our insurance certificate. We get it so that we can go and access health care." But according to Chief Justice John Roberts, the same is true for other goods and services: "A car or broccoli aren't purchased for their own sake, either. They're purchased for the sake of transportation or, in [the case of] broccoli, covering the need for food."

The justices varied predictably in their views of the nature of the cross-subsidies and risk pooling inherent in insurance. According to Justice Samuel Alito, the mandate requires young, healthy people to pay much more than their actuarial risk would dictate, "forcing these people to provide a huge subsidy to the insurance companies for other purposes that the Act wishes to serve," rather than merely requiring people to pay for their own expected services. Roberts also noted a mismatch between covered benefits and each person's potential need. Speaking to the government's lawyer, he said, "[T]he policies that you're requiring people to purchase involve . . . maternity and newborn care, pediatric services, and substance [abuse] treatment. It seems to me that you cannot say that everybody is going to need [these services] and yet that is part of what you require them to purchase."

But as Justice Ruth Bader Ginsburg quickly retorted, "If you're going to have insurance, that's how insurance works." "This is especially true," added Kagan, "because in this context, the subsidizers eventually become the subsidized."

Spreading the costs of care is one reason for the mandate. Another is countering the adverse selection that results from requiring insurers to cover people with preexisting conditions. According to Scalia, that's "a self-created problem" that Congress could avoid by simply not requiring guaranteed issue of insurance and community risk rating. But Scalia seemed to take a different view of the mandate in the next day's argument on whether to strike the entire ACA if the mandate falls. In that context, he saw the mandate and related insurance-market regulations as being at the "heart" of the law's "main purpose," which made him reluctant to leave the rest of the law in place.

This "severability" discussion opened up a revealing exchange on judicial activism versus deference to Congress. In Ginsburg's view, "It's a choice between a wrecking operation . . . or a salvage job. And the more conservative approach would be salvage rather than throwing out everything." But other justices took the opposite view. From Kennedy's perspective, if "one provision was stricken and the others remained to impose a risk on insurance companies that Congress had never intended . . . [that] can be argued, at least, to be a more extreme exercise of judicial power than . . . striking the whole." Scalia was even more resolute: "Do you really think that that is somehow showing deference to Congress and respecting the democratic process? It seems to me it's a gross distortion of it."

Cynics believe that these starkly contrasting views undermine the Court's legitimacy as an apolitical institution. A more sympathetic view is that when the Court confronts novel questions of constitutional principle, each justice's worldview understandably shapes his or her framing of the issues. Either way, it's remarkable how sharply these worldviews differ on the fundamental questions of health policy underlying the ACA.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From Wake Forest University Schools of Law and Medicine, Winston-Salem, NC.

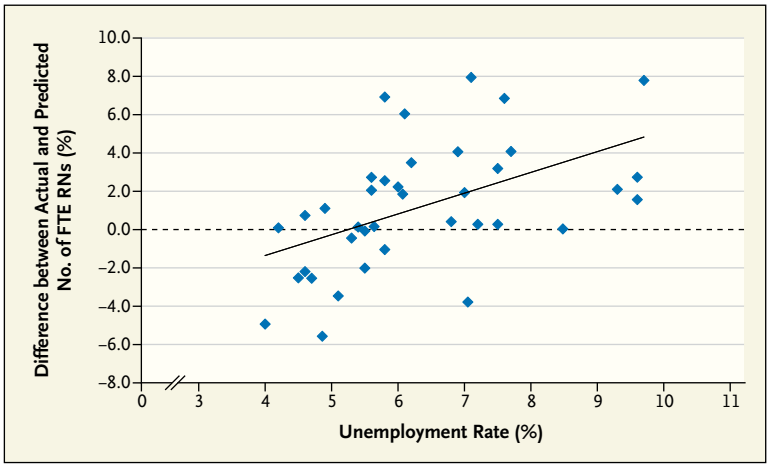
This article (10.1056/NEJMp1201848) was published on April 4, 2012, at NEJM.org.

Registered Nurse Labor Supply and the Recession — Are We in a Bubble?

Douglas O. Staiger, Ph.D., David I. Auerbach, Ph.D., and Peter I. Buerhaus, Ph.D., R.N.

The countercyclical nature of the health care industry, in which job gains occur faster in recessionary than in nonrecessionary periods, was revealed once again during the 18-month recession that officially began in December 2007. Whereas the national economy lost 7.5 million jobs, the health care industry gained 428,000 jobs.[1] In particular, hospital employment of registered nurses (RNs) increased by an estimated 243,000 full-time equivalents (FTEs) in 2007 and 2008 — the largest increase during any 2-year period in the past four decades.[2] Because of this increase at the beginning of the recession, the decade-long national shortage of RNs appears to have ended.

This sharp rise in RN employment is probably attributable to several factors. During economic



National Unemployment Rate and Difference between the Actual National Labor Supply and the Predicted Supply of FTE RNs, 1973–2010.

Data on national unemployment rates are from the Bureau of Labor Statistics. FTE denotes full-time equivalent, and RNs registered nurses.

downturns, demand for health care continues unabated, and RNs tend to fill existing job vacancies because of their concerns about their personal (or their family's) economic uncertainty and diminished alternative opportunities. In addition, because approximately 7 in 10 RNs are married women, an economic downturn may have a particularly large effect, since many RNs who were not working or were working part-time may rejoin the workforce or change to full-time status to bolster their household's economic security.

The Congressional Budget Office projects that the national unemployment rate will not return to its previous "full-employment" level of 5.2% until 2017. Over the next several years, many RNs who entered the workforce during the economic downturn are likely to leave their jobs once the economy recovers. Yet because there is no empirically based understanding of how recessions affect transitions into and out of the RN workforce, employers and workforce planners are unable to anticipate how many nurses might choose to leave the workforce once a robust jobs recovery begins.

To quantify this relationship, we obtained a grant from the Gordon and Betty Moore Foundation and applied a workforce model that we have used to project the future age and supply of RNs.[2-4] The model (described in detail elsewhere[2,3]) predicts RN employment on the basis of estimates of the propensity of people born in any particular cohort to enter nursing (cohort effects), the effects of an RN's age on her or his participation in the workforce (age effects), and changes in the size of the population (population effects). (Data on RN employment come from the Census Bureau's annual Current Population Survey May Extracts for 1973 through 1978 and its Merged Outgoing Rotation Groups [Annual Earnings Files] for 1979 through 2010.)

We plotted the annual unemployment rate against the difference between the actual overall size of the RN workforce and the workforce size that our model would predict for that year on the basis of cohort, age, and population effects (see graph). When the unemployment rate was high, the RN workforce tended to be larger than predicted. That is, over the past 40 years, the supply of RNs has increased more than expected when the unemployment rate rose and decreased more than expected when the unemployment rate fell. To formally quantify this effect, we incorporated the unemployment rate into our workforce model, allowing RN employment in each year to depend on the national unemployment rate as well as on cohort, age, and population effects. An increase of 1 percentage point in the unemployment rate was associated with a 1.2% increase in the size of the RN workforce (95% confidence interval, 0.5 to 1.9; $P<0.001$).

On the basis of our workforce model, we estimated the effect of the recent recession on the growth in the number of FTE RNs between 2005 and 2010 and the projected effect of expected decreases in unemployment on the size of the workforce between 2010 and 2015 (see table). According to the Current Population Survey, the number of FTE RNs increased by 386,000 between 2005 and 2010. According to our estimates, more than a third of this increase (146,000 FTE RNs) can be attributed to the increase in the unemployment rate of 4.5 percentage points during the same period, when national unemployment grew from 5.1% in 2005 to 9.6% in 2010. Therefore, had the unemployment rate remained constant at prerecession levels during this period, the growth in the workforce would have been considerably smaller — approximately 240,000.

Thus, according to the model's projections, this substantial expansion in the RN workforce is largely a temporary bubble that is likely to deflate during the next several years. Unemployment is expected to decrease by 3.5 per-

Actual and Projected Changes in Registered Nurse (RN) Employment and the Estimated Effect of Changes in National Average Unemployment Rates, 2005–2015.*

Variable	2005 to 2010 (Actual)	2010 to 2015 (Projected)
Change in RN employment (FTE)	386,000	109,000
Change in national unemployment rate (percentage points)	4.5	–3.5
Estimated change in RN employment (FTE)		
Attributed to changes in national unemployment rate	146,000	–118,000
If national unemployment rate remained constant over the period	240,000	227,000

* Actual data are from the Current Population Survey. FTE denotes full-time equivalent.

centage points between 2010 and 2015, falling to a projected 6.1% by 2015. Because of this projected improvement in the national economy, we estimate that approximately 118,000 FTE RNs will exit the workforce. As a result, the growth in the RN workforce is projected to be much smaller between 2010 and 2015 — an increase of only about 109,000 FTE RNs. In contrast, if the recession unexpectedly persists and unemployment stays constant at its high 2010 level through 2015, the workforce would be projected to grow by more than twice this amount, or 227,000 FTE RNs.

The growth in the RN workforce that occurred between 2005 and 2010 was the largest expansion over any 5-year period observed in our data extending back four decades. But much of this surge appears to have been driven by the deep recession. Eventually, as the jobs recovery takes hold, our analysis suggests that many of the RNs who entered the workforce between 2005 and 2010 are likely to withdraw as unemployment rates fall. This withdrawal will occur at the same time as an expected wave of retirements among baby-boomer RNs and will further contribute to low levels of growth in the projected workforce during this period. Although the timing of this expected reduction is uncertain, our model suggests that between 2010 and 2015 the RN workforce will grow by only 109,000 FTEs, which would be a smaller 5-year expansion than we have seen in any 5-year period in the past four decades.

Especially in the face of projected shortages by 2015 of both primary care physicians and general surgeons,[5] slower growth in the RN workforce could not come at a worse time. This projected slowdown would occur just when the demand for health care is expected to increase, as an estimated 32 million additional Americans obtain health insurance coverage. Although there was a sharp increase in the number of young people who entered nursing over the past decade, the effect on the size of the RN workforce is not expected to be felt until the latter part of the current decade, and particularly after 2020.[4] Thus, it seems likely that growth in the demand for RNs over the next few years will outstrip the projected growth in the workforce, leading to renewed shortages of RNs in the near term.

Employers and workforce policymakers should not be lulled into complacency by the current absence of a nursing shortage. Instead, they should anticipate that the current positive effect of a weak economy on the RN labor supply is likely to evaporate as the economy improves and that shortages will reemerge. Shortages of RNs may reduce access to care and increase costs as employers raise salaries to attract nurses, potentially imperiling the success of health care reform. Therefore, plans to counter the reemergence of a post-recession shortage and to use existing RNs — both incoming and outgoing — as efficiently and effectively as possible should be a priority for policymakers.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Department of Economics, Dartmouth College, Hanover, NH (D.O.S.); the National Bureau of Economic Research, Cambridge, MA (D.O.S.); RAND, Boston (D.I.A.); and the Center for Interdisciplinary Health Workforce Studies, Institute for Medicine and Public Health, Vanderbilt University Medical Center, Nashville (P.I.B.).

This article (10.1056/NEJMp1200641) was published on March 21, 2012, at NEJM.org.

1. Wood CA. Employment in health care: a crutch for the ailing economy during the 2007-09 recession. Mon Labor Rev 2011; 134(4):13-8.
2. Buerhaus PI, Auerbach DI, Staiger DO. The recent surge in nurse employment: causes and implications. Health Aff (Millwood) 2009;28(4):w657-w668.
3. Buerhaus PI, Staiger DO, Auerbach DI. Implications of a rapidly aging registered nurse workforce. JAMA 2000;283:2948-54.
4. Auerbach DI, Buerhaus PI, Staiger DO. Registered nurse supply grows faster than projected amid surge in new entrants ages 23-26. Health Aff (Millwood) 2011;30:2286-92.
5. The impact of health care reform on the future supply and demand for physicians updated projections through 2025. Washington, DC: Association of American Medical Colleges, June 2010 (https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf).