

Bill of Rights in Action



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THE CONTINUING STRUGGLE FOR U.S. HEALTH-CARE REFORM

FOR 100 YEARS, EFFORTS HAVE BEEN MADE TO REFORM HEALTH CARE IN THE U.S. TODAY, A DEBATE RAGES WHETHER THE FEDERAL GOVERNMENT OR FREE MARKET SHOULD TAKE THE LEAD IN REFORMING THE NATION'S HEALTH-CARE SYSTEM.

During the Progressive Era in the early 1900s, reformers tried to pass state health insurance laws to cover industrial workers, but these laws were defeated. In the 1912 presidential election, the Progressive Party promised health insurance for all Americans. This proposal died with the collapse of the party after its election defeat.

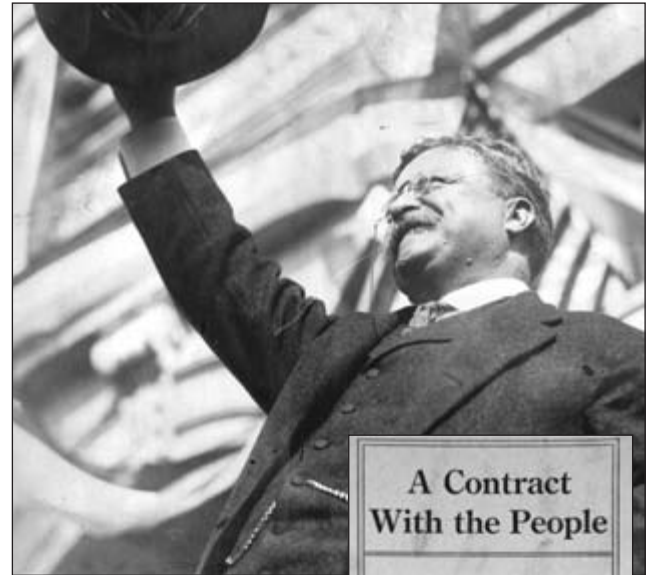
Reformers tried to include a national health-care program in the Social Security Act during the New Deal. But President Franklin Roosevelt, a Democrat, dropped this reform to focus on others. President Harry Truman, also a Democrat, revived the idea in 1949, but it was denounced as “socialized medicine” and failed.

Throughout World War II, a labor shortage and government wage freeze prompted employers to offer free or inexpensive private health insurance to

attract workers. Private employer-provided insurance slowly expanded after the war to become the main way most Americans got medical coverage.

In 1954, during the presidency of Dwight Eisenhower, a Republican, Congress passed tax reforms that excluded employer-paid health insurance premiums for employees from taxation. This provided an incentive for employers to provide health insurance to their workers.

In other reforms, both Democrats and Republicans joined to pass laws to provide health care for certain groups. These include active military personnel, veterans, Native Americans, those over



Former President Theodore Roosevelt ran for president in 1912 on the Progressive Party ticket. The party's platform called for health insurance for all Americans.



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HEALTH-CARE REFORM

This edition of *Bill of Rights in Action* looks at the issue of health-care reform. The first article explores the recently passed Affordable Care Act and conservative and liberal alternatives to it. The second article examines the recent Supreme Court decision on the Affordable Care Act. The last article compares health-care systems in other nations.

The Continuing Struggle for U.S. Health-Care Reform

**The U.S. Supreme Court's Decision on the Affordable Care Act
Health Care: What Do Other Countries Do?**

Guest writer Lucy Eisenberg, Esq., contributed the article on the Supreme Court decision. Our longtime contributor Carlton Martz wrote the other articles.

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65 (Medicare), the poor (Medicaid), and children from low-income families who do not qualify for Medicaid.

In 1974, President Richard Nixon, a Republican, failed to get Congress to pass his proposal requiring most employers to pay for worker health insurance premiums. In 1979, Sen. Ted Kennedy, a Democrat, also failed to get Congress to pass his expanded version of Nixon's plan.

In 1986, Congress passed the Emergency Medical Treatment Act. This required hospital emergency rooms (ERs) to treat people even if they did not have insurance and could not pay. This law shifted the cost of treating uninsured ER patients to the ▶

taxpayer as well as to insured individuals who had to pay higher premiums.

In 1993, as insurance premiums were skyrocketing, President Bill Clinton, a Democrat, proposed a new comprehensive health reform bill. But political differences and fierce opposition from insurance companies sank his plan before it even reached a vote in Congress.

In 2006, the Republican governor of Massachusetts, Mitt Romney, led an effort to enact health-care reform that would potentially cover all citizens in his state. The law mandated that all adults buy health insurance if they did not have it provided at work or by a government program. The state aided those who needed help in purchasing insurance. Those who refused to get health-care coverage were subject to a penalty.

The chief purpose of this so-called “individual mandate” was to enlarge the pool of those paying insurance premiums to include both healthy and sick persons, including patients with pre-existing medical conditions. Without the individual mandate, insurance companies would have had to raise insurance premiums to very high levels to insure people with costly pre-existing conditions. With the mandate, premiums are much lower because healthy people with few medical claims are also paying into the system.

Affordable Care Act

Early in his first term, President Barack Obama moved to reform the U.S. health-care system, which was made up mainly of for-profit insurance companies plus tax-supported government programs. Critics argued that the system, when compared to systems in other developed nations, is much more costly and does not cover every person. The number of uninsured Americans has kept growing, from 35 million in 1990 to about 50 million in 2010. Those typically not covered included low-income families, self-employed people, workers in companies without insurance, the unemployed, and persons with pre-existing medical conditions who were denied coverage by insurance companies.

Obama’s proposed plan was similar to the one adopted in Massachusetts.

The main priority of Obama’s reform effort was to reduce the number of Americans without any health-care insurance by 30 million.

Narrowly passed by Congress in 2010, the Affordable Care Act is scheduled to take full effect in 2014. Among its provisions, the act:

- Mandates that all individuals who do not have any health-care coverage purchase at least a minimum insurance plan or pay a penalty.
- Sets up online state-operated exchanges where uninsured individuals and small businesses may buy insurance from among approved competing private plans; federal tax credits are available for individuals and small businesses that need help in buying insurance.
- Requires companies with more than 50 employees to pay a penalty if they do not offer workers an insurance benefit.
- Prohibits insurance companies from denying insurance to anyone because of a pre-existing health condition and bans lifetime or annual limits on benefits.
- Requires insurance companies and Medicare to provide free preventive care and immunizations.
- Requires insurance companies to spend 80–85 percent of the premiums they receive on medical care (and if they fail to do so, they must refund the excess to policyholders).
- Allows parents to keep their children on their health insurance policies until age 26.

The main priority of Obama’s reform effort was to reduce the number of Americans without any health-care insurance by 30 million.

- Requires states to add more low-income individuals and families to state Medicaid programs; these people who were not poor enough to qualify for Medicaid before the new law, were estimated to make up about half those Americans who lacked insurance.

To pay for this major reform, the Affordable Care Act requires new taxes and fees on some groups, including higher income Medicare beneficiaries, insurance companies, and manufacturers of drugs and certain medical equipment.

The new health-care law also attempts to cut medical costs. A new Center for Medicare and Medicaid Innovation will test reforms such as compensating Medicare doctors for effective treatments rather than paying them a fee for each separate medical service whether it is needed or not. The law also cuts payments to private insurers of Medicare Advantage programs and pays hospitals less if they discharge and re-admit too many patients.

Republicans in Congress strongly opposed Obama’s Affordable Care Act, which they dubbed “Obamacare.” They called the law a “government takeover of health care.”

Republicans argued that the mandate for businesses to provide insurance would put a costly burden on them and prompt many not to hire more workers. Many employers providing insurance, the Republicans claimed, would find it cheaper to drop this benefit and pay the penalty, causing millions of workers to lose their job-related coverage. They also condemned the reform for costing trillions of dollars.

The biggest Republican criticism of the new health-care law was its individual mandate that requires everyone without health-care coverage to buy insurance. Opponents of the law went to court, arguing that this mandate and its penalty were unconstitutional.

In June 2012, the U.S. Supreme Court decided 5–4 that the Affordable Care Act was constitutional. The majority ruled that the penalty for not buying insurance was a tax and therefore constitutional under Congress’ taxing power. In another part of the

majority decision, however, the justices struck down the provision that gave the federal government the power to cut a state's Medicaid funding if it refused to add more low-income people to its Medicaid rolls.

Free-Market Reform

The Supreme Court decision did not end the controversy over the Affordable Care Act. If successful in winning the presidency and control of in the 2012 elections, Republicans vow to "repeal and replace" the act.

While there is as yet no official Republican plan to replace the Affordable Care Act, numerous conservative groups have developed replacement plans, which might influence proposed replacement legislation.

A major element of these plans is to assure more reliance on free-market principles to reduce the rapidly rising medical costs and insurance premiums. Conservatives place most of the blame for rising costs on government spending for health-care programs like Medicare and Medicaid.

Defined Contribution

Conservatives argue that people with insurance should be more aware of the real costs of their health care so they will use medical services only when really needed and thus reduce overall demand. They reason that reducing demand for these services will push down medical costs and insurance premiums.

One way to do this is to gradually shift from employer-provided insurance to an employer "defined contribution." Under this plan, employers will give a cash amount to their workers each year to shop for their own insurance to match their needs.

Conservatives say that managing one's own health insurance policy motivates the worker to keep co-payments and other out-of-pocket charges as low as possible. This will reduce the spending that pushes up medical costs. By having their own insurance, workers will not lose their insurance if they are laid off or move on to another company.

One criticism of defined contribution is that the insurance coverage the worker needs may cost more than what the employer contributes.

Health Savings Accounts (HSAs)

One way to reduce health insurance costs is through high deductible health insurance policies. This kind of insurance requires the patient to pay medical expenses each year out of pocket up to a certain amount, say \$3,000, before the insurance benefits take effect. Because the insurance company does not have to pay for any medical services until the deductible amount is reached, the premiums are quite low compared to traditional medical insurance.

A Health Savings Account makes a high-deductible policy more desirable. It allows people to deposit money into HSAs, and this money is not subject to federal taxes. They can withdraw money from the account to pay for their annual out-of-pocket medical expenses.

Some criticize HSAs since they tend to benefit healthy and higher income persons. Those with chronic medical conditions or with low incomes would probably have difficulty keeping enough money in their accounts to cover large out-of-pocket expenses.

Premium Support for Medicare and Medicaid

One proposed free-market solution for the costly Medicare and Medicaid programs is to shift their beneficiaries from open-ended government health care to individual insurance policies. Proposals call for the federal government to give those with Medicare "premium support." This is a set amount of money each year to pay the premiums for a basic private insurance policy geared to the person's needs. Similar proposals would send federal block grants to the states to subsidize the poor receiving Medicaid to buy their own insurance.

A key idea behind premium support is to encourage the elderly and poor to become more aware of their medical costs so they will not overuse health-care services. Supporters of this free-market alternative say this approach will sharply reduce soaring U.S. health insurance costs.

Critics of Medicare and Medicaid premium support point out that medical coverage would likely be less than under the current government-run programs. Also, there is no guarantee that



National Health Institute

In 2010, about 50 million Americans did not have health insurance.

the government premium support amount would grow to keep pace with the price of insurance.

Additional Proposed Free-Market Reforms

There are many other reforms proposed as free-market alternatives to the Affordable Care Act approaches. These include:

- Ending the current practice that insurance can only be purchased in the state where one lives rather than nationwide.
- Reducing costly lawsuits against doctors by reforming malpractice standards.
- Encouraging states to subsidize insurance for high risk pools of people with pre-existing conditions.
- Eliminating the employer-provided insurance tax break and shifting it to the workers themselves as a federal tax deduction for their annual premiums.

Those opposing reliance on the free market for health-care reform say that it focuses almost entirely on containing the costs of those who already have insurance. Free-market reformers direct very little of their attention, say the critics, on the 50 million Americans who are uninsured. ►

Medicare for All?

Conservatives are not the only critics of the Affordable Care Act. Some liberals object to the law for not guaranteeing health care for all. After the Supreme Court decision, some states declared they would not add more low-income people to their Medicaid programs. This may result in millions of people remaining without health care.

As early as 2003, legislation was introduced in Congress to create a universal “single-payer” health-care system. This means all Americans would have government guaranteed health insurance. They would choose their doctors, hospitals, and other medical providers. The federal government would pay all the providers for their services.

Thus, the government would be the single payer of medical expenses rather than hundreds of insurance companies and multiple government health-care programs. Basically, this is how Medicare for those over 65 already works. Some call this single-payer system “Medicare for All.”

The money currently budgeted for Medicare and the other government health-care programs plus additional payroll and other taxes would finance this new national health-care system. No one would have to pay premiums for private health insurance.

Currently, private insurance premiums are inflated by marketing, administrative costs for reviewing medical claims, and company profits. The current Medicare system for the elderly spends much less on administration than the private insurance companies. Medicare is also non-profit, as a single-payer system would be.

Under Medicare for All, all those with pre-existing conditions would be covered. Workers who lost their jobs would still have health insurance. Everyone who used the ER would have their bills paid by the government. In short, every American would be covered, and the problem of people not having health insurance would disappear overnight.

Some free-market conservatives call the single-payer idea “socialism,” although the government would not employ the doctors or own the hospi-

tals as is the case in socialist systems. The federal government would, however, take over most of the U.S. health insurance industry. For-profit insurance companies could only sell policies with medical services not covered by the single-payer plan.

Some critics predict that since everyone will be covered by the single-payer system, there would soon be a shortage of doctors and hospitals to care for all the additional patients. This could then lead to long waiting times for non-urgent care and surgeries as is the case in Canada, which has a single-payer system. Many also raise concerns about how much a system would cost in additional taxes.

* * * * *

Why has comprehensive health-care reform been so difficult to achieve in the United States? All the other economically developed countries already have national health-care systems that cover every citizen.

One reason for Americans’ resisting health-care reform has been the opposition and conflicts among special interests. These include the private insurance industry, drug companies, doctors, hospitals, employers, unions, and even the government.

Another reason is that since World War II, a majority of Americans have had some form of private or government health-care coverage. They have tended

to resist reforms they fear might increase their costs or lower their benefits.

Finally, the current debate over health-care reform highlights a major political division in the country. This is the conflict between those who want the government versus those who want the free market to take the lead in health-care reform. At the present time, neither side has won over the American public.

FOR DISCUSSION AND WRITING

1. Why do you think the U.S. has never adopted a reform that guarantees health care for every citizen?
2. What effects could the rapidly rising health-care costs and the growing numbers of uninsured persons have on the United States?
3. Do you tend to favor the federal government or free market in taking the lead for health-care reform? Why?

For Further Reading

Haugen, David and Musser, Susan, eds. *Health Care* (Opposing Viewpoints Series). Detroit: Gale, 2012.

Starr, Paul. *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*. New Haven, Conn.: Yale University Press, 2011.

ACTIVITY

Health-Care Reform for the U.S.

Students in small groups will discuss and decide on the best health-care reform for the United States. Each group should review the article and then discuss each of the following options.

- A. The Affordable Care Act
- B. Free-Market Health-Care Reform
- C. Medicare for All
- D. Students design their own reform plan by selecting elements from the other options as well as their own ideas.

Be sure to consider the purposes, benefits, and costs of each option. Based on the discussion, choose the best option and prepare to present arguments defending the choice. The other groups will have an opportunity to ask questions, comment and criticize the choice. Continue the process until all groups have presented.

Take a class vote at the end of the activity to determine which option is considered best.

THE U.S. SUPREME COURT'S DECISION ON THE AFFORDABLE CARE ACT

IN 2010, CONGRESS PASSED AND PRESIDENT OBAMA SIGNED INTO LAW THE AFFORDABLE CARE ACT, THE FIRST MAJOR HEALTH-CARE REFORM IN ALMOST 50 YEARS. THE LAW WAS IMMEDIATELY CHALLENGED, AND IN JUNE 2012, THE U.S. SUPREME COURT RULED ON WHETHER THE LAW WAS CONSTITUTIONAL.

On June 28, 2012, hundreds of demonstrators gathered outside the Supreme Court waiting for the court to issue its ruling on the Affordable Care Act, the Obama administration's plan to reform health insurance. For three days in March, the Supreme Court had heard oral arguments on the challenges to the law. For weeks after the oral arguments, commentators had been trying to predict whether the court would strike down the federal law's mandate requiring everybody to have a government-approved level of health insurance. And there was constant speculation about whether Justice Kennedy, often a "swing vote," would side with the "liberal" justices and vote to uphold the law or join the "conservatives" to strike it down.

The ruling surprised almost everyone. In two separate opinions, a 5–4 majority of the court ruled that the "individual mandate" exceeded Congress' power under the commerce clause, but it did *not* strike down the law. Instead, a different majority voted 5 to 4 that the individual mandate, which imposes a financial "penalty" on adults who do not have insurance, could be considered a "tax" and was therefore within Congress' power to levy taxes. And the court upheld another key part of the law expanding the Medicaid program, but it struck down a part of the law that required states to participate in the expansion or risk losing *all* the Medicaid funds they were already receiving.

Making Health Care Affordable

When President Obama was elected, he promised to reform the



President Barack Obama signed the Affordable Care Act into law on March 23, 2010.

health care system. It was not an easy task. No president since Lyndon Johnson in 1965 (who signed Medicare and Medicaid into law) had been able to pass a major health-care reform law.

Congress held numerous debates, and the press reported about the pros and cons of the legislation that was being proposed. A bill, titled the Patient Protection and Affordable Care Act (ACA), finally passed in March 2010. The ACA was intended to make health care available and affordable to most of the 50 million Americans who were currently uninsured. The Congressional Budget Office (CBO) estimated that with the ACA in place, 32 million more Americans would have health-care coverage by 2019.

An important part of the ACA is to expand the Medicaid program. Medicaid is a joint federal-state program that provides medical care to certain needy people. The states pay part of the costs and the federal government pays an average of 57 percent of the cost. Under the ACA, Medicaid would be expanded to cover an estimated 16 million people who are currently uninsured.

The other key provisions in the ACA focus on making health insurance more affordable and accessible to people who are not poor enough to qualify for Medicaid. The law is designed to make buying insurance easier and less costly. Insurers could no longer deny coverage to people who are already sick — i.e., those with a "pre-existing condition." ►

They could not charge sick people higher premiums. And they could not put a cap on the amount they will pay during a person's lifetime.

Perhaps most important, the law requires everyone to have insurance. People who don't have insurance through their employer or from a government health plan (like Medicare or Medicaid) must buy it from the market or pay a penalty. This provision is called the "individual mandate." Its purpose is to keep the cost of premiums as low as possible. If more people (including the relatively young and healthy) buy insurance, insurance companies have more money to pay for those who are sick, and the cost of premiums can be lower. The individual mandate became the most controversial part of the new law.

Road to the Supreme Court

On the same day that President Obama signed the ACA into law, the state of Florida filed a lawsuit against the federal government claiming that the individual mandate was unconstitutional. Florida was joined by 12 other states — and later by 13 more states, two individuals, and the National Federation of Independent Business. The Florida District Court ruled that Congress did not have the power under the commerce clause to require people to buy health insurance. The federal government appealed, and the 11th Circuit affirmed the lower court's opinion. Similar lawsuits were filed around the country, claiming that the individual mandate — and various other provisions of the law — were unconstitutional.

In November 2011, the Supreme Court agreed to hear the case from the 11th Circuit. By that time, other appellate courts had made conflicting rulings — two Circuit Courts ruling that the mandate was constitutional and one other Circuit striking it down. Instead of following the usual practice of limiting oral argument on each case to one hour, the court scheduled three days and more than five hours for oral argument.

The first day of oral argument was devoted to a technical issue of law. The Anti-Injunction Act bars lawsuits "for the purpose of restraining the assessment or collection of any tax." In other

words, people who object to a tax may not sue until the government has actually collected the tax. If the Anti-Injunction Act applied to this case, it would have delayed the court from hearing the case until the health-care law was fully implemented. Neither the Obama administration nor those challenging the health-care law wanted the court to delay hearing the case. An independent lawyer was brought in to argue that the Anti-Injunction Act barred the lawsuit. All nine Supreme Court justices ultimately agreed that the Anti-Injunction Act did not apply to this case, and it did not need to be delayed.

Can the Government Make You Eat Broccoli?

On day two, the court heard arguments on the individual mandate. The question before the court was whether Congress can compel individuals to buy a product — i.e., health insurance — from private companies. Both parties focused on the commerce clause of the Constitution. It gives Congress the power "to regulate commerce with foreign nations, and among the several states, and with the Indian Tribes." (Art.1, sec. 8, cl. 3)

Instead of following the usual practice of limiting oral argument on each case to one hour, the court scheduled three days and more than five hours for oral argument.

The government argued that the mandate was a valid exercise of Congress' power under the commerce clause. It noted that health-care spending amounted to about one-fifth of our national economy. Like it or not, almost all people require and receive health care at some time in their life. When people need health care and do not have insurance, they often don't pay the bills. And when hospitals don't get paid, they pass on the cost to insurers, and the result is that premiums for those who do have insurance go up. The government argued

that the decision not to buy insurance affects the market for insurance by increasing premiums for the insured and that the individual mandate would make premiums go down.

The states argued that the commerce clause only allows the regulation of activity, and not "inactivity." People who chose not to purchase insurance are not involved in commerce, and Congress does not have the power to regulate how people should spend their money. The states argued that giving Congress the power to impose the individual mandate would start down a slippery slope, where people could be required to buy all kinds of products. As Judge Vinson, in the Florida District Court wrote, "Congress could require people to buy and consume broccoli at regular intervals . . . because people who eat healthier tend to be healthier and . . . put less of a stress on the health care system."

The broccoli argument took hold. The word "broccoli" was mentioned multiple times during oral argument and also in the justices' written opinions. Ultimately Chief Justice Roberts ruled that the commerce clause did not authorize the individual mandate. "Congress," he wrote, "has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product [like broccoli.]" Though the commerce clause does give Congress broad power to regulate commerce, it does not give Congress the same power to regulate what we do *not* do. And therefore, Justice Roberts concluded, the ACA's individual mandate is unconstitutional. Four other justices agreed with this reasoning, although they did not join the chief justice's opinion.

Is a Penalty the Same as a Tax?

Even though the court majority ruled that the commerce clause did not authorize the individual mandate, that did not end the matter. The government also argued that the mandate could be upheld as within the power the Constitution gives to Congress "to lay and collect taxes." (Art. 1, sec. 8, cl. 1). And indeed the ACA provides that the "penalty" on a person who does not have insurance is paid to the

IRS and is “assessed and collected in the same manner” as a tax penalty.

The states objected to the government’s argument based on the wording of the ACA. The individual mandate section of the ACA does not use the word “tax.” It states that individuals must be covered by “minimum essential coverage,” and if they are not, “there is imposed on the taxpayer a penalty” in an amount determined by the IRS. The states argued that if Congress had intended to invoke its taxing power, it would have used the word “tax” and not the word “penalty.”

But Chief Justice Roberts disagreed, and four other justices agreed with him on that point. A law, he wrote, should not be struck down just because Congress used the wrong labels. Requiring an individual to pay a financial penalty for not obtaining health insurance “may reasonably be characterized as a tax.” And it is therefore constitutional under the taxing power. In support of his decision Justice Roberts quoted Justice Oliver Wendell Holmes:

It is well settled that as between two possible interpretations of a statute, by one of which it would be unconstitutional and by the other valid, it is our plain duty to adopt that which will save the Act.

Not Giving the States a Choice

Because of the individual mandate, many people who were previously uninsured will be buying health insurance. The ACA also increases the number of people with health coverage by expanding the Medicaid program.

Congress passed the original Medicaid act in 1965. The law gives states federal matching funds to provide health care to the poor. (The federal government pays between 50 and 83 percent of the states’ Medicaid costs). Before the ACA, only certain groups were covered: pregnant women, families with dependent children, and people who are sick and disabled. Adults without dependent children could not receive Medicaid no matter how low their income. The ACA made a big change in the existing law by requiring states to cover *all* adults with incomes below 133 percent of the

Federal Poverty Level (FPL). The federal government initially will pay 100 percent of the cost for the newly eligible adults (and 90 percent after 2020). This change is expected to provide coverage to 16 million people not previously covered.

The 26 states that challenged the ACA claimed that they should have a choice whether to make the big changes required by the ACA, but they don’t really have a choice because the law gives the federal government power to “withhold all or merely a portion of funding from a noncompliant state.” That means that if a state decides not to expand Medicaid, it could lose all of the federal funding it receives for its existing Medicaid program. For the average state, that would mean losing at least 10 percent of its entire budget. (In 2009, most states received more than \$1 billion each in federal Medicaid funding — and nearly one third received more than \$5 billion). With so much money at stake, the states claimed that they would have no real choice.

The government argued that the ACA is just one more of many amendments that over the years have been made to the Medicaid law. Moreover, when Congress originally passed the Social Security Act (of which Medicaid is a part), it reserved “the right to alter, amend or repeal any provision.”

But the states claimed that the ACA is not just an amendment to the existing Medicaid act, and further, under our federal system, there must be a limit on Congress’ power to use federal dollars to coerce states. The ACA, they claimed, exceeds that limit.

Chief Justice Roberts and six other justices agreed. The government does have power under the Constitution to “pay the Debts and provide for the common Defence and general Welfare of the United States . . .” (Art. 1, sec. 8, cl. 1). Congress, Roberts wrote, may use this power (the “Spending Power”) to grant funds to the states with the condition that the states take actions that Congress could not require them to take. But Congress may only go so far with financial inducements. When “pressure turns into compulsion,” he wrote, the legislation runs contrary to our system of federalism. For Roberts,



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Chief Justice John Roberts surprised many when he voted to uphold the Affordable Care Act’s individual mandate.

therefore, the Medicaid expansion provision of the ACA is constitutional, except for the financial penalty part that allows the government to withhold *all* Medicaid funding from states that choose not to expand their programs.

Saving the ACA With ‘Severability’

If one portion of a law is ruled to be unconstitutional, should the rest of the law still go into effect? The states argued that the answer is no. They claimed that if certain portions of the ACA were found to be unconstitutional, such as the individual mandate, the entire act should be struck down because those portions were not “severable.” Since the court ultimately held the mandate to be constitutional, the court did not have to decide the severability question with respect to the mandate.

But the states also argued that the whole Medicaid expansion program of the ACA should be set aside, because the invalid financial penalty enforcement portion could not be severed from the rest. Roberts and four other justices, however, held that invalidating the financial penalty did not affect the Medicaid expansion portion ➤

of the ACA because of a “severability” clause in the original Medicaid act. The clause specifies that if any section of the Medicaid law is held invalid, “the remainder of the chapter . . . shall not be affected thereby.” Therefore the rest of the states’ Medicaid programs are not affected, and the states that choose not to participate in the expansion will not lose the federal funds for those pre-existing programs. As far as the effect on the rest of the ACA, Roberts held that the test is whether Congress would have wanted to preserve the rest of the act. He determined that the answer was yes. Without the financial penalty, some states may choose not to participate in expanding Medicaid coverage. But “we do not believe that Congress would have wanted the whole Act to fall simply because some may choose not to participate.”

Aftermath

The Affordable Care Act was a hugely important milestone for the president. It was passed by a narrow margin in Congress. And it will affect millions of Americans.

The court faced a daunting task in ruling on the ACA case. The nine justices

expressed deep differences of opinion. Four justices (Scalia, Thomas, Alito, and Kennedy) joined in a strong dissent. Justices Ginsburg and Sotomayor voted with Roberts to uphold the law, but nevertheless wrote their own quite lengthy opinion, disagreeing with aspects of his reasoning. Nevertheless, in an exercise of judicial restraint, Roberts upheld a piece of legislation initiated by the executive branch and passed by Congress. The role of the court, Justice Roberts made clear, is not to strike down a law with which a member of the court does not agree. “It is not our role,” he wrote, “to forbid it or pass upon its wisdom.” Rather, whenever possible, the court should uphold legislation passed by Congress, which is elected by the people.

Some critics worry that the ACA decision will limit Congress’ power under the commerce clause. Others view this as a positive step, seeing the decision as the first significant limit on the federal government’s spending power. Some advocates of expanding health care are concerned about what will happen to low-income adults in states that choose to opt out of the Medicaid expansion. The future effects of the decision are difficult to predict.

What is clear is that by upholding the ACA, the court has allowed the first major expansion of health care in the United States in almost 50 years to remain in effect.

FOR DISCUSSION

1. What is the Affordable Care Act? What parts of it were challenged in court?
2. What is the interstate commerce clause? Do you agree with the court decision that the mandate in the ACA could not be upheld under the commerce clause? Explain.
3. The mandate was upheld on other grounds. What were they? Do you agree with the court? Explain.
4. What is Medicaid? How did the court rule on Medicaid expansion? Do you agree with the court? Explain.
5. How did the court rule on the issue of severability? Do you agree with the court? Explain.

ACTIVITY

The Commerce Clause

In his opinion for the court, Chief Justice John Roberts concluded that the individual mandate could not be upheld under the Constitution’s commerce clause. “The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to ‘regulate Commerce.’ ”

In this activity, students will look at several cases and decide whether Congress has the power *under the commerce clause* to enact this legislation. (For the purpose of the activity, students do not consider whether other parts of the Constitution give Congress the power to enact this legislation.) Divide the class into small groups. Each group should discuss the following questions for each case:

1. Does this law regulate interstate commerce? (Think of all the possible effects that it could have on interstate commerce.)
2. Does the law require anyone to engage in commercial activity that the person otherwise would not engage in?
3. Should this law be upheld under the interstate commerce clause? Explain.

Case #1: Auto insurance. Imagine that Congress has passed a law requiring that all truckers who drive on federally funded interstate highways buy automobile insurance.

Case #2: Flu shot. Imagine that a flu pandemic has broken out and threatens the health of everyone in the U.S. Congress passes a law requiring everyone to get a flu shot.

Case #3: Marijuana grown solely for personal use. In the Controlled Substances Act (1970), Congress banned (among other things) growing marijuana even solely for personal use. (*Gonzales v. Raich*, 2005)

Case #4: 1964 Civil Rights Act. Among other things, the act banned hotels, restaurants, theaters, retail stores, and other facilities open to the public from refusing service to anyone because of the person’s race, color, religion, or national origin. (*Heart of Atlanta Motel v. U.S.*, 1964)

HEALTH CARE:

WHAT DO OTHER COUNTRIES DO?

THE HEALTH-CARE SYSTEMS OF OTHER COUNTRIES INCLUDE PAYING FOR MEDICAL TREATMENT OUT-OF-POCKET, PRIVATE INSURANCE, NON-PROFIT SICKNESS FUNDS, SOCIALIZED MEDICINE, AND GOVERNMENT SINGLE-PAYER PLANS. U.S. HEALTH CARE IS CURRENTLY A MIX OF THESE.

Most people in the world get medical treatment only if they can pay for it out of their own pockets. Out-of-pocket systems exist mainly in poor and developing countries. Many people fall into debt and poverty because of their medical expenses. Private insurance is usually available, but is too expensive for most people. The government in such countries provides few adequate public health-care services.

Except for the United States, each of the world's major economically developed countries has a universal nationwide health-care system. These countries provide health coverage for everyone (even foreign tourists). They also require all citizens to participate in the system.

Despite their common characteristics, universal systems are generally organized around one of three national health-care models:

- **Non-Profit Sickness Funds:** These privately run non-profit funds either pay doctors and hospitals for their services or reimburse patients for their medical expenses. The funds are financed by mandatory private insurance premiums and taxes.
- **Socialized Medicine:** The central government owns and operates the hospitals and pays the salaries of doctors. This system is mainly financed by taxes.
- **Government Single-Payer Plans:** The province or central government pays private doctors and hospitals for their medical services. Financing is mainly by taxes.

By contrast, the **American Mixed System** differs from other major countries' health-care systems in that it does not guarantee universal care for all. Rather, health care in the U.S. is an uncoordinated mix of voluntary private

insurance, government health care for certain groups, and out-of-pocket payments by the uninsured.

Non-Profit Sickness Funds

In 1883, Otto von Bismarck, the conservative leader of Germany, created the first universal health-care system. He did this to undermine the appeal of socialism and communism that were gaining in popularity among German workers. Bismarck's system required all workers and their employers to jointly pay premiums (set payments) for health insurance through paycheck deduction.

Today, about 200 non-profit sickness funds throughout the country collect the premiums. The job of the fund is to pay patient medical bills submitted by doctors and hospitals. Funds cannot deny medical claims, but doctor and hospital fees are tightly regulated by the government. In recent years, patients have been required to make small payments (co-pays) up to a certain amount per quarter for each doctor visit or hospital stay.

Germans choose their doctor and hospital, which are mostly private. Workers are not dropped from their insurance when they change or lose a job. Premiums for unemployed workers are paid by the government. The funds compete over providing such things as health services not covered in the basic plan. Some Germans also buy private insurance to supplement the basic benefits.

France adopted the universal sickness fund system after World War II. It is financed by worker-employer premiums and taxes. French patients, however, pay doctors and hospitals at the time of service and later are reimbursed partly or fully. In most cases, patients are required to pay something



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German statesman Otto von Bismarck (1815-1898) created the first system of universal health care.

out-of-pocket in order to deter overuse of the system.

The sickness funds negotiate medical fees with private doctors through their unions. The same fee chart for treatments covered by the national health plan is posted in every doctor's office. Doctors also make house calls. The income of French doctors is much less than that of American doctors, but medical school is free, and they get special tax breaks.

France has led the world in digitizing patient medical information. All people in France have a *card vital* with a microchip that contains their medical record going back to 1998. Any French doctor can insert the card in a small reader to display the patient's medical history and other records.

At the end of an appointment, the doctor uses the *card vital* to send the medical charges to the patient's sickness fund. The fund then can electronically deposit the reimbursement amount into the patient's bank account.

The non-profit sickness fund health-care system is the most common one in Europe. Japan has also adopted such a system. With rapidly aging populations, medical costs are increasing sharply, and the funds often run a budget deficit. These largely private systems may have to boost patient co-pays or depend more heavily on taxes. ►



An intern checks an outpatient in a Havana clinic. The Cuban medical system is an example of socialized medicine.

Socialized Medicine

In 1948, the United Kingdom (U.K.) of Great Britain and Northern Ireland created the National Health Service (NHS). It was based on the principle that no one would ever have to pay an insurance premium or fee for any medical services.

To do this, the British adopted socialized medicine. Financed by taxes, the NHS operates almost the entire health-care system. The central government owns most hospitals and other medical facilities. While some doctors are employees of the government, most are private practitioners who own and operate their offices. Rather than reimburse doctors for every treatment, the NHS pays them a flat annual sum based on the number of patients who are registered with them.

Patients may choose any primary care doctor in their area. This doctor treats patients and acts as a “gatekeeper” who refers them to specialists. Primary doctors are paid extra to make house calls and for treatments that are successful (“pay for performance”).

Over the years, small fees have been added for such things as prescription drugs, some dental care, and eyeglasses. Private insurance is available to supplement the NHS benefits.

To help control costs, the NHS promotes preventive care to keep people healthy by such means as nationwide flu shot drives. In addition, a special NHS board may decide not to pay for certain expensive tests, treatments, and drugs because they are not cost effective.

The British people pay little out of pocket but endure high taxes for their free medical care. They also may have to wait for months to see a specialist or have elective surgery.

Italy, Spain, and Portugal have adopted socialized health-care systems similar to the one in the U.K. Since most doctors in the U.K. run their own businesses, the system is not quite 100 percent socialized medicine. The best example of that exists in communist Cuba.

Cuba’s tuition-free medical school trains all the doctors and other medical personnel in the country. Cuba even has a surplus of doctors who are sent to other countries in Latin America. Within Cuba, all doctors and nurses are employed by the government, which assigns them in teams to every village, town, and city neighborhood.

The doctor and nurse teams provide free primary treatment, medicine, preventive care, and referrals to specialists and the government-owned hospitals. The quality of health care in Cuba is comparable to and sometimes exceeds that in major developed countries. The Cuban people, however, have little choice of doctor or hospital.

Single-Payer Plans

Different variations of universal care single-payer plans exist in a few European countries, South Korea, Taiwan, and Canada, which originated this system after World War II. These plans combine elements of the German system where most doctors and hospitals are private with the socialized

system in the U.K. where the government pays most medical expenses.

In Canada, health care is decentralized so that the provinces and territories operate the system under national guidelines. They each act as a “single payer” to compensate doctors and hospitals for all medically necessary services.

Most Canadians pay nothing for doctor visits, emergency treatment, hospital stays, tests, shots, and psychiatric care. Not covered are regular dental care and prescription drugs for most people. Many carry private insurance to cover these.

The central federal and provincial governments finance the system with taxes. The federal government negotiates a fee schedule for all doctors with their medical associations. It also negotiates nationwide drug prices.

Government cost-control cuts to doctor fees have reduced the income of Canadian doctors to about half of U.S. doctors. This has resulted in fewer students going to medical school in Canada, causing a doctor shortage and a serious waiting problem for patients. Canadians usually have no trouble getting emergency and primary care. But they may have to wait up to a year or more to see a specialist and additional months for non-urgent or elective surgery.

American Mixed System

The Patient Protection and Affordable Care Act, passed by Congress in 2010, was an attempt to move American health care closer to the universal health-care plans in the other major developed countries. This law was not scheduled to be fully implemented until 2014. Therefore, the description of U.S. health care that follows is how it currently exists.

Large-scale health insurance started in the U.S. during World War II. There was a shortage of workers and government controls on wages. To attract workers, employers began to offer them free or low-cost private health insurance.

The practice of tying health insurance to work continued after the war. Today the majority of Americans get their health insurance through their employers. But this is voluntary. Many employers do not offer a health

Comparison of Health-Care Data for 10 Developed Countries

Country and Type of Health-Care System	Spending as % of GDP	Spending Out-Of-Pocket Per Capita	Spending for Prescription Drug Per Capita	CT Scans Per 1,000 Population
Canada Government Single Payer	11.4	\$635	\$743	125.4
France Non-Profit Sickness Funds	11.8	\$290	\$640	138.7
Germany Non-Profit Sickness Funds	11.6	\$552	\$628	N/A
Italy Socialized Medicine	9.5	\$616	\$572	N/A
Japan Non-Profit Sickness Funds	8.5	\$454 (2008)	\$558 (2008)	N/A (2008)
Sweden Government Single Payer	10.0	\$620	\$465	N/A
South Korea Government Single Payer	6.9	\$609	\$422	93.5
Switzerland Non-Profit Sickness Funds	11.4	\$1568	\$521	N/A
United Kingdom Socialized Medicine	9.8	\$364	\$381 (2008)	N/A
United States Mixed	17.4	\$976	\$956 (2007)	227.9

Source: Based on data for 2009 (unless otherwise noted) as reported in *OECD Health Data 2011*. GDP: Gross Domestic Product Per Capita: Per Person

insurance benefit or have dropped it because of its increasing cost.

Insured workers usually pay monthly insurance premiums, co-pays, and other out-of-pocket expenses while employers also make a contribution. Those without an insurance work benefit may try to purchase an individual insurance policy. But these are usually more expensive, and insurance companies can refuse to sell policies to those with an existing medical problem.

Health care in the U.S. is the most privatized of any developed country. Most doctors are independent private practitioners or members of private doctor groups. Many hospitals are privately owned. The private health insurance companies are mostly for-profit.

Medical costs began to grow rapidly in the 1990s. To control costs, the insurance industry developed “managed care” policies. An insurance com-

pany typically required its insured members to select their doctors from within a certain group or network that it managed.

In addition to work-based and other private health insurance, the U.S. government provides free or low-cost tax supported health care for certain Americans. These stand-alone programs reflect features of other health-care systems in the world.

Medicare for those over age 65, Medicaid for the poor, and health care for children from low-income families that do not qualify for Medicaid all operate much like the Canadian single-payer plan. Qualified Americans get treatment from mostly private doctors and hospitals that are paid by the government from federal and state matching funds.

For the most part, the active military and their families, veterans, and Native Americans get their health care

from doctors employed by and hospitals owned by the federal government. This is similar to the U.K. and Cuban socialized systems.

American medicine is by many measures the best in the world. The medical training for primary doctors, specialists, nurses, and technicians is unmatched. The U.S. has the most modern hospitals, labs, and other facilities. American medical research leads all other nations. Medical personnel utilize the most advanced treatments, drugs, and technology.

At the same time, access to American medicine is a serious problem for many. The number of Americans with no private insurance or government health care rose from just under 15 million in 1990 to nearly 50 million in 2010.

Uninsured individuals must either pay out-of-pocket for treatment or depend on hospital ERs (emergency rooms). Under federal law, ERs must treat them even if they cannot pay. Unpaid ER costs are usually shifted to those with insurance who then pay higher premiums. Most of the uninsured are those who have no insurance benefit at work or who have lost a job with insurance.

Another major problem is that the American mixed system is the most expensive in the world. Total spending for health care in the U.S. each year is about 17 percent of GDP (Gross Domestic Product — the value all goods and services produced in the country in a year). This far exceeds the cost of the other systems in major developed countries.

Why is U.S. health care so expensive? Like in other developed countries, older people in the U.S. are living longer and have greater health-care needs and costs. The greater overall cost of American health care, however, is due to a number of causes unique to the U.S., such as:

- Greater and sometimes unnecessary use of expensive tests, treatments, and technology like CT body scans.
- Higher prescription drug prices and usage.
- Higher hospital prices partly due to unpaid ER charges.
- More doctor malpractice lawsuits. ►

- More doctors paid for each medical service than for the successful treatment of their patients (“pay for performance”).
- Fewer digitized patient medical records.
- Duplication and inefficiency in the mixed system.
- For-profit insurance company administrative costs for reviewing, approving, and sometimes denying patient treatments and claims.

Ranking Health-Care Systems

One measure of a nation’s health system effectiveness is the infant mortality rate: deaths of infants per 1,000 live births. From the highest to the lowest infant death rate, the current *CIA World Factbook* ranks the U.S. 174th of 222 countries. All the other major developed countries rank better than the U.S.

Another measure of the health-care system of a country is life expectancy at birth. The *World Factbook* ranks the U.S. 50th in average life expectancy at 78.49 years. All the other major developed countries have a higher life expectancy, with the Japanese living the longest at an average of 83.43 years.

Perhaps a better measure of a nation’s health-care system is “healthy life expectancy” developed by the U.N.’s World Health Organization. This

calculates how many years the average citizen can expect to live in “full health” before declining and dying. In a 2000 study, Japan ranked at the head of all countries at 74.5 years with the U. S. ranked 24th at 70 years.

A bright spot in American health care is its success in treating cancer. In a 2010 study, the U.S. had the highest five-year survival rates for breast and colon cancer among 12 major developed countries.

FOR DISCUSSION AND WRITING

1. How is health care in the U.S. similar to that in other major developed countries? How is it different?
2. Why do you think the American health-care system is so different?
3. Do you think that the U.S. should adopt a system of universal health care? Why or why not?

For Further Reading

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About Constitutional Rights Foundation

Constitutional Rights Foundation is a non-profit, non-partisan educational organization committed to helping our nation’s young people to become active citizens and to understand the rule of law, the legal process, and their constitutional heritage. Established in 1962, CRF is guided by a dedicated board of directors drawn from the worlds of law, business, government, education, and the media. CRF’s program areas include the California State Mock Trial, youth internship programs, youth leadership and civic participation programs, youth conferences, teacher professional development, and publications and curriculum materials.

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ACTIVITY

Debate: What is the Best Health-Care System?

1. Form four debating groups to each argue for one of the following:
 - a. Non-Profit Sickness Funds
 - b. Socialized Medicine
 - c. Government Single Payer
 - d. American Mixed System
2. Form a fifth group as a judging panel.
3. The debating groups should each make a presentation that covers how their system works and why it is the best. Students should use information from the article and statistical data provided in the comparative chart.
4. After each group presentation, the other debating groups should ask questions and point out flaws in the group’s health-care system. The group should have a chance to respond.
5. After all debating groups have finished, the judging panel will discuss and decide the debate question while the other students observe.

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Standards Addressed

Struggle for Health-Care Reform

National High School U.S. History Standard 31: Understands economic, social, and cultural developments in the contemporary United States. (5) Understands major contemporary social issues and the groups involved....

National High School Civics Standard 16: Understands the major responsibilities of the national government for domestic and foreign policy, and understands how government is financed through taxation. (2) Understands competing arguments concerning the role of government in major areas of domestic and foreign policy (e.g., health care ...).

National High School Economics Standard 6: Understands the roles government plays in the United States economy. (5) Understands that government provides an alternative method to markets for supplying goods and services when it appears that the benefits to society of doing so outweigh the costs to society

California History-Social Science Standard 11.11: Students analyze the major social problems and domestic policy issues in contemporary American society. (6) Analyze the persistence of poverty and how different analyses of this issue influence welfare reform, health insurance reform, and other social policies.

California History-Social Science Standard 12.7: Students analyze and compare the powers and procedures of the national, state, tribal, and local governments. (5) Explain how public policy is formed, including the setting of the public agenda and implementation of it through regulations and executive orders.

U.S. Supreme Court's Decision

National High School Civics Standard 18: Understands the role and importance of law in the American constitutional system and issues regarding the judicial protection of individual rights. (2) Knows historical and contemporary practices that illustrate the central place of the rule of law.

National High School U.S. History Standard 31: Understands economic, social, and cultural developments in the contemporary United States. (5) Understands major contemporary social issues and the groups involved....

California History-Social Science Standard 11.11: Students analyze the major social problems and domestic policy issues in contemporary American society.

California History-Social Science Standard 12.5: Students summarize landmark U.S. Supreme Court interpretations of the Constitution and its amendments.

What Do Other Countries Do?

National High School World History Standard 44: Understands the search for community, stability, and peace in an interdependent world. (14) Understands how specific countries have implemented social and cultural changes

National High School U.S. History Standard 31: Understands economic, social, and cultural developments in the contemporary United States. (5) Understands major contemporary social issues and the groups involved....

California History-Social Science Standard 10.9: Students analyze the international developments in the post-World War II world.

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Commitment to Quality

by Marshall Croddy, CRF Vice President

Throughout its history, CRF has recognized the need to assure the quality of its programs and publications. They go through extensive review, field testing, teacher and student feedback, assessment, and formal evaluation. We have also sought to assure quality by incorporating research-based “best practices” into our offerings. Here are just a few highlights.

In the early 1980s, CRF participated in an evaluation of its Los Angeles Project Status program, designed to reduce delinquent factors among students, and found some of the most significant results ever reported in the field. Later in the 1980s, CRF participated with its national partners in a rigorous study of the effectiveness of law-related education programs and found that if properly implemented, they could have a delinquency prevention effect. The study also identified criteria for the success of such programs. Both of these studies have influenced CRF program design for many years.

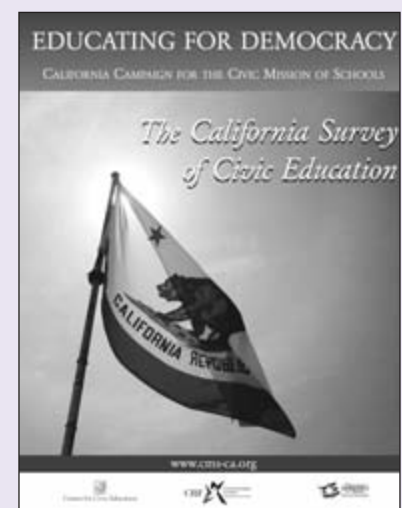
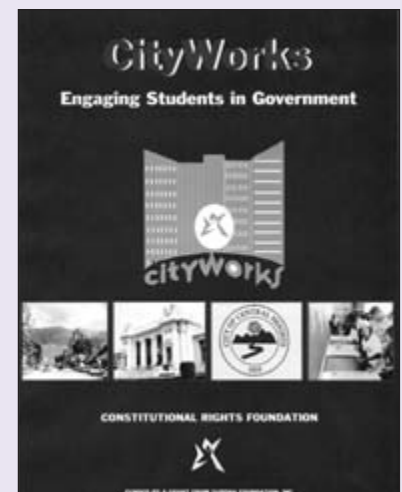
The experimental design research conducted on CityWorks in the early 2000s demonstrated that students in the program performed better on standard U.S. government content items than regular students and developed significantly greater civic capacities and competencies. The findings on the positive effect of simulations from the evaluation have been cited in national studies.

In the late 2000s, through its California Campaign for the Civic Mission of Schools program, CRF supported and participated in research replicating national studies on the positive effects of certain educational practices on the development of student civic competencies and capacities and led to findings that a civic education opportunity gap existed between white, college-bound students and those from lower socio-economic backgrounds, those of color, and those non-college bound. This research has influenced both policy and the development of proposed national legislation.

All of CRF’s programs and publications are based on the latest educational research. For example, CRF’s new online Civic Action Project was intentionally designed and developed to incorporate the research-based “proven practices” of civic education. These practices include quality instruction, open classroom discussion of issues, civics-based service learning, and the use of simulation. CAP also incorporates the lessons of project-based and blended learning and the extensive use of student work to assess and promote learning.

As we celebrate our 50th year, we wish to thank the thousands of teachers and students who have participated in CRF evaluations, field tests, and research. Because of you, we are able to continuously improve our programs and publications.

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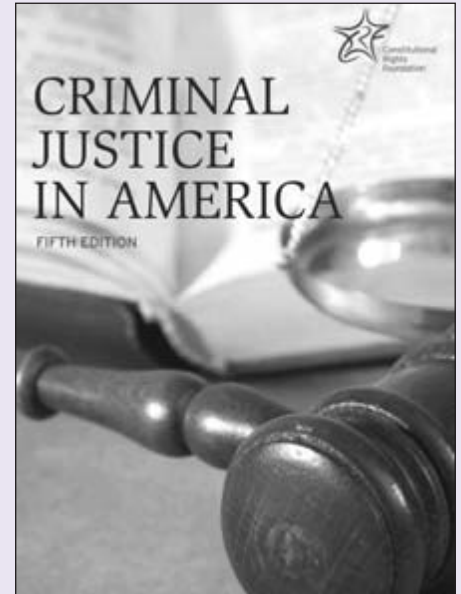
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