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HEALTH-CARE CHANGE IN THE UNITED STATES: REFORM AND REACTION

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Health care in the United States is experiencing considerable turmoil due to rising costs and partisan conflict over recent efforts to reform the health-care system. The United States has a complex system of public and private health-care institutions, which, historically, have been rooted in the states and in the private sector. Only since the mid-1960s has the federal government come to play a huge role in health care. On the whole, this complex system performs well, and Americans express high levels of satisfaction with their health care, but it is becoming overly expensive while still leaving some people without adequate health care.

This chapter will discuss the historical development of U.S. health care, outline its principal institutional structure, describe the major contemporary federal health-care programs, and examine the recent health-care reform and the challenges to it.

HISTORICAL DEVELOPMENT AND INSTITUTIONAL CONTEXT

During the eighteenth and nineteenth centuries, health care was primarily a private, local activity. Various individuals offered health-care services with little or no government regulation or licensing. Some local governments also offered health-care services, especially for the poor. Most people were treated in their home, and medicine was too underdeveloped to be of much benefit to them.

In 1789, the U.S. Congress established the U.S. Marine Hospital Service, which was financed by compulsory 1 percent deductions from seamen's wages. This act also created the U.S. Public Health Services Commissioned Corps, which seeks to prevent the spread of disease from sailors returning from foreign ports, immigrants entering the country, and communities affected by natural and

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manmade disasters. In 1870, the Corps' hospital administration was centralized in the Marine Hospital Service headquartered in Washington, DC, under the position of the supervising surgeon (now called the Surgeon General).

Since 1776, the national government also has provided for the health-care needs of military veterans. Up until the mid-twentieth century, veterans' health care was delivered by state and local facilities, including state-established homes for disabled veterans. The federal government provided payments to veterans and to their widows and dependents as well as some financial aid for the state veterans' homes. During the twentieth century, the federal government assumed direct responsibility for veterans' health care by constructing a system that grew from 54 hospitals in 1930 to a nationwide network of 153 hospitals, 956 outpatient clinics, 134 community living centers, 90 domiciliary residential rehabilitation treatment programs, 232 veterans centers, and 57 veterans benefits regional offices available to about 22,658,000 veterans today. This is the largest integrated health-care system in the United States, and it treated more than 5.6 million patients in 2010. It is operated by the U.S. Department of Veterans Affairs, which $118 billion in funds and 280,000 full-time employees in 2010.

In 1847, the Massachusetts Health Insurance Company, located in Boston, became the first company to offer sickness insurance. Two years later, New York became the first state to enact a general insurance law. Hence, the pattern that became prevalent during the twentieth century was set during the mid-eighteenth century, that is, private-sector provision of health insurance and health services coupled with regulation by the state governments.

This private provision included not only commercial companies but also non-profit associations. For example, a French mutual-aid society, La Societe Francaise de Bienfaisance Mutuelle, created a pre-paid plan for hospital care in San Francisco in 1853. Hospitals were established most commonly as non-profit religious or fraternal institutions. Today, there are 2,918 such hospitals (50.4 percent of the 5,795 hospitals in the United States).

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In 1863, The Travelers Insurance Company began to sell accident insurance to railroad passengers. It soon offered other forms of accident insurance. A large mail-order retailer of various consumer goods, Montgomery Ward, entered one of the first group-insurance contracts in 1910. A decade later, General Motors entered a contract with Metropolitan Life to insure its 180,000 workers.

The American Medical Association (AMA) was founded in 1847 and began to spread across the states. The AMA also initiated medical research and launched several journals, such as the *Archives of Ophthalmology* (1869), *Journal of Cutaneous Diseases* (1882)--now the *Archives of Dermatology*--and *Journal of the American Medical Association* (1883).

During the 1870s, railroad, mining, and some other industrial corporations began to provide physicians to their workers. These health-care plans were funded by deductions from employees' wages. Labor unions also entered the health-care field. In 1877, for instance, the Granite Cutters Union founded the first national sick-benefit program. In 1913, the International Ladies Garment Workers Union initiated the first union-provided medical services to its members and their families.

By the late nineteenth century, governments became more aware of their public health responsibilities. Local governments, especially, assumed greater responsibilities for public sanitation, clean drinking water, waste disposal, food vendor inspections, building and fire code enforcement, and quarantines. These remain predominantly local responsibilities. States passed many public health laws such as food and drug inspection and safety laws. Because of the growing national economy, the federal government also entered the public health field with, for example, passage of the Pure Food and Drug Act of 1906 and Federal Meat Inspection Act of 1906.

Modern organized medicine emerged in the early 1900s. In 1901, the AMA reorganized itself into a national association of state and local medical associations. It began to work more systematically to organize, inspect, and accredit medical schools and to advise states on licensing and other regulations. The AMA's membership soared from about 7,000 physicians in

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1900 to about 70,000 by 1910. In 1912, state insurance commissioners (now organized as the National Association of Insurance Commissioners) developed the first model state law, called the Standard Provisions Law, to regulate health insurance. (A model state law is a law proposed by a group of experts for adoption by all the states. States are not required to adopt such laws.)

In light of the spread of government-supported national health-insurance programs in Europe, beginning with Germany in 1883, American reformers, such as President Theodore Roosevelt (1901-09) advocated national health insurance. In 1915, the American Association for Labor Legislation drafted a model state law for compulsory health insurance. It then campaigned to have the legislation enacted in each of the states. The AMA initially supported this proposal, but many state medical societies opposed it. Furthermore, the president of the large American Federation of Labor condemned compulsory health insurance as a paternalistic scheme that would impose state supervision on people's health. Some labor leaders worried that government-supported insurance would weaken unions by displacing the social benefits they offered to their members. Commercial insurance companies also opposed the model law. With American entry into World War II in 1917, opponents of the proposal assailed it as "German socialist insurance" and a "Prussian menace."

Prior to 1920, most people spent little on health care. A Bureau of Labor Statistics survey of 211 families living in Columbus, Ohio, in 1918 found that only 7.6 of their average annual medical expenditures paid for hospital care. The principal cost of illness was not medical care but loss of wages from being unable to work. A study conducted by Illinois in 1919 found that wage losses due to illness were four times higher than the costs of medical treatment. Consequently, most people did not seek health insurance; instead, they purchased "sickness" insurance--comparable to today's "disability" insurance--to replace income when they became too ill to work.

The first modern group health-insurance plan was established in 1929 when a group of teachers in Dallas, Texas, contracted with Baylor Hospital for room, board, and medical services for 21 days in exchange for a $6.00 payment. This plan was the forerunner of non-profit associations called Blue Cross or Blue

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Shield, which were first established in 1932 and soon offered group health plans in various states. The Blues were initially non-profit insurers who served local community organizations and fraternal societies. They negotiated contracts with hospitals and physicians for discounted services in return for providing more customers and paying promptly for services. In exchange for a tax break, the Blues also kept premiums fairly low. The Blues, which still exist today, became enormously successful in every state. As health insurance became more popular during the 1930s and 1940s, a number of life-insurance companies also began selling health insurance.

As these plans became more popular, employers also soon turned to these organizations to provide health insurance for their workers and their families. Employer-provided health insurance, which usually also includes prescription drugs, quickly became the most common form of such insurance. Under these plans, the employer pays a part of the annual premium for the health insurance, and the employee pays a part of the premium through payroll deductions. Many employers offer employees a choice of two or more insurance plans.

To facilitate the spread of health insurance, the federal government enacted legislation in 1939 and 1954 to provide tax advantages for these employer-provided plans. Employers can deduct their health-insurance premium payments as business expenses from their federal income-tax liability. In turn, the employer's premium contributions do not count as taxable income for employees. Many states enacted similar legislation.

State and local governments, however, have long provided health care services for the poor and others not covered by insurance. During the nineteenth century, states and counties (which are administrative arms of state governments) established hospitals and other public facilities for the care of mentally and physically disabled people. For example, Cook County Hospital serving the Chicago area originated as a poor house in 1835 that provided medical care for the indigent. In 1885, the Los Angeles County Hospital became affiliated with the University of Southern California Medical School to become what is now a 600-bed public teaching hospital. This facility, which is one of the largest public hospitals and medical training centers in the United States, is the

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biggest single health-care provider in Los Angeles County. Altogether, there are about 1,092 state and local government community hospitals (18.8 percent of the country's 5,795 hospitals).

State governments have the primary regulatory responsibility for most aspects of health care, as well as health insurance. They also enact tort laws that pertain to medical malpractice lawsuits and to defective medicines and medical devices. State governments also license all occupations associated with health care, such as physicians, nurses, dentists, psychologists, and social workers.

Thus, by the mid-twentieth century, health insurance was provided by the private sector, mostly through employers. The federal and state governments gave these health-insurance plans favorable tax treatment, and the states continued to regulate health insurance, a power that was reinforced by the federal McCarran-Ferguson Act of 1948. Consequently, health-insurance plans, such as Blue Cross and Blue Shield, vary across the states because state have somewhat different rules. They also have different mandates requiring the services that insurers must provide in their health-insurance plans (e.g., massage therapy and acupuncture) that are beyond ordinary and customary health-care services. The number of such mandates ranges from 68 in Minnesota to 13 in Idaho.

Likewise, health care was provided principally by the private sector, especially the non-profit sector, but with the federal government having direct responsibility for military veterans and state and local governments (mostly county governments) providing free and low-cost health care for the poor.

THE FEDERAL GOVERNMENT'S CONTEMPORARY ROLE

During the 1960s, there was considerable political pressure to reform American society and to promote greater equality among citizens. President Lyndon B. Johnson (1963-69) launched a series of Great Society programs to improve social welfare. Despite the widespread availability of health insurance and health care, two groups were less likely to have insurance and access to care:

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the poor and the elderly. In the early 1960s, for instance, about 56 percent of people age 65 and older did not have health insurance, in part because some employers discontinued health insurance for retired employees. Approximately 15 percent of Americans were poor according to official measures.

In addition, there had been attempts under Presidents Theodore Roosevelt, Franklin D. Roosevelt (1933-45), and Harry S. Truman (1945-53) to enact some type of national health-insurance. In 1960, the federal government enacted a policy called Medical Assistance for the Aged, which offered funds to states that chose to adopt the program. However, less that half of the states elected to participate in the program. Some participating states, moreover, complained that federal funds were insufficient to pay for the effort required to comply with federal rules.

In 1965, however, President Johnson signed two large health-insurance policies into law at the Truman Presidential Library in Independence, Missouri: Medicare and Medicaid.

MEDICARE

Medicare is a health-insurance program for all citizens and legal residents (for at least five years) who are age 65 or older; individuals who are under age 65 but permanently disabled physically or have a congenital physical disability; and some other people who meet specified criteria. Medicare pays 80 percent of the government-approved amount of any health-care cost. The remaining 20 percent of the cost must be paid from Medicare supplemental insurance purchased from a private company or from the patient's personal money. Individuals obtain health care from physicians, hospitals, and other providers of their choice, though all Medicare benefits are subject to medical necessity. Medicare does not hire doctors directly or operate its own hospitals or other medical facilities. Instead, it contracts with regional insurance companies to process its fee-for-service claims. It does, however, fund residency training for most physicians in the country.

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Medicare is a federal-government program, funded partly by a national payroll tax, which is equal to 2.9 percent of annual wages, salary, and other compensation paid to an employee. Ordinarily, 1.45 percent is withheld from the worker's pay, while the employer pays a matching 1.45 percent. Starting in 2013, individuals earning more than $200,000 annually and couples earning more than $250,000 annually will pay a 3.8 percent payroll tax on income they receive above those amounts. However, Medicare payroll taxes and beneficiary premiums cover only 57 percent of current benefits; the other 43 percent is financed from general federal-government revenues. Medicare is administered by the Centers for Medicare and Medicaid Services, a unit of the U.S. Department of Health and Human Services.

Medicare has four parts: Part A is hospital insurance; Part B is medical insurance; Part D covers prescription drugs; and Part C allows recipients voluntarily to enter private-sector Medicare Advantage plans through which they can receive their Part A, B, and D benefits.

Part A covers inpatient hospital stays, including a semiprivate room, tests, physicians' fees, and food, and also convalescent stays in a skilled nursing facility for up to 100 days, although Medicare pays the full cost of only the first 20 days while the patient must pay a portion ($141.50 per day) of the cost for the remaining 80 days. Some patients can use private health insurance to pay those costs. Most Medicare recipients pay no premiums for Part A because they (or their spouse) have paid Medicare taxes for 40 or more three-month quarters. Recipients who do not fulfill that criterion pay $248 to $450 per month in premiums.

Part B is medical insurance that helps to pay for many services and products not paid by Part A, usually on an outpatient basis. After a patient has paid a certain deductible amount, Part B ordinarily covers 80 percent of approved services; the patient pays the remaining 20 percent. Coverage includes, among other things, physician and nursing services, x-rays, medical tests, blood transfusions, renal dialysis, chemotherapy, immunosuppressive drugs for organ transplants, hormonal treatments, influenza and pneumonia vaccinations, hospital outpatient procedures, other outpatient treatments administered in a

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physician's office, and some ambulance transportation. Part B also pays part of the cost of durable medical equipment, such as wheelchairs, walkers, canes, mobile scooters, artificial limbs, breast prosthesis, and oxygen for home use. Most Medicare beneficiaries pay a monthly $96.40 or $110.50 Part B premium. This amount increases up to $369.10 per month for individuals earning $214,000 annually and married couples earning more than $428,000 annually.

Part C is a voluntary program created by the Balanced Budget Act of 1997 that allows Medicare beneficiaries to receive their benefits through private health-insurance plans rather than Medicare Parts A and B. These programs are known as Medicare Advantage plans. Traditional "fee-for-service" Medicare offers a standard benefit package covering health care that members can obtain from almost any hospital or physician in the country. For members of a Medicare Advantage plan, Medicare pays the private health plan a fixed amount each month. Members usually also pay a monthly premium in addition to the Medicare Part B premium to cover services not covered by Medicare Parts A and B, such as dental and vision care, prescription drugs, and health-club memberships. However, enrollees may be limited in the providers from whom they can obtain services without paying extra money. Many plans have a network of providers for patients to use; going outside that network usually requires permission or additional fees. About 11.5 million Medicare recipients are enrolled in a Medicare Advantage plan.

Part D, which went into effect on 1 January 2006, was advocated by President George W. Bush. Any person covered by Part A or B is eligible for Part D. An eligible Medicare recipient must enroll in a free-standing prescription-drug plan or Medicare Advantage plan that includes prescription-drug coverage. Although these plans are approved and regulated by the Centers for Medicare and Medicaid Services, they are designed and administered by private health-insurance corporations. Unlike Parts A and B, Part D does not offer standardized coverage. Instead, plans choose which drugs or drug classes they wish to cover and the level at which they will cover them.

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Some individuals purchase supplemental coverage, known as a Medigap plan, to pay for things not paid by Medicare Parts A and B. Although these policies have a standard form mandated by the federal government, they are sold and administered by private companies.
Today, Medicare covers nearly 48 million people, accounts for about 14 percent of federal government spending, and equals about 5.3 percent of U.S. GDP.

MEDICAID

Medicaid, also created in 1965, is a joint federal-state program, or "partnership," that provides health-insurance coverage or nursing-home coverage to certain people whose annual income and assets fall below government-specified levels. Medicaid serves approximately 58 million people, but does not cover all poor people. The categories of low-asset people eligible for Medicaid are children, pregnant women, parents of eligible children, people with disabilities, and senior citizens needing nursing-home care. Each category includes eligibility requirements other than income, such as age, assets (e.g., ownership of a home or automobile), pregnancy, disability, blindness, and status as a U.S. citizen or legal immigrant. Separate rules apply to individuals living in a nursing home and to disabled children living at home. A child may receive Medicaid if she or he is a U.S. citizen or permanent resident, even if his or her parents or guardians are not eligible (e.g., illegal immigrants). A child living with someone other than a parent also may be eligible because of his or her own status.

Each state operates its own Medicaid program, but all the state programs are overseen by the federal Centers for Medicare and Medicaid Services, which also promulgates requirements for service eligibility, delivery, quality, and funding. Some states have their own name for their program, such as Medi-Cal in California, MassHealth in Massachusetts, Spoonercare in Oklahoma, the Oregon Health Plan, and TennCare in Tennessee. Separate programs also exist in some localities (usually counties) that are funded by the states or by local governments to provide Medicaid coverage. Some states also combine the administration of Medicaid with other related programs such as the Children's Health Insurance Program (see below).

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State participation in Medicaid is voluntary. The last state to join Medicaid was Arizona in 1982. Generally, each state experienced a period of debate or conflict over the role of government in health care. In some states, Medicaid administration is contracted out to private health-insurance companies; other states administer the program and pay approved providers (i.e., physicians, clinics, and hospitals) directly. Hence, Medicaid does not pay benefits to individuals; it pays health-care providers. In some states, Medicaid beneficiaries are required to pay a small fee for health-care services. Eligibility rules differ from state to state, although all states must comply with rules issued by the federal government. Under certain circumstances, a person can be denied coverage; however, a state cannot limit the number of Medicaid recipients if individuals meet the specified criteria for inclusion.

As a joint federal-state program, the federal government reimburses each state for a percentage of the cost of Medicaid each year. States pay the remainder from their own funds. The matching rate provided to states is determined by a formula called Federal Medical Assistance Percentages, which produces reimbursement rates that differ from state to state, depending on each state's per capita income. The wealthiest states receive a federal reimbursement of only 50 percent (i.e., California, Colorado, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, and Wyoming) while the poorer states receive more money (e.g., 71 percent for Kentucky, New Mexico, and Utah, 72 percent for Arkansas and Louisiana, 74 percent in West Virginia, and 76 percent in Mississippi).

CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program (CHIP), called the State Children's Health Insurance Program until 2009, was created in 1997, and was the biggest expansion of publically funded health-insurance for children since the creation of Medicaid in 1965. CHIP is administered by the U.S. Department of Health and Human Services, which provides matching funds to states for CHIP health-insurance to families with children. The program serves uninsured children in families with annual incomes that are low but too high to qualify for Medicaid. By

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February 1999, 47 states had set up an SCHIP program; today, all 50 states have a CHIP program.

Each state administers its own program in compliance with rules set forth by the federal Centers for Medicare and Medicaid Services. States can set up their CHIP program as an independent program separate from Medicaid, use CHIP money to expand their Medicaid program, or combine these arrangements. States receive enhanced federal funds for their CHIP programs at a rate above their regular Medicaid match.

President Barack Obama's first major legislative initiative was to seek expansion of CHIP. In 2009, the Congress and president authorized an additional $32.8 billion to expand CHIP to include about four million more children, including legal immigrants with no waiting period. To help pay for the expansion, they approved a cigarette tax increase of $0.62, bringing the total federal tax on a pack of cigarettes to $1.01, an increase of the chewing-tobacco tax from $0.195/lb. to $0.50/lb., and tax increases on other tobacco products.

In December 2009, 5,085,107 children were enrolled in CHIP, a 4.5 percent increase over the number enrolled in 2008. Total CHIP spending was $10 billion in 2008--$7 billion by the federal government and $3 billion by the states. Many states, however, are struggling with CHIP costs in today's recessionary environment, and Arizona passed a budget in 2010 that eliminated CHIP, although the state has not dismantled the program.

SUMMARY OF U.S. HEALTH-CARE SPENDING

According to the federal Centers for Medicare and Medicaid Services, U.S. health expenditures increased by 4.0 percent from during 2009 to total $2.5 trillion, or $8,086 per person, accounting for 17.6 percent of U.S. GDP. Medicare spending grew 7.9 percent to $502.3 billion, which was 20 percent of total health spending, while Medicaid spending grew 9.0 percent to $373.9 billion, or 15 percent of total health spending. Private health-insurance spending grew 1.3 percent to $801.2 billion, or 32 percent of total health spending, while

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expenditures by individuals from their own funds grew 0.4 percent to $299.3 billion, or 12 percent of total health expenditures. The federal government's share of health-care spending increased by slightly more than three percentage points in 2009 to 27 percent, while the proportions of spending by households (28 percent), private businesses (21 percent) and state and local government (16 percent) fell by about 1 percentage point each.

THE CURRENT REFORM LAW AND CONTROVERSY

The 2008 elections, which swept Barack Obama into the presidency and gave the Democrats sizable majorities in the U.S. Congress created a political opportunity for legislation to overhaul the U.S. health-care system. This reform was motivated by a number of factors. For one, national health insurance has long been an objective of the Democratic Party. The last major Democratic effort to enact some type of national health insurance occurred under President Bill Clinton (1993-2001), a Democrat. Second, despite the panoply of private and public health-insurance programs in the United States, it was estimated that as many as 45 million people still had no health-care insurance. Third, many experts argued that reform would be necessary in order to constrain health-care costs, which were spiraling out of control. As a result, the president declared health-care reform to be one of his highest legislative priorities.

The Patient Protection and Affordable Care Act (PPACA) first passed the U.S. Senate on 24 December 2009 by a vote of 60–39. All the Democrats and two independents voted for it; all the Republican senators opposed it. However, to obtain final passage, both houses had to enact the Health Care and Education Reconciliation Act of 2010, which passed the House on 21 March 2010 by a vote of 219–212. All 178 Republicans, as well as 34 Democrats, voted against the bill. On 25 March, the Senate, after removing two minor provisions from the PPACA, passed the bill by a vote of 56-43 in an unprecedented parliamentary maneuver that avoided a Republican filibuster. A few hours later, the House passed the amended bill by a vote of 220-207.

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The PPACA is extremely complex, encompassing ten titles across 2,409 pages. The number of pages of administrative regulations needed to implement the law could produce ten times more pages. The law will take effect over several years, which began in 2010. Many provisions will take effect in 2014. All that can be provided here is a summary of major facets of the PPACA.

The most controversial provision is the "individual mandate," which requires uninsured citizens and legal residents to purchase federally approved health insurance by 2014 unless they are exempt (e.g., for religious reasons). Those who do not buy insurance will have to pay to the U.S. Treasury a penalty of up to 2.5 percent of their annual income. The mandate is deemed necessary because the PPACA requires insurers to offer the same premium to all applicants of the same age and geographic location regardless of any pre-existing health conditions (except for tobacco use). Without the mandate, many people, especially young people, would wait until they are sick or injured to purchase health insurance. The PPACA allows young people to remain on their parents' insurance to age 26.

The PPACA, moreover, increases eligibility for Medicaid to 133 percent above the official poverty level. This will likely increase Medicaid enrollment by about 25 percent (18 million more enrollees) by 2014. The law also simplifies procedures for enrolling in Medicaid and CHIP.

The law authorizes states to establish health-insurance exchanges that will provide a marketplace where individuals and small businesses can compare commercial health-insurance policies and premiums, and buy health insurance with a government subsidy if eligible. The law also will introduce minimum standards for health insurance policies, require standard summaries of benefits and costs for consumers, and remove all annual and lifetime coverage caps. The PPACA further requires some health-insurance benefits to be provided as essential coverage for which there will be no requirement for patients to pay a portion of costs. However, insurance policies issued before the PPACA became effective are grandfathered in and not affected by most of the new rules.

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With respect to federalism, though, the PPACA contains a blockbuster *de facto* preemption, namely, authority for the federal government to enter a state to establish an exchange to sell federally approved health insurance to a state's residents when the elected officials of their state refuse to operate such an exchange. This will be a revolutionary federal displacement of traditional state power.

Low-income individuals and families having annual incomes above the Medicaid eligibility level and up to 400 percent of the official poverty level will receive federal subsidies on a sliding scale when they purchase insurance through a state-based exchange (e.g., an individual with income at 150 percent of the poverty level would be subsidized so that his or her premium cost would be limited to 2 percent of income or $50 a month for a four-person family). Small businesses also will receive a subsidy if they purchase health insurance for their employees through an exchange.

Companies that employ 50 or more people but provide no health insurance for their employees will pay a penalty to the federal government if the government has subsidized any of their employees' health care. Some health-care economists predict that many firms will choose to pay the penalty, which they believe will be less costly than providing health insurance to their employees.

The PPACA further allows a restructuring of Medicare reimbursements from fees for specific services to "bundled payments" for overall patient treatments.

The PPACA also includes within it the Community Living Assistance Services and Supports Act (CLASS Act), which establishes a national insurance trust. Individuals can choose voluntarily to participate in the trust. If they need assistance with daily living activities because of a disability at any age, they can receive a daily cash benefit of about $50 to $75, depending on their type of disability. The trust is sponsored by the government with the intent of keeping the cost low for participants. The trust is intended to be actuarially sound and self-sustaining.

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The PPACA also provides additional financial support for medical research and the National Institutes of Health.

The overall cost of the PPACA is expected to be about $1 trillion over ten years. Within that amount, about $434 billion in federal funds and $20 billion in state funds will be spent on Medicaid. The PPACA also provides $466 billion in subsidies for insurance premiums for individuals with incomes up to 400 percent of the official poverty level. Small business will receive about $40 billion in tax credits, and $56 billion will be spent on Medicare prescription-drug coverage.

The PPACA will be financed through new taxes and $507 billion of reductions in current programs, mainly Medicare. New sources of tax revenue include, among others, a broadened Medicare tax on incomes over $200,000 (for individuals) and $250,000 (for married couples), which is expected to raise $210.2 billion in revenue; an annual fee on insurance providers of health insurance (about $60 billion of revenue); a 40 percent tax on so-called "Cadillac" insurance policies that provide coverage above $10,200 per year for individuals and $27,500 for couples ($32 billion of revenue); an annual fee on manufacturers and importers of brand-name pharmaceuticals ($27 billion of revenue); and a 2.3 percent excise tax on manufacturers and importers of certain medical devices Total new tax revenue from the PPACA is expected to be $409.2 billion over 2010-2019.

The PPACA has been extremely controversial, in part because it has been ensnared by the political party polarization now prevalent in Congress and the country. Many public opinion polls showed a majority of Americans opposing the legislation. During the 2010 congressional and gubernatorial elections, Republican candidates made their opposition to the PPACA a major campaign issue. Republicans gained control of the U.S. House by winning 61 additional seats, giving them 240 House seats (55 percent). One-third of the U.S. Senate's seats were subject to election. Republicans captured six more seats, bringing to 47 the number of seats they hold in the 100-member Senate. Also, 37 states held elections for governor. Republicans won seven more governorships, giving them control of 29 governorships. Republicans also won majority control in 19 more state legislative chambers.

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Most fascinating are the many legal challenges that have been mounted in the courts against the PPACA. The most dramatic and confrontational lawsuit is the constitutional challenge initiated jointly and individually by Republican governors or attorneys general of 28 states against the PPACA.

The challengers' principal contention is that the PPACA violates state sovereignty. Specifically, the core challenge is that the PPACA's individual mandate requiring almost everyone to purchase health insurance exceeds Congress's commerce power (Article 1, Section 8 of the U.S. Constitution). When Congress debated this mandate, the president said the penalty for not buying insurance was "absolutely not" a tax or tax increase, but in response to states' challenges, the U.S. Department of Justice has defended the mandate as a proper exercise of Congress's "power to lay and collect taxes."

The key issues are whether 'activity' is required for Congress to employ its interstate commerce power and whether the individual mandate is 'activity' or 'inactivity.' The challengers contend that the individual mandate regulates inactivity because not buying insurance is 'inactivity' and that compelling individuals to purchase insurance would remove all conceivable limits on Congress's commerce power, thereby nullifying the concept of federalism that is embedded in the principle of limited federal power. The PPACA's defenders contend that activity is not needed to trigger Congress's commerce power but that even if activity is required, not purchasing insurance is 'activity.' They also argue that the individual mandate can be upheld because it is an appropriate exercise of Congress's power "to make all Laws necessary and proper" to regulate interstate commerce.

Partly what is at issue here is that Congress lacks the police power. The police power, which is possessed by the states, is the inherent authority to legislate for the health, safety, welfare, and morals of the people. This power allowed Massachusetts to establish a universal health-insurance system in 2006 under Republican Governor Mitt Romney. The Massachusetts policy requires almost every Massachusetts resident to purchase a minimum amount of health-care insurance as regulated by the state. It also provides free health-care insurance for residents earning less than 150 percent of the official federal poverty level

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and who are not eligible for Medicaid. The police power enables a state to enact such a mandate, just as every state requires every automobile driver to purchase automobile insurance. The federal government has not previously been deemed to have such a power.

A key judicial precedent that might uphold the PPACA mandate is *Wickard* v. *Filburn* (1942), which upheld federal regulation of home-grown wheat used for home consumption. A key precedent that might invalidate the mandate is *United States* v. *Lopez* (1995), which struck down the federal Gun-Free School Zones Act of 1990 as exceeding Congress's commerce power.

Another challenge is that the PPACA violates the Tenth Amendment (which reserves to the states or the people all powers not delegated to the federal government) because it 'commandeers' the states to enforce federal law. This ground might be tenuous, though, because the PPACA allows the states to implement its provisions or to let the federal government do so instead. Some states contend that the law also violates the Constitution's spending clause as well as the Ninth and Tenth Amendments because it unilaterally increases state Medicaid costs. In addition, Virginia's attorney general filed a separate lawsuit contending that his state's law nullifying the PPACA preempts federal law. Indeed, some 29 state legislatures have considered state constitutional amendments to nullify sections of the PPACA, thus resurrecting the once discredited pre-Civil War doctrine of nullification, which holds that states can nullify and refuse to comply with federal laws they believe are unconstitutional. However, more than half of tye state legislatures have rejected such nullification proposals.

As of August 2011, three federal district-court judges (all appointed by Democratic presidents) had upheld the PPACA, while two federal district-court judges (both appointed by Republican presidents) had struck down all or parts of the PPACA. Two separate federal appeals courts have so far ruled on the PPACA. One appeals court upheld the constitutionality of the law; the other declared it unconstitutional. The majority opinion by the latter court termed the PPACA's individual mandate "breathtaking in its expansive scope" and wrote that: "The government's position amounts to an argument that the mere fact of

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an individual's existence substantially affects interstate commerce, and therefore Congress may regulate them at every point in their life. This theory affords no limiting principles in which to confine Congress's enumerated power." Because of these conflicting appellate court rulings, it appears to be certain that the U.S. Supreme Court will have to rule on the constitutionality of the PPACA. If the PPACA falls, health reform could shift to the states, which have had major, historical health-policy responsibilities and where Republicans have a better record than Democrats in expanding health insurance coverage. Meanwhile, however, nearly all the states are proceeding with implementation of the PPACA.

CONCLUSION

The future structure of health care in the United States is, therefore, uncertain. Whatever the structure, though, one certainty is rapidly rising health-care costs. Costs are being driven up by a number of factors, but the major factor is an aging population. There were 39.6 million people 65 years or older in 2009 (12.9 percent of the U.S. population). By 2030, there will be about 72.1 million such people, constituting about 19 percent of the population. The dependency ratio (i.e., number of people 65 and older per 100 working-age persons) is expected to rise from 22 in 2010 to 35 in 2030. This aging population is one major factor in the substantial growth in government spending on Medicare and Medicaid. For example, the cost to Medicaid of treating people with Alzheimer's disease and other dementias is expected to increase from $34 billion in 2010 to $46 billion in 2020, while Medicare's cost will rise from $88 billion to $128 billion. The U.S. Congressional Budget Office has concluded that even with anticipated savings from the PPACA, building a sustainable federal budget will almost certainly require a significant reduction in the growth of federal health spending.

Rising costs, especially for Medicaid, are having detrimental impacts on state and local governments. Medicaid alone now accounts for 22 percent of state spending, making it the largest category of state spending. As a result, Medicaid is consuming revenue that would otherwise have gone to education,

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infrastructure, transportation, economic development, criminal justice, and many other state and local functions.

Consequently, whether or not the PPACA survives court challenges, health-care reform will continue to receive considerable federal, state, and local attention for the foreseeable future.

BIOGRAPHICAL SUMMARY

John Kincaid is the Robert B. and Helen S. Meyner Professor of Government and Public Service and Director of the Meyner Center for the Study of State and Local Government at Lafayette College, Easton, Pennsylvania. He also is Senior Editor of the Global Dialogue on Federalism, a joint project of the Forum of Federations and International Association of Centers for Federal Studies, and an elected fellow of the National Academy of Public Administration. He is the recipient of the Distinguished Scholar Award from the Section on Federalism and Intergovernmental Relations of the American Political Science Association and of the Distinguished Scholar Award from the Section on Intergovernmental Administration and Management of the American Society of Public Administration. He has served as Editor of *Publius: The Journal of Federalism* (1981-2006); Editor of a series of books on the Governments and Politics of the American States; and Executive Director of the U.S. Advisory Commission on Intergovernmental Relations, Washington, D.C. (1988-1994). He is the author of various works on federalism and intergovernmental relations, and co-editor most recently of *The Covenant Connection: From Federal Theology to Modern Federalism* (2000), *Constitutional Origins, Structure, and Change in Federal Countries* (2005), *Interaction in Federal Systems* (2008), *Local Government in Federal Systems* (2008), and *Federalism* (4 vols, 2011).

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