to upholding the individual mandate through his discussion of the constitutional avoidance doctrine.[102] Relying on past opinions penned by Justices Story[103] and Holmes,[104] Roberts stated that "it is well established that if a statute has two possible meanings, one of which violates the Constitution, courts should adopt the meaning that does not do so."[105] And by describing

the inquiry as determining whether a particular interpretation is "fairly possible" or "a reasonable construction," Roberts embraced the government's argument that the individual mandate was, for purposes other than the AIA, a tax.[106] Roberts's somewhat cryptic analysis of the individual mandate during his AIA discussion did, in fact, prove to be a foreshadowing of a second tax analysis.[107]

Using the constitutional avoidance doctrine, Roberts upheld the individual mandate as a permissible exercise of Congress's power granted by the Constitution's Tax and Spend Clause.[108] His opinion was joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan. In light of holding that the mandate was *not* a tax for AIA purposes, the Chief Justice stated:

> It is of course true that the Act describes the payment as a "penalty," not a "tax." But while that label is fatal to the application of the Anti–Injunction Act, . . . it does not determine whether the payment may be viewed as an exercise of Congress's taxing power. It is up to Congress whether to apply the Anti–Injunction Act to any particular statute, so it makes sense to be guided by Congress's choice of label on that question. That choice does not, however, control whether an exaction is within Congress's constitutional power to tax.[109]

After reaching this result, Roberts also held that the individual mandate, being a tax, complied with the Constitution's Direct Tax Clause.[110]

Although he upheld the individual mandate under the Tax and Spend Clause, Roberts, joined by Justices Breyer and Kagan, concluded his opinion by striking down the Medicaid expansion provision for being unconstitutionally coercive.[111] Generally, Congress is able to enact legislation "to pay the Debts and provide for the . . . general Welfare of the United States."[112] And, the Court has held that Congress may condition states' acceptance of federal funding by requiring them to take specific or certain actions.[113] After establishing this premise, Roberts focused on the bounds of permissible conditions Congress might tie to such grants.[114] Without establishing a bright-line, the Chief Justice did ultimately hold that the Medicaid expansion provisions of the Affordable Care Act proved too coercive to pass constitutional muster.[115] However, in Roberts's view, the Affordable Care Act could be upheld by precluding withdrawal of existing Medicaid funding for failure to meet the new conditions Congress attempted to tack on; in other words, the provision was severable.[116]

Justice Ginsburg, joined by Justice Sotomayor, wrote separately to express her views that the individual mandate was a proper exercise of Congress's power under the Commerce Clause[117] and that the Medicaid expansion provisions did not violate the Spending Clause.[118] In her Commerce Clause discussion, which was also joined by Justices Breyer and Kagan, Ginsburg seemed to easily reach the conclusion that inactivity could always be seen as activity from a slightly different perspective: "An individual who

opts not to purchase insurance from a private insurer can be seen as actively selecting another form of insurance: self-insurance. . . . The minimum coverage provision could therefore be described as regulating activists in the self-insurance market."[119] Getting over the activity-inactivity hurdles, Ginsburg had no problem establishing the constitutionality of the individual mandate under Congress's Commerce power.[120]

Going beyond the Commerce Clause, Ginsburg criticized the Chief Justice's discussion of the Necessary and Proper Clause.[121] Here, she and Sotomayor were again joined by Justices Breyer and Kagan. Although Ginsburg appeared to focus more on criticism than anything else, her opinion surely suggested that the individual mandate also falls within Congress's purview under the Necessary and Proper Clause.[122]

In the last section of the joint concurrence that Justices Breyer and Kagan endorsed, Justice Ginsburg briefly stated that she agreed with Roberts's holding that Congress was permitted to enact the individual mandate under the Tax and Spend Clause, but not without offering one last parting criticism:

> I concur in that determination, which makes THE CHIEF JUSTICE's Commerce Clause essay all the more puzzling. Why should THE CHIEF JUSTICE strive so mightily to hem in Congress' capacity to meet the new problems arising constantly in our ever-developing modern economy? I find no satisfying response to that question in his opinion.[123]

Writing only for herself and Sotomayor, Ginsburg concluded her concurrence by expressing her desire to uphold the Medicaid expansion.[124] Although she agreed with Roberts's holding that the constitutional violation could be remedied by not withdrawing federal funding for the States that choose not to adopt the expansion's new conditions, Ginsburg found that the expansions were not too coercive to begin with.[125]

Justice Scalia, joined by Justices Kennedy, Thomas, and Alito, penned the joint dissenting opinion.[126] In the individual mandate discussion, the joint dissent pointed out that the Court's prior decisions offer the following idea:

> [T]he Commerce Clause, even when supplemented by the Necessary and Proper Clause, is not *carte blanche* for doing whatever will help achieve the ends Congress seeks by the regulation of commerce[,] . . . [and] the scope of the Necessary and Proper Clause is exceeded not only when the congressional action directly violates the sovereignty of the States but also when it violates the background principle of enumerated . . . federal power.[127]

The government's argument in the instant case took Congress's action far beyond what it was permitted to do by the Necessary and Proper Clause.[128] But even after reaching that conclusion, the joint dissent contin-

ued on to suggest, as Roberts did in the majority opinion, that the individual mandate exceeded Congress's Commerce Clause power despite its creative efforts to keep it within permissible bounds; this creative effort was that the individuals who chose not to purchase insurance would later become members of the healthcare market.[129] "Such a definition of market participants is unprecedented, and were it to be a premise for the exercise of national power, it would have no principled limits."[130]

The joint dissent went on to tackle the majority's discussion of the individual mandate as permitted by the Tax and Spend Clause. There, the joint dissent quickly pointed out the dichotomy of the majority's analysis in holding that the mandate was "[a] penalty for constitutional purposes [and] is *also* a tax for constitutional purposes."[131] Using a variety of statutory interpretation tools and doctrines—including the constitutional avoidance doctrine—the joint dissent concluded that the individual mandate was a penalty and not a tax.[132] Because the mandate was not a tax, the dissenting justices believed, like the majority, that the AIA did not preclude the suit.[133]

Before concluding with his discussion on severability, the dissent discussed the constitutionality of the Medicaid expansion provisions of the Affordable Care Act.[134] Like all but Ginsburg and Sotomayor, the dissenting justices also found that the expansion proved too coercive to withstand scrutiny.[135] Where they differed, however, was whether the expansion could stand based on the proposed remedy precluding withdrawal of funding from the states that opted against meeting the additional conditions imposed by the expansion provisions.[136] The crux of this holding, according to the dissent, was an impermissible example of judicial activism.[137]

Finally, the joint dissent concluded with an extended discussion on severability.[138] Operating from the premise that both the individual mandate and the Medicaid expansion provisions should be stricken in their entirety, the dissenting justices demonstrated how the Affordable Care Act's various provisions were too intertwined to withstand severability.[139] In holding that the Affordable Care Act's individual mandate and Medicaid expansion provisions were not severable, the dissenting justices aptly concluded their opinion.

Through all the concurring and dissenting opinions,[140] the Medicaid expansion provisions would remain the only victim to constitutional challenges. More importantly, many would say, the real changes occurred in the development of constitutional jurisprudence.

V. THE SYMPOSIUM

The United States Supreme Court's *NFIB v. Sebelius* decision is already considered to be one of the landmark opinions of the Roberts court. No case has been followed so closely and carefully since *Bush v. Gore*.[141] The broad scope of the Court's holding has raised numerous questions about

the current state of constitutional law. Because these fundamental issues have been raised, *NFIB v. Sebelius* is worthy of extended study.

David C. Jung[*]

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered titles of the U.S. Code).

2. *See, e.g.*, Ezra Klein, *The Most Important Issue of this Election: Obamacare*, WONKBLOG (Oct. 26, 2012, 11:13 AM), http://www.washingtonpost.com/blogs/wonkblog/wp/2012/10/26/the-most-important-issue-of-this-election-health-reform.

3. Office of the Clerk, *Final Vote Results for Roll Call 165*, U.S. HOUSE OF REPRESENTATIVES (Mar. 21, 2010, 10:49 PM), http://clerk.house.gov/evs/2010/roll165.xml. The Act passed in the House with a final vote of 219 to 212. *Id.* Thirty-four Democratic congressmen joined unanimous Republicans in opposition to the Act. *Id.*

4. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 24, 2010, at A19.

5. *See* Paul Starr, *Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915–1980*, 72 AM. J. PUB. HEALTH 78, 78 (1982).

6. *Id.*

7. *Id.* The progressive era lasted until the early 1930s. *Id.* at 78–81.

8. *Id.* at 79.

9. *Id.* at 81–84. This second era, some say, lasted much longer than its predecessor, eventually giving way to a third chapter in the late 1960s. *Id.*

10. *Id.* at 81.

11. Starr, *supra* note 5, at 81.

12. *Id.*

13. *Id.* at 78.

14. *Id.* at 85.

15. *Id.*

16. *Id.*

17. *See* George J. Annas, *Health Care Reform in America: Beyond Ideology*, 5 IND. HEALTH L. REV. 441, 442–45 (2008).

18. *E.g.*, *Summary of a 1993 Republican Health Reform Plan*, KAISER HEALTH NEWS (Feb. 23, 2010), http://www.kaiserhealthnews.org/Stories/2010/February/23/GOP-1993-health-reform-bill.aspx. In 1993, Republican Senator John Chafee introduced a healthcare reform bill that sought goals similar to the ACA, including universal coverage. *Id.*

19. *See, e.g.*, *id.* The cost-focus seems most evident in the third era of reform; although the previous eras may not have campaigned on cost-control, the topic, inevitably, also came to be a significant part of the discussion. Starr, *supra* note 5, at 79–85.

20. Thomas R. McLean, *The Offshoring of American Medicine: Scope, Economic Issues and Legal Liabilities*, 14 ANNALS HEALTH L. 205, 255–61 (2005).

21. A British scholar, using the phrase "inconsistent triad" in lieu of "iron triangle," characterized the issue as being without technical solutions. *See* JOHN BUTLER, THE ETHICS OF HEALTH CARE RATIONING: PRINCIPLES AND PRACTICES 3 (1999). "[T]he problem is inherently contestable because it touches upon *social, political and economic values* about which people not only care but disagree." *Id.*

22. *See* Robert M. Sade, *Foundational Ethics of the Health Care System: The Moral and Practical Superiority of Free Market Reforms*, 33 J. MED. & PHIL. 461, 462–63 (2008).

23. *Id.* at 463.

* Please refer to original version with footnotes for accurate page numbers

24. *See id.* at 488; *see also* William Kristol, *How to Oppose the Health Plan—and Why*, WALL ST. J., Jan. 11, 1994, at A14.

25. *See* Sade, *supra* note 22, at 463.

26. *See* Barack Obama, President of the U.S., Remarks on Healthcare at a Joint Session of Congress (Sept. 9, 2009), *available at* http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/. The President stated that "government has to step in to help deliver on [the] promise" of universal healthcare. *Id.*

27. *See, e.g.*, Complaint, Virginia v. Sebelius, 702 F. Supp. 2d 598 (E.D. Va. 2010) (No. 3:10CV188), 2010 WL 1038397; *see also* Katherine Hayes & Sarah Rosenbaum, *Legal Challenges to the Affordable Care Act*, HEALTHREFORMGPS (Dec. 14, 2010), http://healthreformgps.org/resources/health-reform-and-the-constitutional-challenges.

28. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 119–30 (2010).

29. 42 U.S.C. § 18091 (Supp. 2010); 26 U.S.C. § 5000A (Supp. 2010).

30. Marc Siegel, *The Individual Mandate Is Obamacare's Linchpin*, NAT'L REVIEW ONLINE (Aug. 15, 2011, 4:00 AM), http://www.nationalreview.com/articles/274576/individual-mandate-obamacare-s-linchpin-marc-siegel#. Many view this provision as the key to maintaining "a market-based system of health insurance." Jenna L. Kamiat, *PPACA and the Individual Mandate: A Healthy Approach to Severability*, 80 FORDHAM L. REV. 2237, 2250 (2012) (citing Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1974 (2011)). Unlike the distribution of people who receive health insurance through employers, individuals without such employer-based coverage tend to allocate risk inefficiently. *See id.* Younger people are, as a whole, healthier and tend to forego coverage, which leaves older people, who are comparatively not as healthy or even unhealthy, as the primary demographic in the insurance pool. *See id.* Without requiring those healthy persons to acquire coverage, the insurers would be unable to operate.

31. 26 U.S.C. § 5000A (Supp. 2010). Failure to do so would subject the individual to a monetary penalty. *Id.* § 5000A(c).

32. *Id.* § 4980H.

33. 42 U.S.C. § 18022 (Supp. 2010).

34. *Id.* § 18031.

35. J. Angelo DeSantis & Gabriel Ravel, *The Consequences of Repealing Health Care Reform in Early 2013*, 60 CLEV. ST. L. REV. 365, 372 (2012) (citing 42 U.S.C. §§ 300gg-2, 300gg-3, 300gg-12 (Supp. 2010)).

36. Neil S. Siegal, Essay, *Distinguishing the "Truly National" from the "Truly Local": Customary Allocation, Commercial Activity, and Collective Action*, 62 DUKE L.J. 797, 810 (2012) (citing 42 U.S.C. § 300gg-11 (Supp. 2010)).

37. 42 U.S.C. § 300gg-13 (Supp. 2010)).

38. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 121–22 (2010).

39. DeSantis & Ravel, *supra* note 35, at 373 (citing 42 U.S.C. § 1396(a) (Supp. 2010)).

40. *Id.*

41. DEMOCRATIC POLICY & COMMC'NS CTR., THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: DETAILED SUMMARY 3–4, *available at* http://dpc.senate.gov/healthreformbill/healthbill04.pdf.

42. *See* DeSantis & Ravel, *supra* note 35, at 373–74 (citing 42 U.S.C. § 1315(a) (Supp. 2010)).

43. DEMOCRATIC POLICY & COMMC'NS CTR., *supra* note 41, at 4–6.

44. *Id.* at 6.

45. *Id.* at 6–7.

46. *See id.* at 7–9.

47. *Id.* at 7–9; *see also* DeSantis & Ravel, *supra* note 35, at 374 (citing Karen Davis et al., *How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation*, 26 J. INTERNAL MED. 1201, 1201–02 (2011)).

48. *See* DEMOCRATIC POLICY & COMMC'NS CTR., *supra* note 41, at 9.

49. *See* DeSantis & Ravel, *supra* note 35, at 374.

50. *See* DEMOCRATIC POLICY & COMMC'NS CTR., *supra* note 41, at 12.

51. *See id.* Although not truly a generic, as used in pharmaceutical jargon, biologic drugs, which are the focus of Title VII, "are treatments created by biological processes, such as vaccines, blood, and tissues. Biologic drugs are larger, more complex molecules than the 'small-molecule drugs' more typically associated with prescription drugs. Their complexity makes creating generic versions difficult." DeSantis & Ravel, *supra* note 35, at 374–75 (footnotes omitted).

52. DEMOCRATIC POLICY & COMMC'NS CTR., *supra* note 41, at 12.

53. *Id.*

54. DeSantis & Ravel, *supra* note 35, at 375.

55. *Id.*

56. *See id.* at 371.

57. *See* discussion *supra* Part I.

58. Hayes & Rosenbaum, *supra* note 27. For a good description of the various challenges made in different United States Federal District Courts, see *Defending the Affordable Care Act*, U.S. DEP'T OF JUSTICE, http://www.justice.gov/healthcare (last visited Apr. 13, 2013).

59. *See* NFIB v. Sebelius, 132 S. Ct. 2566 (2012).

60. *Id.* at 2580 [hereinafter *NFIB v. Sebelius*].

61. *Id.* For a discussion of the two different provisions, see *supra* Part II. For a general overview of the Supreme Court's opinion in *NFIB v. Sebelius*, see Comment, *National Federation of Independent Business v. Sebelius: The Patient Protection and Affordable Care Act*, 126 HARV. L. REV. 72 (2012).

62. Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120, 1129–30 (N.D. Fla. 2010).

63. *See id.*

64. *See id.*

65. *Id.* at 1130.

66. *Id.* The district court outlined the plaintiffs' six claims more specifically as follows:

> (1) [T]he individual mandate and concomitant penalty exceed Congress's authority under the Commerce Clause and violate the Ninth and Tenth Amendments . . . ; (2) the individual mandate and penalty violate substantive due process under the Fifth Amendment . . . ; (3) "alternatively," if the penalty imposed for failing to comply with the individual mandate is found to be a tax, it is an unconstitutional unapportioned capitation or direct tax in violation of U.S. Const. art. I, § 9, cl. 4, and the Ninth and Tenth Amendments . . . ; (4) the Act coerces and commandeers the states with respect to Medicaid by altering and expanding the program in violation of Article I and the Ninth and Tenth Amendments . . . ; (5) it coerces and commandeers with respect to the health benefit exchanges in violation of Article I and the Ninth and Tenth Amendments . . . ; and (6) the employer mandate interferes with the states' sovereignty as large employers and in the performance of government functions in violation of Article I and the Ninth and Tenth Amendments . . . .

Id. at 1129–30.

67. Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1265 (N.D. Fla. 2011).

68. 483 U.S. 203 (1987).
69. *Bondi*, 780 F. Supp. 2d at 1266–69.
70. *Id.*
71. *See id.* at 1273.
72. *Id.* at 1286.
73. *Id.* at 1295.
74. *Id.* at 1298–99.
75. *Bondi*, 780 F. Supp. 2d at 1298.
76. *Id.* at 1305.
77. *Id.*
78. Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1268 (11th Cir. 2011).
79. *Id.* at 1311.
80. *Id.* at 1313–14. Importantly, Congress's Tax and Spend power is quite broad. *Id.* at 1314. The issue here was that the ACA's legislative history and statutory text indicated that the provision was a penalty as opposed to a tax. *Id.*
81. *See Bondi*, 780 F. Supp. 2d at 1265 n.4.
82. *Id.* at 1328.
83. *See* Petition for Writ of Certiorari, NFIB v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11-400); Petition for Writ of Certiorari, *Sebelius*, 132 S. Ct. 2566 (No. 11-398); Petition for Writ of Certiorari, *Sebelius*, 132 S. Ct. 2566 (No. 11-393).
84. Florida v. Sebelius, 132 S. Ct. 604 (2011); Sebelius v. Florida, 132 S. Ct. 604 (2011); NFIB v. Sebelius, 132 S. Ct. 603 (2011).
85. Petition for Writ of Certiorari, *Sebelius*, 132 S. Ct. 2566 (No. 11-393).
86. Petition for Writ of Certiorari, *Sebelius*, 132 S. Ct. 2566 (No. 11-398).
87. *Id.*
88. Petition for Writ of Certiorari, *Sebelius*, 132 S. Ct. 2566 (No. 11-400).
89. *See Patient Protection and Affordable Care Act Cases*, SUPREME COURT OF THE UNITED STATES, http://www.supremecourt.gov/docket/PPAACA.aspx (last visited Apr. 13, 2013).
90. *See* NFIB v. Sebelius, 132 S. Ct. 2566, 2566 (2012).
91. *Id.* at 2577, 2609.
92. *Id.* at 2582–84.
93. *See* 26 U.S.C. § 7421(a) (Supp. 2010). The Anti-Injunction Act provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." *Id.* "This statute protects the Government's ability to collect a consistent stream of revenue, by barring litigation to enjoin or otherwise obstruct the collection of taxes." *Sebelius*, 132 S. Ct. at 2582.
94. *Sebelius*, 132 S. Ct. at 2582–84.
95. *Id.*
96. *Id.* at 2583.
97. *Id.* at 2585–93.
98. *Id.* at 2585–91 ("The Framers gave Congress the power to *regulate* commerce, not to *compel* it . . . .").
99. *See id.*
100. *Sebelius*, 132 S. Ct. at 2592.
101. *See id.* at 2592–93.
102. *See id.* at 2593–94.
103. Parsons v. Bedford, 3 Pet. 433, 448–49 (1830).
104. Blodgett v. Holden, 275 U.S. 142, 148 (1927).
105. *Sebelius*, 132 S. Ct. at 2593.

106. *Id.* at 2593–94.
107. *See id.*
108. *Id.* at 2594–95.
109. *Id.* at 2594.
110. *Id.* at 2598–99. The Direct Tax Clause provides, "No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or Enumeration herein before directed to be taken." U.S. CONST. art. I, § 9, cl. 4.
111. *Sebelius*, 132 S. Ct. at 2594–95.
112. U.S. CONST. art. I, § 8, cl. 1.
113. *See Sebelius*, 132 S. Ct. at 2601–02.
114. *Id.* at 2602–03.
115. *Id.* at 2606–07.
116. *See id.* at 2638–40.
117. *Id.* at 2609 (Ginsburg, J., concurring in part, concurring in judgment, dissenting in part).
118. *Id.* at 2641–42.
119. *Sebelius*, 132 S. Ct. at 2622 (internal citations omitted) (footnote omitted).
120. *Id.* at 2625.
121. *Id.* at 2626–28.
122. *See id.*
123. *Id.* at 2629.
124. *Id.* at 2629–42.
125. *Sebelius*, 132 S. Ct. at 2629–42 (Ginsburg, J., concurring in part, concurring in judgment, dissenting in part).
126. *Id.* at 2642 (joint opinion of Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).
127. *Id.* at 2646.
128. *See id.* at 2647.
129. *See id.* at 2647–48.
130. *Id.* at 2648.
131. *Sebelius*, 132 S. Ct. at 2651 (joint opinion of Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).
132. *Id.* at 2650–55.
133. *Id.* at 2655–56.
134. *Id.* at 2656–66.
135. *Id.*
136. *Id.* at 2666–68.
137. *See Sebelius*, 132 S. Ct. at 2666–68 (joint opinion of Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).
138. *Id.* at 2668–77.
139. *See id.*
140. Justice Thomas, writing for himself, also offered a brief dissent. *Id.* at 2677 (Thomas, J., dissenting). There, he expresses discontent for the Commerce Clause's "substantial effects" test and suggests that its existence gave the government a basis for it to argue that inactivity could be activity. *Id.*
141. 531 U.S. 98 (2000).

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