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## Private Law Alternatives to the Individual Mandate

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**Article**

**Private Law Alternatives to the Individual Mandate**

**Wendy Netter Epstein<sup>†</sup>**

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<sup>†</sup> Professor of Law, DePaul University College of Law, and Faculty Director, Jaharis Health Law Institute. The author wishes to thank Afra Afsharipour, Omri Ben-Shahar, Lisa Bernstein, Brad Bernthal, Christopher Buccafusco, Anthony Casey, Emily Cauble, I. Glenn Cohen, Brian L. Frye, Allison Hoffman, Jill Horwitz, David Hyman, Valerie Gutmann Koch, Anthony LoSasso, Gregory Mark, Jonathan Masur, Govind Persad, Nicholson Price, Christopher Robertson, Rachel Sachs, Ana Santos Rutschman, Nadia Sawicki, Megan Shaner, Avraham Stoler, Nicolas Terry, Charlotte Tschider, and Jonathan Will. The author also thanks readers of the Take Care Blog, listeners of the Ipse Dixit podcast, and attendees of the UCLA School of Law Faculty Workshop, Cardozo Faculty Workshop, Loyola University Chicago School of Law Faculty Workshop, Health Law Professors Conference, Winter Deals Conference, Chicago Health Law Professors Workshop, and Mississippi College Law School Workshop for insightful comments. Copyright © 2020 by Wendy Netter Epstein.

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## INTRODUCTION

The Affordable Care Act's (ACA) individual mandate was controversial from the start and evolved over time into the most unpopular provision of the law.<sup>1</sup> The requirement to buy health insurance or pay a tax was maligned mainly because of its alleged invasion on personal liberty and the negative impact on principles of federalism.<sup>2</sup>

Despite the controversy, however, the mandate served an important purpose in enabling the most popular provisions of the law—the pre-existing conditions protections, guaranteed issue of policies, and community rating, which taken together mean that insurance companies must issue policies to everyone and set rates without regard to health status.<sup>3</sup> These provisions are now considered by most to be a moral imperative.<sup>4</sup> But in a world

1. 26 U.S.C. § 5000A (2012), *amended by* Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 2054 (2017), *invalidated by* *Texas v. United States*, 340 F. Supp. 3d 579 (N.D.Tex. 2018) (pending appeal); Jon Greenberg, *How Unpopular Is the Obamacare Individual Mandate?*, POLITIFACT (Nov. 14, 2017), <https://www.politifact.com/truth-o-meter/statements/2017/nov/14/donald-trump/how-unpopular-obamacare-individual-mandate/> (last visited Oct. 27, 2019) (66% of poll-participating Americans opposed the mandate).

2. See discussion *infra* Part II.A.

3. 42 U.S.C. § 300gg (2012) (describing some exceptions, for instance allowing some rate variance based on age, geography, and smoker-status).

4. See *Poll: The ACA's Pre-Existing Condition Protections Remain Popular with the Public, Including Republicans, As Legal Challenge Looms This Week*, KAISER FAM. FOUND. (Sept. 5, 2018), <https://www.kff.org/health-costs/press>

where insurers are not permitted to refuse coverage to people with pre-existing conditions nor charge them more based on their actuarial risk, healthy people can simply wait to buy insurance until they get sick.<sup>5</sup> This leaves insurers to cover only a sicker, more expensive population. And the higher the cost of the risk pool, the higher premiums must be.<sup>6</sup> Higher premiums, in turn, price people out of the market.<sup>7</sup> Even if the market is stable enough to avoid the feared “death spiral”<sup>8</sup>—in part because it continues to be steadied by other parts of the ACA including the premium tax credits—the trend toward more uninsureds, higher premiums, and sicker risk pools is still problematic.<sup>9</sup> This is the world that the drafters of the ACA attempted to foreclose through the individual mandate—by giving healthier policyholders an important incentive to buy insurance and even out the higher costs of sicker insureds.<sup>10</sup> But the recent repeal of the

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-release/poll-acas-pre-existing-condition-protections-remain-popular-with-public/ [https://perma.cc/E9YJ-9542].

5. Open enrollment periods moderately mitigate this effect. An “open enrollment period” is the annual period when people can enroll in a health insurance plan. *Open Enrollment Period*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/open-enrollment-period/> [perma.cc/W524-28MQ]. If an individual gets sick mid-way through the year, she would have to wait until the next open enrollment period to enroll in a plan.

6. *King v. Burwell*, 135 S. Ct. 2480, 2486 (2015).

7. *Id.*

8. *Id.* at 2495 (describing how removing tax credits would push a state’s insurance market into a death spiral); David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, 1 F. FOR HEALTH ECON. & POL’Y 1, 5–6 (1998) (discussing adverse selection and the result of the “death spiral”); Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 HOUS. L. REV. 1029, 1039 (2014) (discussing the troubling signs of an unbalanced risk pool (citing Seth Chandler, *Even the New York Times Acknowledges the ACA Is Collapsing*, ACA DEATH SPIRAL (Oct. 3, 2016), <http://www.acadeathspiral.org/> [https://perma.cc/5W44-VHXV])).

9. Brief of Amici Curiae for Bipartisan Economic Scholars in Support of Intervenor Defendant-Appellants at \*25, *Texas v. United States*, No. 19-10011 (5th Cir. Jan. 7, 2019) (citing CONG. BUDGET OFFICE, *FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65: 2018 TO 2028*, at 2–3, 5 (2018)).

10. I do not take on in this paper the question of whether the ACA’s community rating approach is the right one. Frequent and fervent debate on this question can be found at almost every turn. See, e.g., Michael Lee, Jr., *Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act*, 29 YALE L. & POL’Y REV. 559, 578 (2011) (claiming the “ACA’s imposition of community rating would exacerbate adverse selection”); David B. Rivkin, Jr. et al.,

mandate penalty means these problems deserve renewed attention.

Further, the uninsured problem is not one caused *only* by the repeal of the mandate penalty. Even when the mandate was enforced, millions of Americans still lacked health insurance. At its lowest, in 2016, the uninsured rate among non-elderly adults was still about 10% of the population, or 27 million Americans.<sup>11</sup> Young adults (aged twenty-six to thirty-four) were the least likely to be insured.<sup>12</sup> Putting aside concerns about the stability of the individual market, there are other reasons to address the insurance problem: high rates of uninsurance lead to worse health outcomes and adverse spillover effects for the rest of the population that ultimately bears the cost of uncompensated care.<sup>13</sup>

Health policy debates are now focused on major policy initiatives, with a move to a single payer system at the forefront.<sup>14</sup> While these larger debates are undoubtedly important, the present political landscape makes any major changes exceedingly unlikely in the short term. Meanwhile, the troubling regime where so many Americans are not enrolled in a health insurance plan receives inadequate attention.

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*A Healthy Debate: the Constitutionality of an Individual Mandate*, 158 U. PA. L. REV. PENNUMBRA 93, 94–95 (2009) (challenging community rating which tries to fund universal coverage by “[m]aking healthy young adults pay billions of dollars in premiums into the national health care market . . .”); David A. Super, *The Modernization of American Public Law: Health Care Reform and Popular Constitutionalism*, 66 STAN. L. REV. 873, 947 (2014) (stating ACA’s community rating redistributed wealth from the healthy to the sick by restricting insurance companies’ ability to fully charge people needing extensive care). Many other possibilities exist, including separately insuring more costly individuals in high-risk pools or subsidizing the cost of sicker insureds in mixed risk pools. I simply take as a starting point that the intent of the ACA—which remains in effect—was to mix sick and healthy people in the same risk pool.

11. *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 7, 2018), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> [https://perma.cc/6XYR-BT4M].

12. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2017 (2018), <https://www.census.gov/library/publications/2018/demo/p60-264.html> [https://perma.cc/SG5Z-35BY].

13. See discussion *infra* Parts II.D.1–2.

14. *Compare* Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019) (proposal by Rep. Pramila Jayapal), and Medicare for America Act of 2019, H.R. 2452, 116th Cong. (2019) (proposal by Rep. Rosa DeLauro), with American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).

This Article takes on that problem. It considers both neo-classical economic theory and the realities of individual decision-making described by behavioral economics to begin to grapple with the complex problem of why people do not enroll in health insurance policies. Building on that theory, it then surveys a universe of alternatives to the individual mandate, grounded in private law principles, designed to incentivize individuals to buy health insurance without mandating that they do so.<sup>15</sup> These are solutions that could be attempted separately or in combination. Many could be implemented by insurers with only limited government intervention.

The first suggestion co-opts tactics with proven success that have caused crises when deployed in dangerous ways: longer-term policies with low introductory rates and limited exit rights. These methods have successfully attracted consumers to make purchases when it was not in the best interests of society—consider for instance the subprime mortgage crisis—but should be revisited for their potential to prompt purchases we now seek to encourage.

Other suggestions respond to various economic rationales and cognitive biases that are currently deterring insurance purchase by the young and healthy, including return of premium policies, simplified plans, and plans sold according to a generosity frame rather than a rational choice frame. Although it would require some legal changes, automatically enrolling individuals in plans with the right to opt-out merits serious consideration as well.

All of these solutions take the current reality of our health care system at face value.<sup>16</sup> None are perfect. And some will be

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15. Most of these alternatives can be achieved through insurer-side action. I therefore characterize them as “private law” initiatives because they primarily involve changes to contract provisions. Some of the solutions would require Congressional action, although I endeavor to minimize reliance on significant changes to the legal framework in recognition of the political climate. *See infra* Part IV for additional detail. Also, see Tom Baker & Peter Siegelman, *Tontines for the Invincibles: Enticing Low Risks into the Health Insurance Pool with an Idea from Insurance History and Behavioral Economics*, 2010 WIS. L. REV. 79, 79, which lays some early groundwork that I build upon in this Article.

16. In other words, if I were designing a system from scratch, it would not be the system we currently have. Indeed, many scholars have argued that what we have is not fixable. *See, e.g.*, Allison K. Hoffman, *Health Care’s Market Bureaucracy*, 66 UCLA L. REV. (forthcoming 2019) (manuscript at 9) (on file with

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more effective for certain sub-populations of the uninsured than others.<sup>17</sup> In a world of increasing access to consumer data, particular options could be targeted to the segments of consumers most likely to be influenced. But individually or deployed together, these solutions hold the potential to significantly improve upon the status quo.

This Article proceeds in four parts. Part I tells the story of the individual mandate, including why it was needed and how it was designed to work. It describes the impact that the mandate penalty had while it was in effect but also considers the mandate's shortcomings.

Part II sets forth the current problem. The mandate was abhorred by many. Consequently, it was effectively repealed. The repeal will have a negative impact on the insurance markets. Further, there is a persistent problem with uninsurance in America that exists even with an enforced mandate. Part II also describes the negative implications of decreased health insurance enrollment, beyond just the instability that healthy people leaving insurance markets will cause.

Part III then explores the theoretical underpinnings of this complicated problem. There are reasons grounded in both neo-classical economic theory and behavioral economics that individuals choose not to purchase health insurance. An analysis of these reasons is essential to crafting solutions and to assessing the likely effectiveness of the solutions.

Finally, Part IV draws on that theory to introduce a menu of alternatives to the individual mandate. It explores both the advantages and disadvantages of these various options.

The world that we currently inhabit is neither the one that many Republican thought leaders would prefer—a system that relies on delegation to the States—nor the one that most Democrats ultimately seek—universal health care. But with major

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UCLA Law Review) (arguing that “health care’s market-based solutions have failed” and that they cannot be fixed). I argue that while we strive for major health reform, we should continue to try to improve upon the *status quo* in ways that are politically viable.

17. As Tom Baker and Peter Siegelman correctly note, “[d]ifferent people have different preferences for insurance. Designing new insurance products to meet insurance-resistant young people’s preferences offers a potentially promising new way to entice low risks into the health-insurance pool.” See Baker & Siegelman, *supra* note 15, at 82.

policy changes likely still years away, it is a system we must nonetheless attempt to fix. Any voluntary solution, grounded in private law, that might prompt more healthy insureds to purchase and then maintain policies is worthy of further exploration.

## I. THE AFFORDABLE CARE ACT AND THE INDIVIDUAL MANDATE

Prior to the ACA, almost fifty million people (over sixteen percent of the population) were uninsured.<sup>18</sup> In 2010, in an attempt to address the problem, Congress passed and President Obama signed into law the Patient Protection and Affordable Care Act.<sup>19</sup> It was landmark health reform legislation—the first *major* change to the delivery of health care in the U.S. since Medicare and Medicaid became law in 1965.<sup>20</sup> The individual Shared Responsibility Payment (or “individual mandate”) was only one provision in a web of interconnected provisions intended to make health insurance more available and affordable, ultimately to address the uninsured problem. But the mandate was an important tool that facilitated some of the very popular provisions of the ACA.

### A. THE JOB THE INDIVIDUAL MANDATE WAS SUPPOSED TO DO

Health insurance exists because health spending is unpredictable. Most people do not know when they will get sick and

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18. See *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 7, 2018), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> [https://perma.cc/6XYR-BT4M].

19. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of the Internal Revenue Code and 42 U.S.C.).

20. The ACA has been called a “superstatute” because its implementation has changed so much about the delivery of health care. Abbe Gluck, *Obamacare As Superstatute*, BALKINIZATION BLOG (July 29, 2017, 10:18 AM), <https://balkin.blogspot.com/2017/07/obamacare-as-superstatute.html> [https://perma.cc/H5ZH-BDDC] (discussing the “normative transformation” the ACA brought in terms of our “gut understanding of what a health care system should be and what the government’s role in it should look like”). This is not to minimize other advances in health policy. See *Timeline: History of Health Reform in the U.S.*, KAISER FAM. FOUND., <https://kaiserfamilyfoundation.files.wordpress.com/2011/03/5-02-13-history-of-health-reform.pdf> (last visited Sept. 29, 2019), for an informative overview of health reform.



how much it will cost them when they do. And most people are, at least to a degree, risk averse.<sup>21</sup> When given a choice between a two percent risk of having to pay \$30,000 for medical treatment or paying \$600 in premiums, many if not most would choose the premium.<sup>22</sup> Health insurance works when an individual who faces a risk agrees to pay a premium to an insurance company, which in turn agrees to bear that risk (at least partially, if not entirely) for the insured.<sup>23</sup>

But a health insurance system can be designed in two fundamentally different ways: either based on principles of actuarial fairness or social solidarity.<sup>24</sup> A system is actuarially sound if it attempts to match premium charges with insurance risk.<sup>25</sup> Put simply, individuals who are likely to incur higher claims costs are charged higher premiums than those likely to incur lower claims costs. An individual who is obese or who has diabetes or who has a family history of early-onset breast cancer will, by design, be charged higher premiums than a young, healthy individual with family members who lived to old age and died of natural causes.<sup>26</sup> An actuarially fair health care system requires an underwriting process to assess risk.<sup>27</sup> Individuals who apply for insurance must provide detailed health information and family

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21. See generally Ted O'Donoghue & Jason Somerville, *Modeling Risk Aversion in Economics*, 32 J. ECON. PERSP. 91 (2018) (explaining the relevance of risk aversion for understanding economics, including discussion of insurance policies).

22. See N. GREGORY MANKIW, *THE ECONOMICS OF HEALTHCARE* 5 (2017), [https://scholar.harvard.edu/files/mankiw/files/economics\\_of\\_healthcare.pdf](https://scholar.harvard.edu/files/mankiw/files/economics_of_healthcare.pdf) [<https://perma.cc/KL2W-3B4M>].

23. *Id.*

24. Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 134 n.18 (2011) (citing sources describing the tradeoffs between actuarial fairness and social solidarity); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y, & L. 287, 289 (1993) (discussing the distinction between actuarial fairness and social solidarity).

25. Stone, *supra* note 24, at 293 (describing a system based in actuarial fairness and contrasting it with a system based on social solidarity).

26. Arguably, the most desirable insured is someone whose family members died young of non-chronic conditions.

27. Stone, *supra* note 24, at 294 ("Underwriting is the process insurers use to find 'the best and most desirable insureds.'").

history so that underwriters can set rates that, to the best of their ability to predict, approximate anticipated cost.<sup>28</sup>

Prior to 2010, the individual health insurance market was predicated on an actuarial fairness model.<sup>29</sup> This meant that many young, healthy individuals could obtain coverage at relatively low rates, while older and sicker policyholders either paid much higher rates or were denied coverage entirely. These rates were “fair” because they reflected an individual’s likely cost to the insurer.<sup>30</sup> A system based in actuarial fairness, however, does not attempt to be redistributive or to be *morally* fair.<sup>31</sup> And the reality of the pre-ACA system was that nearly fifty million Americans did not have health insurance,<sup>32</sup> even though, for most of them, their conditions were not their fault.<sup>33</sup>

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28. *Id.* (“The more durable (long-lived) and well-made (resistant to disease) the policyholders are, the more money the insurance company makes.”).

29. See Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1599–602 (2011) (describing the premium implications for people under actuarial fairness insurance models); Monahan & Schwarcz, *supra* note 24, at 135–36 (describing the pre-ACA model).

30. Baker, *supra* note 29, at 1600 (“Within the framework of actuarial fairness, a price is unfairly discriminatory when two people presenting the same risk are charged different prices for the same product, but not when two people presenting different risks are charged different prices.”).

31. This is at least the case in a world where other provision is not being made to cover higher risk individuals. See Stone, *supra* note 24, at 308 (“The principle actually distributes medical care in *inverse* relation to need, and to the large extent that commercial insurers operate on this principle, the American reliance on the private sector as its main provider of health insurance establishes a system that is perfectly and perversely designed to keep sick people away from doctors.”).

32. Dan Managan, *Obamacare Kept Reducing Number of Americans Without Health Insurance During Trump’s First Months in Office*, CNBC (Aug. 26, 2017 8:13 PM), <https://www.cnbc.com/2017/08/29/obamacare-kept-reducing-number-of-americans-without-health-insurance.html> [<https://perma.cc/PYY6-HVFM>] (“In 2010, 16 percent of Americans, or 48.6 million people, were uninsured . . .”).

33. Prior to the ACA, most states maintained high-risk pools, where individuals who could not obtain coverage by other means could get state-subsidized insurance. See *High-Risk Pools*, HEALTH REFORM TRACKER, <http://www.healthreformtracker.org/high-risk-pools/> [<https://perma.cc/H2XZ-SV5F>] (explaining the structure of high-risk pools and their successes and failures). This Article takes no position on whether adequately-funded high risk pools would have solved the pre-ACA problems. But risk-pools pre-ACA were not adequately funded and were problematic for many reasons, ranging from caps on enrollment, caps on reimbursement, failure to provide coverage for the pre-existing

The Affordable Care Act was, in large part, an attempt to address this problem. It marked a move from an actuarial fairness approach toward a social solidarity approach. A social solidarity system makes no attempt to match risk and rate.<sup>34</sup> Rather, it spreads cost evenly over the covered population.<sup>35</sup> Medicare is just one example of a social solidarity system.<sup>36</sup> When an individual turns sixty-five, he or she is automatically enrolled in Medicare.<sup>37</sup> And for Part B, which charges premiums, premiums are assessed without regard to individual risk.<sup>38</sup> Essentially, every insured bears an equal percentage of the cost even if the claims costs paid out for one individual are higher than for another individual.

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conditions itself, and the list goes on. See Julie Rovner & Francis Ying, *Sounds Like a Good Idea? High-Risk Pools*, KAISER HEALTH NEWS (May 4, 2017), <https://khn.org/news/sounds-like-a-good-idea-high-risk-pools/> [<https://perma.cc/K8HA-KCU9>] (explaining high-risk pools and why they did not work in the past); see also Harris Meyer, *Why High-Risk Pools Won't Crack the Pre-existing Condition Dilemma*, MODERN HEALTHCARE (Feb. 13, 2017, 12:00 AM), <https://www.modernhealthcare.com/article/20170213/NEWS/170219968> [<https://perma.cc/AY34-4GLY>] (“[E]xperts say that state high-risk pools generally were a policy failure across the country, and making them work properly would require a large amount of taxpayer funding.”).

34. See Karl Hinrichs, *Social Insurances and the Culture of Solidarity: The Moral Infrastructure of Interpersonal Redistributions with Special Reference to the German Health Care System* 7 (Ctr. Soc. Policy Research, Working Paper No. 3/1997) (“[A] uniform contribution (rate) unrelated to the risk status is applied for all members of the insured collectivity.”).

35. *Id.*

36. Notably, though, Medicare does not simply pool costs and charge everyone the same premium because it relies substantially on general revenue funding from the entire tax base. The larger point is that it covers everyone and does not charge sicker people higher rates. See generally *An Overview of Medicare*, KAISER FAM. FOUND. (Feb. 13, 2019), <https://kff.org/medicare/issue-brief/an-overview-of-medicare/> [<https://perma.cc/DL4H-A2WC>] (providing an overview of the Medicare system, including coverage details and how it is financed).

37. 42 U.S.C. § 423 (2012).

38. There is no Premium for Part A. The premiums assessed for Part B do differ somewhat based on ability to pay, but not based on actuarial risk. SOCIAL SECURITY ADMINISTRATION, PUB. NO. 05-10536, *MEDICARE PREMIUMS: RULES FOR HIGHER-INCOME BENEFICIARIES* (2019), <https://www.ssa.gov/pubs/EN-05-10536.pdf>.

A central motivating idea behind the ACA was to address the immorality of turning away sick people from insurance coverage or charging astronomically high premiums to cover them.<sup>39</sup> As such, the ACA's health insurance "Market Reforms"<sup>40</sup> were born. These reforms do several things. First, they guarantee availability of coverage, meaning that insurers can no longer turn away prospective insureds who are "bad risks."<sup>41</sup> Second, they prohibit insurers from discriminating against those with pre-existing conditions or risky health statuses, including based on genetic information.<sup>42</sup> And they implement so-called "[f]air health insurance premiums," otherwise known as "community rating," which mandates that rates vary only by individual or family, rating area, age (but not more than 3:1 for adults), and tobacco use (not more than 1.5:1). Basically, everyone is charged (close to) the same regardless of risk.<sup>43</sup>

By these provisions, the ACA prevents insurers from turning away more expensive insureds or charging them higher rates, which had been the pre-ACA approach.<sup>44</sup> Before the ACA, insurers could keep premiums down by choosing to cover only lower-risk and lower-cost individuals (or by refusing to pay for high-cost care). After the ACA, insurers must include sicker and more expensive insureds in their risk pools.

The ACA was designed to work, however, by attracting sufficient numbers of younger, healthier, lower-cost individuals into

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39. See *The Affordable Care Act's Individual Mandate Helps Make Health Insurance Affordable and Available*, FAMILIES USA (Nov. 2017), <https://familiesusa.org/product/affordable-care-act-individual-mandate-helps-make-health-insurance-affordable> [<https://perma.cc/V6XR-8852>] (explaining that premiums skyrocketed when states were required to cover individuals with preexisting conditions and healthy individuals were not required to enroll).

40. Jennifer Tolbert, *The Coverage Provisions in the Affordable Care Act: An Update*, KAISER FAM. FOUND. (Mar. 2, 2015), <https://www.kff.org/report-section/the-coverage-provisions-in-the-affordable-care-act-an-update-health-insurance-market-reforms/> [<https://perma.cc/VU85-MUMT>] (detailing the market reforms established by the ACA).

41. Public Health Service Act of 1944, Pub. L. No. 78-410, 58 Stat. 682 (codified as amended at 42 U.S.C. § 300gg-1 (2012)).

42. *Id.* §§ 2704–2705 (codified as amended at 42 U.S.C. §§ 300gg-3 to gg-4 (2012)). These protections began even before the ACA with the Genetic Information Nondiscrimination Act of 2008. See Pub. L. No. 110-233, 122 Stat. 881 (2008).

43. *Id.* § 2701 (codified as amended at 42 U.S.C. § 300gg (2012)).

44. See *supra* notes 29–31.

the risk pools to even out the cost of the sicker ones.<sup>45</sup> Two mechanisms were used to do this. First, the ACA makes subsidies available to lower-income individuals.<sup>46</sup> Those who make less than 400% of the federal poverty level receive premium tax credits that essentially work to lower premiums and make them affordable.<sup>47</sup> Second, because lower-cost individuals might balk at paying more than their fair actuarial share and choose not to enroll at all, the ACA included an individual mandate.<sup>48</sup>

The mandate required that most individuals<sup>49</sup> prove that they had qualifying insurance coverage or else pay a penalty. The penalty was assessed through the tax system: when filing taxes, individuals were required to submit a form demonstrating that they had maintained essential coverage throughout the year, or pay a tax.<sup>50</sup>

#### B. IMPLEMENTATION OF THE MANDATE: BOTH SUCCESSES AND FAILURES

The mandate was first implemented in 2014. That year, the penalty was \$95 per adult or 1% of family income, whichever was

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45. See Illana Graetz et al., *Lessons Learned From the Affordable Care Act: The Premium Subsidy Design May Promote Adverse Selection*, 75 MED. CARE RES. & REV. 762, 768 (2018) (“To achieve a balanced risk pool and curtail continued premium growth, the ACA marketplaces need to attract sufficient numbers of younger, healthier individuals.”); Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 12 (2010) (describing the redistributive policy objective of the individual mandate).

46. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAM. FOUND. (Nov. 20, 2018), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/> [<https://perma.cc/U3WD-HQU5>].

47. *Key Facts: Premium Tax Credit*, HEALTH REFORM: BEYOND THE BASICS (Sept. 13, 2018), [http://www.healthreformbeyondthebasics.org/wp-content/uploads/2013/08/KeyFacts\\_Premium-Tax-Credits.pdf](http://www.healthreformbeyondthebasics.org/wp-content/uploads/2013/08/KeyFacts_Premium-Tax-Credits.pdf) [<https://perma.cc/HN45-25BF>].

48. 26 U.S.C. § 5000A(a) (2012). Cost-sharing reduction payments also reduce out-of-pocket costs for eligible insureds. *Key Facts: Premium Tax Credit*, *supra* note 47.

49. 26 U.S.C. § 5000A(b)(1). However, some people were exempt. *See id.* §§ 5000A(d)(2)(A), (d)(3)–(4), (e)(1)–(5).

50. *The Fee for Not Having Health Insurance*, HEALTHCARE.GOV, <https://www.healthcare.gov/fees/fee-for-not-being-covered/> [<https://perma.cc/JWL4-YX5G>].

greater.<sup>51</sup> Gradually, the penalties increased until they hit their maximum in 2016 of \$695 per adult or 2.5% of income, whichever was greater.<sup>52</sup>

In many respects, the mandate successfully incentivized the purchase of insurance policies. The best evidence is that nearly twenty million previously uninsured people became insured following the ACA's implementation.<sup>53</sup>

Of that number, about half purchased policies on the Exchanges and half received coverage through the Medicaid expansion.<sup>54</sup>

The mandate does not deserve sole credit for this reduction in uninsureds. Strong economic growth during this period supported enrollment<sup>55</sup> and the premium tax credits (usually referred to as “subsidies”) also made it possible for many poorer

51. Matthew Rae et al., *The Cost of the Individual Mandate Penalty for the Remaining Uninsured*, KAISER FAM. FOUND. (Dec. 9, 2015), <https://kff.org/health-reform/issue-brief/the-cost-of-the-individual-mandate-penalty-for-the-remaining-uninsured/> [<https://perma.cc/XMD8-LDNE>].

52. *The Fee for Not Having Health Insurance*, *supra* note 50.

53. See NAMRATA UBEROI ET AL., U.S. DEPT OF HEALTH & HUMAN SERVS., HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010–2016, at 2 (2016), <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf> [<https://perma.cc/HC4T-X6RZ>]; see also KAISER FAM. FOUND., NO. 8306-T, SURVEY OF NON-GROUP HEALTH INSURANCE ENROLLEES, (June 2014), <https://www.kff.org/wp-content/uploads/2014/06/8306-t2.pdf> [<https://perma.cc/5S7Z-AX7C>] (presenting survey results examining views and experiences of individuals who purchase health insurance through insurance companies or the ACA). But the uninsured rate has been trending higher since the start of the Trump Administration and its attempts to undermine the ACA. A total of 12.2% of all adults now lack health insurance, an increase of 1.3 percentage points since the last quarter of 2016. Zac Auter, *U.S. Uninsured Rate Steady at 12.2% in Fourth Quarter of 2017*, GALLUP (Jan. 16, 2018), <https://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx> [<https://perma.cc/FD49-UQ3A>].

54. The twenty million previously uninsured who obtained insurance post-ACA also includes about two million young adults who obtained insurance because of the ACA provision that allowed them to stay on their parents' plans until age twenty-six. See Tara O'Neill Hayes, *How Many Are Newly Insured as a Result of the ACA?*, AM. ACTION FORUM (Jan. 4, 2017), <https://www.americanactionforum.org/insight/20-million/> [<https://perma.cc/F7QC-CXQZ>].

55. JOHN HOLAHAN ET AL., URBAN INST., U.S. HEALTH REFORM—MONITORING AND IMPACT: THE EVIDENCE ON RECENT HEALTH CARE SPENDING GROWTH AND THE IMPACT OF THE AFFORDABLE CARE ACT at 9–11 (2017), [http://www.urban.org/sites/default/files/publication/90471/2001288-the\\_](http://www.urban.org/sites/default/files/publication/90471/2001288-the_)

individuals to afford insurance that they could not afford before.<sup>56</sup> Because the mandate and the subsidies were implemented at the same time, it is hard to empirically separate the effect that one had relative to the other.

Nonetheless, there is good reason to believe that the mandate provided an important (while not the only) incentive for enrollment.<sup>57</sup> Massachusetts had implemented a similar scheme prior to the ACA.<sup>58</sup> There, a population of individuals had access to subsidies to purchase insurance both before and after the implementation of a mandate. Even when the subsidies were held constant, a higher percentage of individuals chose to buy insurance when subject to the mandate than they did without a mandate.<sup>59</sup> It seems likely, therefore, that the ACA mandate also prompted new enrollments.

This, however, does not answer the question of *who* enrolled because of the mandate. Recall that a main rationale for the mandate was to prompt younger, healthier, and therefore less costly enrollees.

Here, there is limited data.<sup>60</sup> We know that for the coveted bracket of individuals aged nineteen to thirty-four, the uninsured rate dropped from 29.9% (before the ACA) to 17.3% (after the ACA).<sup>61</sup> There is also data that young policyholders aged

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evidence\_on\_recent\_health\_care\_spending\_growth\_and\_the\_impact\_of\_the\_affordable\_care\_act.pdf/ [https://perma.cc/EM4X-CQCZ].

56. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KAISER FAM. FOUND. (Nov. 20, 2018), <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/> [https://perma.cc/U3WD-HQU5].

57. Notably, the incentive may not be a desire to avoid the financial penalty, but rather a desire to comply.

58. See Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, COMMONWEALTH FUND (July 11, 2018), <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors> [https://perma.cc/L3BC-B3VF].

59. See *id.*

60. Insurance companies surely have this data. They have the claims costs of the insured and could assess how many lower-cost individuals registered for insurance post-ACA.

61. See BOWEN GARRETT & ANUJ GANGOPADHYAYA, URBAN INST., *ACA IMPLEMENTATION—MONITORING AND TRACKING: WHO GAINED HEALTH INSURANCE COVERAGE UNDER THE ACA, AND WHERE DO THEY LIVE?* 4 (2016), <https://www.urban.org/sites/default/files/publication/86761/2001041-who>

eighteen to thirty-four made up about 28% of enrollees on the Exchanges.<sup>62</sup> So there was at least some success attracting young policyholders.

But there is also evidence that the mandate did not attract *enough* low-risk policyholders. Anecdotally, insurers reported that they “saw very little of the young and healthy.”<sup>63</sup> Many actuaries calculated that younger policyholders needed to make up 40% of the risk pool “to create a more stable rate environment.”<sup>64</sup> And the Exchanges did not produce that.<sup>65</sup> There is also evidence from insurers that medical costs were higher than expected from 2014 to 2017, suggesting that risk pools attracted more sick people than healthy people.<sup>66</sup>

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-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf [https://perma.cc/L3BC-B3VF]. *But see* Hayes, *supra* note 54 (describing new rules permitting children to stay on parental plans until age twenty-six partially explain the drop). And for those aged thirty-five to fifty-four, the uninsured rate also dropped—from 19.6% to 13.3%. GARRETT & GANGOPADHYAYA, *supra*, at 4.

62. Bob Herman, *What, Me Buy Insurance? How Slow Uptake by “Young Invincibles” Is Driving the ACA’s Exchange Rates Higher*, MODERN HEALTHCARE (May 14, 2016), <https://www.modernhealthcare.com/article/20160514/MAGAZINE/305149980> [https://perma.cc/Z7Y9-BV6U].

63. *Id.* (quoting Sherri Huff, “a consultant and former chief financial officer of Common Ground Healthcare Cooperative in Wisconsin, one of the insurance co-ops funded by ACA loans”).

64. *Id.*; Mike Walden, *You Decide: How Is Economics Involved in Health Insurance?*, N.C. ST. U.: CALS NEWS (Apr. 14, 2017), <https://cals.ncsu.edu/news/you-decide-how-is-economics-involved-in-health-insurance/> [https://perma.cc/D48Y-4PJC] (“One study estimated that for Obamacare to work, 40 percent of enrollees needed to be young people (18–34 age group). But the actual share has only been about 25 percent. The lack of sufficient numbers of younger enrollees is one reason why Obamacare premiums have risen more than expected.”).

65. See DEP’T HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL ANNUAL OPEN ENROLLMENT PERIOD at 3 (2014), [https://aspe.hhs.gov/system/files/pdf/76876/ib\\_2014Apr\\_enrollment.pdf](https://aspe.hhs.gov/system/files/pdf/76876/ib_2014Apr_enrollment.pdf) [https://perma.cc/R2NA-4766] (showing that young adults made up 31% of individuals selecting health insurance plans between October 1, 2013 and March 31, 2014).

66. Evidence shows that medical costs were 6% to 10% higher in 2014 than in the prior year. Allison Inerro, *Claims Costs, Policy Decisions Factors in Early ACA Insurer Participation*, GAO Report Says, AJMC (Jan. 31, 2019), <https://www.ajmc.com/focus-of-the-week/claims-costs-policy-decisions-factors-in-early-aca-insurer-participation-gao-report-says> [https://perma.cc/957Q-EV2S]. Rate increases may be attributed to insurer difficulty in predicting claims experiences without experience rating. U.S. GOV’T ACCOUNTABILITY OF-



Perhaps the strongest evidence that the mandate was not entirely successful in attracting less expensive policyholders is the rise of premiums post-ACA. These increases were significant, particularly in certain geographic locations—although rate increases are more modest when they are weighted by number of enrollees in specific plans.<sup>67</sup> And even at its lowest, the uninsured rate for non-elderly adults still did not go below 10% of the population.<sup>68</sup>

There are many reasons why the mandate might not have been entirely successful. Two are particularly salient: the mandate was not strong enough, and errors in its design prevented it from having the full, intended effect.<sup>69</sup>

First, the amount of the tax was much less than the cost of the cheapest plan. As Dr. Kevin Volpp, a Wharton health economist, put it: “An individual could quite rationally conclude, ‘I’m willing to pay a \$700 penalty. I’m not willing to pay \$4,000 or more for my coverage.’”<sup>70</sup> A mandate that was more similar in price to the lowest price plan would likely have prompted more sign-ups. But the larger and more punitive the mandate, the less likely that it would have been deemed constitutional.<sup>71</sup>

Second, the consequence of having to pay the penalty was far removed from the decision point to purchase insurance.<sup>72</sup> The

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FICE, GAO-19-215, HEALTH INSURANCE EXCHANGES: CLAIMS COSTS AND FEDERAL AND STATE POLICIES DROVE ISSUER PARTICIPATION, PREMIUMS, AND PLAN DESIGN 10–11 (2019).

67. Prices did go up, but maybe not by as much as people think. See Peter Ubel, *Everyone Agrees Obamacare Prices Have Been Rising Rapidly. But Everyone Is Wrong.*, FORBES (Feb. 23, 2018), <https://www.forbes.com/sites/peterubel/2018/02/23/everyone-agrees-obamacare-prices-have-been-rising-rapidly-heres-why-everyone-is-wrong/#70f3c1a5b19c> [<https://perma.cc/9UTK-UJER>] (arguing that price increases look a lot smaller when number of enrollees per plan are considered).

68. See KAISER FAM. FOUND., *supra* note 11.

69. Ideological objections to the mandate also likely had an impact. See discussion *infra* Part II.A.

70. *How Behavioral Economics Could Save America’s Health Care Woes*, KNOWLEDGE@WHARTON (May 12, 2017), <http://knowledge.wharton.upenn.edu/article/four-general-principles-health-care-reform/> [<https://perma.cc/R7BB-PTJ2>].

71. Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519, 572–73 (2012) (finding the individual mandate to be constitutional as a proper exercise of Congressional taxing authority, but noting that it could not be punitive).

72. See *Behavioral Economics*, *supra* note 70.

time lag between open enrollment and the filing of taxes could be almost a year and a half.<sup>73</sup> People are much more likely to focus on immediate consequences. As such, the mandate likely did not pack the punch that lawmakers intended.

Despite its failure to fully accomplish the goals set forth for it,<sup>74</sup> the mandate did serve an important purpose in prompting insurance uptake. And yet the next Part describes how the opposition to the mandate led to the repeal of the penalty. It then describes the negative impact that the repeal is likely to have on the markets and uninsured rates in the near future. It also takes up the problem of high rates of uninsurance even when the mandate was in effect.

## II. THE REPEAL OF THE INDIVIDUAL MANDATE

The individual mandate was always highly unpopular. According to most polls, around 66% of Americans were opposed to it<sup>75</sup> and over 80% of Trump supporters opposed it.<sup>76</sup> This public opposition ultimately fed the political will to repeal the mandate, removing a key (even if imperfect) incentive for insurance enrollment.

### A. OBJECTIONS TO THE MANDATE

There were two major legal and policy objections to the mandate (aside from debates about whether or not it was effective):

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73. *Id.*

74. See Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 12 (2010) (predicting that “the individual mandate will not be able to realize such benefits that rely upon its ability to promote health redistribution if it is implemented in a fragmented health insurance market”).

75. Jon Greenberg, *How Unpopular Is the Obamacare Individual Mandate?*, POLITIFACT (Nov. 14, 2017), <https://www.politifact.com/truth-o-meter/statements/2017/nov/14/donald-trump/how-unpopular-obamacare-individual-mandate/> [<https://perma.cc/589J-3C69>]; Tara O’Neill Hayes, *Alternative Policy Options to the Individual Mandate*, AM. ACTION F. (June 20, 2017), <https://www.americanactionforum.org/insight/alternative-policy-options-individual-mandate/#ixzz5fR0fISUz> [<https://perma.cc/589J-3C69>].

76. ASHLEY KIRZINGER ET AL., KAISER FAM. FOUND., KAISER HEALTH TRACKING POLL: NOVEMBER 2016 (2016), <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016/> [<https://perma.cc/N73K-XY5S>].

it infringed on individual liberty and autonomy, and it violated the proper operation of federalism.<sup>77</sup>

First, the mandate was viewed as coercive in the sense that it violated economic liberty. It forced people to buy insurance that they did not want. Young people, so the argument went, may “choose not to buy insurance precisely because they do not expect to use medical care much—and usually they don’t.”<sup>78</sup> The mandate amounted to a coercion of these individuals to enter into private contracts, which in many cases were contrary to their self-interest.<sup>79</sup> This theory of liberal autonomy, emphasizing self-determination, was largely adopted by the majority of the Supreme Court in its commerce clause analysis in *NFIB v. Sebelius*, the case challenging the constitutionality of the mandate.<sup>80</sup> Although the Court went on to uphold the mandate on other grounds, it found that Congress lacked authority to mandate the purchase of insurance under the commerce clause.<sup>81</sup>

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77. See also Ezra Klein, *Unpopular Mandate*, NEW YORKER (June 18, 2012), <https://www.newyorker.com/magazine/2012/06/25/unpopular-mandate> [https://perma.cc/59FV-ZAF9] (arguing that opposition to the mandate grew largely as it became a “conservative issue,” even among people who had previously supported it).

78. Rivkin, Jr., *supra* note 10, at 94; see also Steven Z. Hodaszy, *Testing for Regulatory Penalties: Insuring the Health of Federalism in the Age of Obamacare*, 119 W. VA. L. REV. 145, 159–60 (2016); Gillian E. Metzger, *To Tax, To Spend, To Regulate*, 126 HARV. L. REV. 83, 83 (2012) (describing conservative and Tea Party arguments against the mandate).

79. Abigail R. Moncrieff, *Safeguarding the Safeguards: The ACA Litigation and the Extension of Indirect Protection to Nonfundamental Liberties*, 64 FLA. L. REV. 639, 668 (2012). Another autonomy-based argument concerned freedom of health. This argument gained less traction, though, because nothing about the mandate forced anyone into a health care decision—just a decision about health insurance. As Abigail Moncrieff stated, “In short, the individual mandate does not require Americans to ‘eat their broccoli’—only to pay for it.” *Id.* at 671.; see also Abigail R. Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2247 (2011).

80. 567 U.S. 519, 545–55 (2012).

81. See Catherine A. Hardee, *Considering Consequences: Autonomy’s Missing Half*, 43 PEPP. L. REV. 785, 788 (2016). It is worth noting that coercion may be warranted. See Scotty Jenkins, *Republicans’ Proposed “Continuous Coverage” Protections Are Even More Coercive Than Obamacare’s Individual Mandate*, RANTT MEDIA (Jan. 7, 2017), <https://medium.com/rantt/republicans-proposed-continuous-coverage-protections-are-even-more-coercive-than-obamacare-s-6340dedb2d44> [https://perma.cc/KU9R-4E27] (“The Republicans are right that the individual mandate is coercive. But they’re wrong that it is, in principle, immoral or otherwise undesirable because it’s coercive. Coercion

There are lots of responses to the autonomy concerns, both as a legal matter and a policy matter, including that the mandate simply responded to the costs that the uninsured externalized onto the insured when they obtained emergency room care for which they could not pay. Essentially, the mandate was a valid response to the free-rider problem. But the larger point is that the perceived coercive nature of the mandate was always a significant stumbling block in its adoption and viability.

Second, many objected to the individual mandate because it exemplified an overreach of authority on the part of the federal government. Indeed, the core argument in *NFIB v. Sebelius* was just that—that Congress lacked the constitutional authority to regulate, and that the issue should instead be left to the states.<sup>82</sup> Put another way, “the individual mandate exceeds Congress’s affirmative powers as a matter of federalism doctrine.”<sup>83</sup> In general, many objected to the federal government assuming such pervasive authority over an issue that had traditionally been the province of the individual states.<sup>84</sup>

As a legal matter, this argument did not carry the day. The Supreme Court held the mandate to be a valid exercise of Congressional taxing authority within the limited power of the federal government.<sup>85</sup> But particularly when viewed together with

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can be justified if it achieves other things we value, like providing access to health insurance to as many people as possible.”)

82. Peter J. Smith, *Federalism, Lochner, and the Individual Mandate*, 91 B.U. L. REV. 1723, 1737 (2011); Elizabeth Weeks Leonard, *Affordable Care Act Litigation: The Standing Paradox*, 38 AM. J.L. & MED. 410, 435–36 (2012) (“The core legal question before the Supreme Court in the ACA litigation is the scope of federal enumerated powers vis-a-vis states’ reserved powers.”).

83. Smith, *supra* note 82, at 1737.

84. See Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 2–3 (2017); Bridget A. Fahey, *Health Care Exchanges and the Disaggregation of States in the Implementation of the Affordable Care Act*, 125 YALE L.J.F. 56, 57 (2015); Thomas C. Feeney, *Federalism Under Attack: How Obamacare Turns Citizens into Government Minions*, HERITAGE FOUND. (May 3, 2010), [http://thf\\_media.s3.amazonaws.com/2010/pdf/hl\\_1154.pdf](http://thf_media.s3.amazonaws.com/2010/pdf/hl_1154.pdf) [https://perma.cc/TB6N-ASEB]; Edmund Haislmaier & Brian Blase, *Obamacare: Impact on States*, HERITAGE FOUND. (July 1, 2010), <https://www.heritage.org/health-care-reform/report/obamacare-impact-states> [https://perma.cc/J3RW-2YJ6].

85. *NFIB*, 567 U.S. 519, 575 (2012).

the perceived coercive nature of the law, many continued to object to the mandate on federalism grounds.<sup>86</sup> And despite the outcome of *NFIB v. Sebelius*, the political will to repeal the mandate only continued to grow.

#### B. THE 2017 REPEAL OF THE MANDATE PENALTY

As soon as the ACA became law in 2010, Republicans rallied around repealing it. From 2010 to 2017, Congress considered more than one-hundred resolutions to do away with—in one respect or another—the ACA.<sup>87</sup> But the popularity of the pre-existing conditions protections and other ACA provisions proved a significant stumbling block. After seven years of failed repeal attempts, the GOP changed course.

Instead of attempting to repeal the entire ACA, it targeted instead one highly unpopular ACA provision: the individual mandate. In December 2017, buried in a 560-page tax reconciliation act,<sup>88</sup> Congress effectively repealed the individual mandate.<sup>89</sup> As a technical matter, the mandate remains in the ACA and still requires that individuals maintain minimum essential coverage for each month. However, the tax act zeroes out the penalties the mandate had imposed. Therefore, those who do not maintain insurance no longer have any consequence for non-compliance. Because Congressional authority to issue the mandate resided only in its taxing powers, with the tax gone, the mandate is, for all intents and purposes, repealed.<sup>90</sup>

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86. Steven Z. Hodaszy, *Testing for Regulatory Penalties: Insuring the Health of Federalism in the Age of Obamacare*, 119 W. VA. L. REV. 145, 160–61 (2016).

87. *100: The Resolutions*, HOW MANY TIMES HAS THE HOUSE VOTED TO REPEAL OBAMACARE?, <http://howmanytimeshasthehousevotedtorepealobamacare.com/> [<https://perma.cc/KDD2-75ZR>].

88. H.R. REP. NO. 115-466, at 324 (2017) (Conf. Rep.).

89. *Id.* The repeal of the mandate was justified by its financial savings to the federal government. See generally MATTHEW BUETTGENS ET AL., URBAN INST., *THE COST OF ACA REPEAL* (2016). If fewer low-income individuals purchase policies, then the federal government will owe less in subsidies. *Id.*

90. Because the mandate still technically exists, law-abiding citizens may feel compelled to comply with it regardless of whether a penalty is associated. See *infra* Part II.C.1; see also *Texas v. United States*, 340 F. Supp. 3d 529, 619 (N.D. Tex. 2018), *appeal docketed*, No. 19-10011 (5th Cir. Jan 7, 2019) (considering whether the entirety of the ACA must also fall with the repeal of the mandate penalty).

The repeal of the mandate penalty first went into effect in January 2019.<sup>91</sup> Individuals who fail to maintain health insurance for any month in 2019 will no longer be assessed a penalty when taxes are due in April 2020. It is too soon to know with certainty what effect this will have. Ultimately, it is an empirical question. But there is reason to fear a host of negative consequences.

### C. NEGATIVE IMPLICATIONS OF THE REPEAL

The most troubling consequences of the repeal flow from the inevitability that more Americans will either choose—or be forced—to become uninsured. Indeed, the Congressional Budget Office has estimated that thirteen million more Americans will become uninsured over the next ten years as a result of the repeal of the penalty.<sup>92</sup> Although the once-feared “death spiral,” where markets were expected to collapse, is now unlikely due to other market-stabilizing features of the ACA,<sup>93</sup> the rise in the uninsured population will lead to higher premiums.<sup>94</sup>

While insurance markets are not facing imminent collapse absent a mandate penalty, the concerns underlying the “death spiral” theory persist.<sup>95</sup> Those concerns stem from the concept of adverse selection, which occurs when individuals know more about their health status than insurance companies do. Those in poorer health therefore sign up for the most robust coverage,

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91. H.R. REP. No. 115-466, at 40, 324.

92. CONG. BUDGET OFFICE, REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE: AN UPDATED ESTIMATE at 1 (2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf> [<https://perma.cc/B28Y-RBZG>]. There is debate on the accuracy of this estimation, although there is wide agreement on the trend direction toward higher rates of uninsured.

93. Brief of Amici Curiae for Bipartisan Economic Scholars in Support of Intervenor Defendant-Appellants at 26, *Texas*, No. 19-10011 (5th Cir. Apr. 1, 2019), <https://www.cbo.gov/publication/53826> [<https://perma.cc/5WCU-BNYX>] [hereinafter Brief for Bipartisan Economic Scholars] (citing CONG. BUDGET OFFICE, FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65: 2018 TO 2028, at 2–3, 5 (May 2018)).

94. Indeed, the repeal of the penalty has already “caused the number of uninsured to rise, increased premiums for those who remain insured, and had a serious negative effect on the economy . . .” *Id.* at 4 (arguing that these effects might continue to marginally increase but that the consequences of invalidating the entire ACA would be far worse).

95. Cutler & Zeckhauser, *supra* note 8, at 8.

knowing that they will need to utilize the benefits offered, and those in good health sign up for the skimpiest coverage. Healthy individuals may also choose to forego coverage entirely, particularly as premiums increase. In a world where no one has any extra incentive to buy insurance (such as having to pay a penalty if one goes without it), sicker people will continue to purchase policies but many healthy people will not.<sup>96</sup> This skews the risk pools, which start to contain more expensive, sicker insureds.<sup>97</sup> In order to account for the higher claims costs of a sicker risk pool, insurance companies raise premiums. Then as premiums increase, fewer healthy policyholders, doing a cost-benefit analysis, find the cost of premiums to be worth it relative to their anticipated health expenses. So those healthier policyholders drop out of the risk pool, and the risk pool gets increasingly sicker and more expensive over time. If this effect is severe, and premiums keep increasing and risk pools keep contracting, then the whole market collapses, resulting in the “death spiral.”<sup>98</sup>

Economists are in wide agreement that repeal of the mandate penalty will cause some enrollees to drop coverage. Young and healthy policyholders (sometimes called the “young invincibles”),<sup>99</sup> are likely to comprise a sizable percentage of the newly uninsured—in part because they have fewer financial resources to spend on premiums and because they know they are less likely to need to use their coverage (although there is still risk). Premium increases will also cause additional individuals, who would no longer be able to afford policies, to become uninsured.<sup>100</sup>

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96. See Rebecca Adams, *GAO Examines Alternatives to Individual Mandate*, COMMONWEALTH FUND (Mar. 25, 2011), <https://www.commonwealthfund.org/publications/newsletter-article/gao-examines-alternatives-individual-mandate> [<https://perma.cc/BJC2-8CKQ>].

97. See Jonathan S. Skinner & Kevin G. Volpp, *Replacing the Affordable Care Act: Lessons from Behavioral Economics*, 317 JAMA 1951 (2017).

98. *Behavioral Economics*, *supra* note 70 (describing how premiums climb when “lower-risk people differentially decide not to buy coverage”).

99. See, e.g., Baker & Siegelman, *supra* note 15, at 79 (2010) (describing young invincibles as “those who (wrongly) believe that they do not need health insurance because they will not get sick”).

100. With the subsidies, those making under 400% of the federal poverty level are insulated from these rate increases. If premiums increase, the government simply pays a higher percentage of the rate. But rate increases are particularly salient for the lower middle class who make above 400% of the federal

While economists are in wide agreement that the uninsured rate will increase and that premiums will go up, estimates of degree vary.<sup>101</sup> One recent study issued by California's insurance marketplace estimates that insurance premiums for ACA plans will jump by 35% to 94%, depending on the state, in the next three years.<sup>102</sup> Another study finds that just in 2019, premiums for silver-level plans are already 15% higher.<sup>103</sup> But the latest estimate from the Congressional Budget Office predicts premium increases on average of 7% between 2019 and 2028.<sup>104</sup>

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poverty level and therefore do not qualify for subsidies, but are nonetheless not wealthy.

101. Auter, *supra* note 53. "Gallup noted that 'it seems likely that the uninsured rate will rise further in the years ahead,' given the effective repeal, starting in 2019, of Obamacare's requirement that most Americans have some form of health insurance or pay a fine." Dan Mangan, *Number of Americans Without Health Insurance Jumped by More Than 3 Million Under Trump*, CNBC (Jan. 16, 2018), <https://www.cnn.com/2018/01/16/americans-without-health-insurance-up-more-than-3-million-under-trump.html> [<https://perma.cc/FL28-6QMN>]; *see also* CONG. BUDGET OFFICE, *REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE: AN UPDATED ESTIMATE* (2017), <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf> [<https://perma.cc/B28Y-RBZG>] (estimating that average premiums in the individual market will increase by 10% in 2019); Jonathan Keisling, *2019 ACA Marketplace Premiums*, AM. ACTION F. (Dec. 7, 2018), <https://www.americanactionforum.org/research/2019-aca-marketplace-premiums/> [<https://perma.cc/2D4Z-WRT3>].

102. *Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Act, with Wide Variation Among States*, COVERED CAL. (Mar. 8, 2018), [https://hbex.coveredca.com/data-research/library/CoveredCA\\_High\\_Premium\\_Increases\\_3-8-18.pdf](https://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf) [<https://perma.cc/889E-VH5T>]. "Insurance premiums for Affordable Care Act health plans are likely to jump by 35 to 94 percent around the country within the next three years, according to a new report concluding that recent federal decisions will have a profound effect on prices." Amy Goldstein, *Premiums for ACA Health Insurance Plans Could Jump 90 Percent in Three Years*, WASH. POST (Mar. 8, 2019), [https://www.washingtonpost.com/national/health-science/premiums-for-aca-health-insurance-plans-could-jump-90-percent-in-three-years/2018/03/08/1ebb4c44-22e3-11e8-94da-ebf9d112159c\\_story.html?noredirect=on&utm\\_term=.762c0ff0c658](https://www.washingtonpost.com/national/health-science/premiums-for-aca-health-insurance-plans-could-jump-90-percent-in-three-years/2018/03/08/1ebb4c44-22e3-11e8-94da-ebf9d112159c_story.html?noredirect=on&utm_term=.762c0ff0c658). Note that these estimates are attributed to multiple legal and policy changes. The portion attributable to losing the mandate is expected to have the greatest impact.

103. Kelly Brantley & Chad Brooker, *Double-Digit Premium Increases Expected in the Exchange Market in 2019*, AVALERE (June 21, 2018), <https://avalere.com/press-releases/double-digit-premium-increases-expected-in-the-exchange-market-in-2019> [<https://perma.cc/6GDC-TWPV>].

104. Brief for Bipartisan Economic Scholars, *supra* note 93.



Notably, premium increases are not just a negative consequence for individuals. Premium increases, even in the private market, create a tremendous problem *for the government*. About 87% of individuals who purchase policies on the Exchanges are receiving tax credits.<sup>105</sup> As premiums go up, the federal government is footing a larger and larger bill.

Still, the story is also not as dire as once feared. There is also now wide agreement that the insurance markets are stable and will not collapse absent the mandate penalty.<sup>106</sup> First, the premium subsidies and cost-sharing reduction payments will continue to ensure that silver plans are affordable for lower-income individuals. For those who make under 400% of the federal poverty level who are eligible for subsidies, the federal government picks up a higher percentage of the bill as premiums go up, essentially insulating those purchasers from premium increases. Eighty-seven percent of Exchange purchasers are eligible for these subsidies.<sup>107</sup> As premiums increase, those who purchase policies on the Exchange and who are not eligible for subsidies are therefore more likely to drop coverage. But at least to a degree, the existence of the subsidies and the cost-sharing reduction payments will mute the effect of the mandate penalty repeal.

Second, the stickiness of insurance status means that some people who purchased insurance because of the mandate will maintain their coverage even when the mandate penalty is repealed. That is, because of the status quo bias, people tend to leave things as they are.<sup>108</sup> Some people who purchased policies because of the mandate will keep their coverage even after the

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105. DEP'T HEALTH & HUMAN SERVS., CTR. FOR MEDICARE & MEDICAID SERVS., FIRST HALF OF 2018 AVERAGE EFFECTUATED ENROLLMENT DATA, at 3 (2018), <https://www.cms.gov/sites/default/files/2018-11/11-28-2018%20Effectuated%20Enrollment%20Table.pdf> [<https://perma.cc/C397-AQ6E>].

106. Brief for Bipartisan Economic Scholars, *supra* note 93, at 2–3.

107. Sara R. Collins & Munira Z. Gunja, *Premium Tax Credits Are the Individual Market's Stabilizing Force*, THE COMMONWEALTH FUND (Aug. 15, 2018), <https://www.commonwealthfund.org/blog/2018/premium-tax-credits-are-individual-markets-stabilizing-force> [<https://perma.cc/WTM8-3Q2B>]. See generally Steven Findlay, *Health Insurance Costs Crushing Many People Who Don't Get Federal Subsidies*, KHN (Dec. 14, 2018), <https://khn.org/news/health-insurance-costs-crushing-many-people-who-dont-get-federal-subsidies/> [<https://perma.cc/2NN8-JZNG>].

108. See additional discussion of status quo bias *infra* Part III.B.1.

mandate is repealed. This is even more likely because of auto-reenrollment. If an individual signed up for a policy on the Exchange, that individual is automatically re-enrolled each year unless she affirmatively opts out.<sup>109</sup> Also, the fact that the mandate still exists as a matter of law may encourage some people to continue to comply, even absent any penalty mechanism.<sup>110</sup>

Third, there are other ACA mechanisms that encourage enrollment and will continue to positively impact insurance rates even in a post-mandate world. For instance, allowing children to stay on their parents' plans until they turn twenty-six will mean that some young and healthy people will continue to be insured. And changes requiring that coverage be more comprehensive, including that it cover essential health benefits, will encourage some to maintain their policies.

Nonetheless, there is little question that uninsured numbers will rise and that premiums will as well. It is not a matter of *whether* these problems will manifest at all, it is just a matter of degree.<sup>111</sup>

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109. Jennifer Bresnick, *CMS Mulls End of Auto-Reenrollment, Silver Loading in ACA Market*, HEALTH PAYER INTELLIGENCE (Jan. 18, 2019), <https://healthpayerintelligence.com/news/cms-mulls-end-of-auto-reenrollment-silver-loading-in-aca-market> [<https://perma.cc/F53Q-Z8W6>] (“Currently, any consumer who does not notify his or her plan of any changes will have their existing coverage automatically renewed during the open enrollment period. Close to two million Americans were re-enrolled in their plans for 2019 coverage.”). CMS is presently seeking public comment on a plan to end the re-enrollment procedure. See DEP’T HEALTH & HUMAN SERVS., CTR. FOR MEDICARE & MEDICAID SERVS., PATIENT PROTECTION AND AFFORDABLE CARE ACT; HHS NOTICE OF BENEFIT AND PAYMENT (2019) <https://www.govinfo.gov/content/pkg/FR-2019-01-24/pdf/2019-00077.pdf> [<https://perma.cc/QTL9-RY3B>].

110. Propitious selection, where the risk averse over-insure, may be another stabilizing force on insurance markets. See, e.g., Tsvetanka Karagyozeva & Peter Siegelman, *Can Propitious Selection Stabilize Insurance Markets?*, 35 J. INS. ISSUES 131 (2012).

111. Joseph R. Antos & James C. Capretta, *CBO’s Revised View of Individual Mandate Reflected in Latest Forecast*, HEALTH AFF. BLOG (June 7, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180605.966625/full/> [<https://perma.cc/UH26-CLRE>] (citing CBO’s new forecast on number of uninsured after ACA repeal fell from thirteen million to only slightly more than eight million annually). But see Daniel W. Sacks et al., *Does the Individual Mandate Affect Insurance Coverage? Evidence from the Population of Tax Returns*, NAT’L BUREAU ECON. RES. [https://conference.nber.org/conf\\_papers/f120008.pdf](https://conference.nber.org/conf_papers/f120008.pdf) [<https://perma.cc/W555-YJPY>] (“[Y]oung people, men, and people without markers of serious health problems are all especially responsive.”).

#### D. THE BROADER PROBLEM OF UNINSURED

The repeal of the individual mandate is not the only cause for concern when it comes to high rates of uninsured Americans. The uninsured problem has been pervasive in the U.S. system and even if the ACA still existed intact, with both the individual mandate and a 50-state Medicaid expansion, it would not have completely solved the problem.<sup>112</sup>

High rates of uninsured are problematic not just for the individual market-based reasons discussed in the prior Section. The uninsured also cause adverse spillover effects. And being uninsured leads to worse health outcomes for those individuals who face real difficulties in accessing care.

##### 1. The Adverse Spillover Effects

Concern about premium increases is serious, but it is not the only negative market consequence of higher rates of uninsured. While young and healthy individuals may assume that their health expenditures will be limited, the nature of health care spending is that it is unpredictable.

Prior to the ACA, the problem of young invincibles who suddenly found themselves less than invincible was oft-discussed.<sup>113</sup>

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112. It is worth mentioning that the original ACA not only contained an individual mandate penalty, but it also envisioned a fifty-state expansion of Medicaid. After *NFIB v. Sebelius* made Medicaid expansion optional, many individuals who live in non-expansion states who would have obtained coverage through Medicaid became counted among the uninsured. See 567 U.S. 519, 545–55 (2012). Nonetheless, the ACA was never a model for universal coverage and always required individuals to make the decision to enroll in an insurance policy.

113. See Munira Z. Gunja et al., *Young Adults Will Be Among the Last-Minute ACA Enrollees This Week: How Have the Coverage Expansions Affected Them?*, COMMONWEALTH FUND (Dec. 12, 2017) <https://www.commonwealthfund.org/blog/2017/young-adults-will-be-among-last-minute-aca-enrollees-week-how-have-coverage-expansions> [https://perma.cc/9P26-G6GQ]; Erin Hemlin, *What's Happened to Millennials Since the ACA? Unprecedented Coverage & Improved Access to Benefits*, YOUNG INVINCIBLES (Apr. 2017), <http://younginvincibles.org/wp-content/uploads/2017/05/YI-Health-Care-Brief-2017.pdf> [https://perma.cc/33K7-DXS7]; Bisundev Mahato et al., *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update*, COMMONWEALTH FUND (May 1, 2018), [https://www.commonwealthfund.org/publications/fund-reports/2008/may/rite-passage-why-young-adults-become-uninsured-and-how-new?redirect\\_source=/publications/reports/2008/may/rite-passage-why-young-adults-become-uninsured-and-how-new-policies](https://www.commonwealthfund.org/publications/fund-reports/2008/may/rite-passage-why-young-adults-become-uninsured-and-how-new?redirect_source=/publications/reports/2008/may/rite-passage-why-young-adults-become-uninsured-and-how-new-policies) [https://perma.cc/DNR5-9DX5].

These stories are often tragic—the twenty-seven-year-old who is in a serious car accident or the thirty-year-old unexpectedly diagnosed with cancer. These individuals who lack insurance frequently wait to seek care until they are very ill, at which point care is more expensive.<sup>114</sup> Many present in emergency rooms and consume care at a high cost that they cannot afford to pay. These costs are ultimately born by the insured population and the government.<sup>115</sup> They are negative externalities not internalized by the uninsured, but by the system more generally. As uninsured rates increase, these adverse spillover effects increase as well.<sup>116</sup>

## 2. The Health Risk of Being Uninsured

High rates of uninsurance is also concerning because it is tied to increased difficulties accessing quality health care.<sup>117</sup> In many studies, including a seminal one conducted by the Insti-

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114. See Margot Sanger-Katz, *Getting Sick Can Be Really Expensive, Even for the Insured*, N.Y. TIMES (Mar. 21, 2018), <https://www.nytimes.com/2018/03/21/upshot/getting-sick-is-really-expensive.html>; Anna Wilde Mathews & Louise Radnofsky, *Health Care's Bipartisan Problem: The Sick Are Expensive and Someone Has to Pay*, WALL ST. J. (Jan. 12, 2017), <https://www.wsj.com/articles/health-cares-bipartisan-problem-the-sick-are-expensive-and-someone-has-to-pay-1484234963>.

115. Ricardo Alonso-Zaldivar, *How Much Do Health Insurance Subsidies Cost Taxpayers?*, INS. J. (Dec. 19, 2016), <https://www.insurancejournal.com/news/national/2016/12/19/435878.htm> [<https://perma.cc/VA3M-2KFL>]; Maureen Groppe, *Who Pays When Someone Without Insurance Shows Up in the ER?*, USA TODAY (July 3, 2017), <https://www.usatoday.com/story/news/politics/2017/07/03/who-pays-when-someone-without-insurance-shows-up-er/445756001/> [<https://perma.cc/XZ2N-549H>].

116. See *How ACA Repeal and Replace Proposals Could Affect Coverage and Premiums for Older Adults and Have Spillover Effects for Medicare*, KAISER FAM. FOUND. (June 5, 2017), <https://www.kff.org/health-reform/issue-brief/how-aca-repeal-and-replace-proposals-could-affect-coverage-and-premiums-for-older-adults-and-have-spillover-effects-for-medicare/> [<https://perma.cc/ZYH7-7PZ6>]; Julie Rovner, *An Increase in the Uninsured Could Impact the Insured, Too*, GOVERNING (July 17, 2017), <http://www.governing.com/topics/health-human-services/khn-uninsured-insured-spillover.html> [<https://perma.cc/E9HR-RYWM>].

117. See Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1890 (2011) (describing the “Health Promotion” model of health insurance).

tute of Medicine, uninsured individuals have been found to experience worse health outcomes.<sup>118</sup> The reasons might be obvious. Uninsured patients often cannot access medical care outside of an emergency room.<sup>119</sup> And even then, emergency departments are not required to treat uninsured patients unless they are having a medical emergency.<sup>120</sup> Uninsured individuals receive less preventive care, and even if they can access care, they often delay it until their health condition has worsened.<sup>121</sup> In general, uninsured patients have more unmet health needs.<sup>122</sup> Even Medicaid, which is often criticized for offering a lower quality of care than private insurance or Medicare, is connected with significantly improved health outcomes when compared to having no insurance at all.<sup>123</sup>

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118. INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 116 (2009); Erin Schumaker, *7 Things That Will Happen if 14 Million More People Are Uninsured Next Year*, HUFFINGTON POST (May 30, 2017), [https://www.huffpost.com/entry/health-care-bill-consequences-2018\\_n\\_592d92f5e4b0065b20b873b7](https://www.huffpost.com/entry/health-care-bill-consequences-2018_n_592d92f5e4b0065b20b873b7) [<https://perma.cc/KQ8C-8VCB>].

119. See David Doyle, *Emergency Rooms Continue to Serve as Patients' Primary-care Provider*, MOD. MED. (Mar. 8, 2013), <https://www.physicianspractice.com/blog/emergency-rooms-continue-serve-patients-primary-care-provider> [<https://perma.cc/5FZC-8VES>]; *Nearly Half of US Medical Care Comes from Emergency Rooms*, SCI. DAILY (Oct. 17, 2017), <https://www.sciencedaily.com/releases/2017/10/171017091849.htm> [<https://perma.cc/LA44-P6P5>]; Elizabeth Pratt, *Why Do So Many People Still Go to the Emergency Room?*, HEALTHLINE (Nov. 7, 2017), <https://www.healthline.com/health-news/medical-care-in-emergency-rooms#4> [<https://perma.cc/CC3G-WKXS>].

120. Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (2011).

121. See Lydia Saad, *Delaying Care a Healthcare Strategy for Three in 10 Americans*, GALLUP (Dec. 17, 2018), <https://news.gallup.com/poll/245486/delaying-care-healthcare-strategy-three-americans.aspx> [<https://perma.cc/NU86-LXXY>].

122. Lynn M. Olson et al., *Children in the United States with Discontinuous Health Insurance Coverage*, 353 NEW ENG. J. MED. 382, 382 (2005).

123. A recent large-scale, randomized, controlled trial suggested that being on Medicaid increases health care use, reduces financial strain, and substantially improves self-reported health relative to being uninsured. Katherine Bickler & Amy Finkelstein, *The Effects of Medicaid Coverage—Learning from the Oregon Experiment*, 365 NEW ENG. J. MED. 683, 684 (2011); see also Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011), <https://doi.org/papers/w17190.pdf> [<https://perma.cc/94NS-7S5G>]. Some studies, however, have found that access to health insurance most improves mental and financial well-being, but not necessarily physical health.

If nothing is done to address the increase in the uninsured population, we can expect to see health outcomes worsen.<sup>124</sup>

### III. DETERRENTS TO HEALTH INSURANCE PURCHASE: THE ROLE OF ECONOMIC THEORY AND ITS LIMITATIONS

To address the uninsured problem and mitigate the negative repercussions of the mandate penalty repeal, it is imperative to examine alternate ways to prompt individuals, and particularly healthy individuals, to purchase insurance.<sup>125</sup> But designing and evaluating alternatives first requires a better understanding of the impediments to enrollment.<sup>126</sup>

This Part explores the neoclassical economic deterrents to enrollment—why it is in the rational self-interest of some *not* to enroll. But it also describes the limits of economic theory in explaining individual decision-making. It surveys some of the relevant findings of behavioral economics, which provides a long list of reasons that people do not purchase health insurance policies even if it *would* be in their rational self-interest to do so.

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124. This Part highlights just some of the negative implications of repeal of the mandate. There are certain to be others. Consider, for instance, the likely reduction in jobs and economic growth that the repeal will cause. See JOSH BIVENS, ECON. POL'Y INST., *REPEALING THE AFFORDABLE CARE ACT WOULD COST JOBS IN EVERY STATE*, 1 (2017).

125. This Part assumes that universal health care in the form of “Medicare for All” or a similar plan will not be implemented in the short-term. Even the most optimistic proponents of such plans envision a lengthy period of transition during which the problem of uninsureds will still need to be addressed.

126. There are other entirely different schemes that may mitigate the repercussions of the repeal of the mandate, but this article assumes that major changes to current law, while possible, are not likely to be imminent. Sara R. Collins et al., *A Roadmap to Health Insurance for All: Principles for Reform*, COMMONWEALTH FUND (2007), [https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_fund\\_report\\_2007\\_oct\\_a\\_roadmap\\_to\\_health\\_insurance\\_for\\_all\\_principles\\_for\\_reform\\_collins\\_roadmaphtinsforall\\_1066\\_pdf.pdf](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2007_oct_a_roadmap_to_health_insurance_for_all_principles_for_reform_collins_roadmaphtinsforall_1066_pdf.pdf) [https://perma.cc/UXL4-8B39]. States are also passing state-level mandates. Dana Palanker et al., *State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers*, COMMONWEALTH FUND (June 14, 2018), <https://www.commonwealthfund.org/blog/2018/state-efforts-pass-individual-mandate-requirements-aim-stabilize-markets-and-protect> [https://perma.cc/33TR-ZBML].

## A. NEOCLASSICAL ECONOMICS

In a recent survey of uninsured nonelderly adults that queried why individuals lacked health insurance, the most popular answer was: “cost is too high.”<sup>127</sup> Although the survey did not further parse this response, the cost deterrent likely means either one of two things: (1) premiums are unaffordable or (2) individuals have made a calculation that the cost of a policy is too high relative to the predicted benefit.

First, there is strong evidence that many individuals quite simply cannot afford health insurance premiums.<sup>128</sup> They are faced with choices like paying for housing, paying down loans, or buying health insurance. And they choose—although arguably it is hardly a choice—not to purchase insurance. Those who cannot afford premiums are more likely to be young. Just as an example, on the individual market, an average “silver” plan in Cheyenne, Wyoming costs \$9,600 in premiums per year.<sup>129</sup> In Richmond, Virginia, it is \$6,000 per year.<sup>130</sup> While the ACA tax subsidies help make insurance more affordable for many Americans,<sup>131</sup> costs can still be prohibitive. This is particularly the case for individuals who fall into the “coverage gap” because their states chose not to expand Medicaid.<sup>132</sup>

The coverage gap occurs because the ACA was drafted to provide all individuals living below 138% of the federal poverty

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127. See *supra* note 11; see also *supra* note 4 (citing a poll taken by 45% of the population).

128. The costs given are approximated. They are derived by taking the “Second Lowest Silver Cost Plan” for 2019 and multiplying by twelve for the year for the respective cities. Katherine Baicker et al., *Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics*, 90 MILBANK Q. 107, 110 (2012), (“The evidence suggests that the principal problem is affordability.”).

129. Rabal Kamal et al., *2019 Premium Changes on ACA Exchanges*, KAISER FAM. FOUND. (Oct. 11, 2018), <https://www.kff.org/health-costs/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/> [<https://perma.cc/3P6Y-XELJ>].

130. *Id.*

131. See Elizabeth Davis, *How the ACA Health Insurance Subsidy Works*, VERYWELL HEALTH (Dec. 24, 2018), <https://www.verywellhealth.com/how-the-health-insurance-subsidy-works-1738915> [<https://perma.cc/D5ZD-4LT7>].

132. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Mar. 21, 2019), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/> [<https://perma.cc/NQ9E-Y7BQ>].

level with access to Medicaid.<sup>133</sup> Therefore, it only provides subsidies for those making between 138% and 400% of the federal poverty level. Individuals who make below 138% of the federal poverty level, and who do not qualify for Medicaid, do not have access to subsidies.<sup>134</sup> Indeed, many people who live in non-expansion states and make below 138% of the federal poverty level do not have access to Medicaid.<sup>135</sup> Most state Medicaid plans do not cover healthy adults at all, and for those that do, coverage generally only applies for individuals who make far less than 138% of the federal poverty level.<sup>136</sup> The vast majority of these coverage gap individuals cannot afford to buy a health insurance policy and still pay for necessities like food and shelter. Perhaps it is unsurprising that around two-thirds of the uninsured make a below-median income.<sup>137</sup>

Not all of the respondents who cite cost concerns as the reason to not purchase insurance truly cannot afford it. They nonetheless view cost as the primary deterrent to purchasing a policy because the cost is too high relative to their expected benefit from the policy. This reason is particularly salient for the population insurers most desire to enroll—the young and healthy.<sup>138</sup>

The classical assumptions of traditional economic theory are that rational individuals will make choices in their own self-interests, seeking to maximize their own utility or the satisfaction that they derive from an outcome.<sup>139</sup> There are significant limits to applying traditional economic theory in health care, discussed in more detail below. And yet as a starting point, it can help to explain when individuals will choose to buy health insurance and when they will forego it.

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133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, at 26 (2011).

138. Consider, as well, that young people of limited benefits might become Medicaid-eligible if they get sick. And they can always access emergency department care in the case of a true emergency. *See, e.g.*, 42 U.S.C. § 1395dd (although EMTALA does not forgive the duty to pay for care).

139. *See, e.g.*, Richard A. Posner, *Theories of Economic Regulation*, 5 BELL J. ECON. & MGMT. SCI. 335, 343 (1974).



Health insurance is a mechanism for spreading financial risk in the face of uncertainty.<sup>140</sup> An individual deciding whether or not to buy insurance does not know what health costs he or she will incur during the term of a policy. Indeed, if one could easily calculate that insurance would cost \$6,000 in premiums in a year, but that the individual would incur \$15,000 in health care costs, that person would buy the insurance policy every time. Or on the flip side, if a policy costs \$6,000 in premiums, and an individual knew that she would only incur \$1,000 in out-of-pocket costs absent a policy, that individual would never buy the policy.<sup>141</sup>

Some individuals do know with a greater degree of certainty what their health care costs will look like than others. For instance, patients who suffer from chronic conditions may know with higher certainty that their health costs will be high. But a currently healthy middle-age person might have a very hard time predicting her health costs. For the most part, all one can usually do is estimate the likelihood of various states of health and the attendant costs. Insurance exists precisely because an individual cannot know with certainty what his or her costs will be.

Further complicating matters, individuals have different degrees of risk tolerance. A risk-averse person might choose to pay \$6,000 in premiums even if there is a high likelihood that her health costs will be less, while an individual with a higher risk

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140. See AARP PUB. POLICY INST., BEYOND AGE RATING: SPREADING RISK IN HEALTH INSURANCE MARKETS (2009), <https://assets.aarp.org/rgcenter/ppi/health-care/i35-age-rating.pdf> [<https://perma.cc/V3B9-JXZ9>]; Douglas M. McIntyre, *Risk Selection, Risk Sharing, and Policy*, in EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 167, 200 (Marilyn J. Field & Harold T. Shapiro eds., 1993).

141. And these examples ignore the transaction costs in enrollment, which also figure into an individual's decision. See *supra* note 128, at 111. There is a cost associated with researching, applying for, and dealing with the general administration of having a health plan. Transaction costs may further impact insurance enrollment decisions. See, e.g., KETCHUM & LAKE RES. PARTNERS, INFORMING CHIP AND MEDICAID OUTREACH AND EDUCATION, CMS REPORT (2011); JENNIFER P. STUBER ET AL., GEO. WASH. U. MED. CTR., BEYOND STIGMA: WHAT BARRIERS ACTUALLY AFFECT THE DECISIONS OF LOW-INCOME FAMILIES TO ENROLL IN MEDICAID? (2000), [https://hsrc.himmelfarb.gwu.edu/sphhs\\_policy\\_briefs/53](https://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/53) [<https://perma.cc/AF6X-8M7J>].

tolerance might choose to forego insurance in an otherwise identical scenario.<sup>142</sup>

In general, though, economic theory suggests that when there are several possible outcomes, and the chance of those outcomes varies, an individual's decision can be modeled using the expected utility model of choice under risk.<sup>143</sup> Under expected utility theory, an individual determines her utility for each possible outcome and then weights those outcomes by the likelihood that the outcome will occur. An individual will then select the choice with the highest weighted utility, subject to risk tolerance.<sup>144</sup>

The next Section will discuss why individuals are imperfect at these calculations. There is much they do not understand in the technical world of health insurance and they often make choices that are against their own stated preferences.<sup>145</sup> But for purposes of standard economic theory, the role of prices and information in determining coverage is paramount.<sup>146</sup> And at least some individuals *do* seem to decide whether or not to purchase

142. See generally Matthew Rabin, *Risk Aversion and Expected-Utility Theory: A Calibration Theorem*, 68 *ECONOMETRICA* 1281 (2000).

143. Bob Clemen, *Assessing Risk Tolerance*, 23 *DECISION ANALYSIS* 4, 4 (2004); James Chen, *Expected Utility*, *INVESTOPEDIA* (Apr. 26, 2019), <https://www.investopedia.com/terms/e/expectedutility.asp> [<https://perma.cc/UEM7-L27V>].

144. Nathan Berg & Gerd Gigerenzer, *As-If Behavioral Economics: Neoclassical Economics in Disguise?*, (Munich Personal RepEc Archive, Paper No. 26586, 2010), [https://mpra.ub.uni-muenchen.de/26586/1/MPRA\\_paper\\_26586.pdf](https://mpra.ub.uni-muenchen.de/26586/1/MPRA_paper_26586.pdf) [<https://perma.cc/C8RD-PVAF>]; see also Clemen, *supra* note 143. Expected utility theory is an account of how to choose rationally when you are not sure which outcome will result from your acts. Its basic slogan is: choose the act with the highest expected utility. M. SUSAN MARQUIS & MARTIN R. HOLMER, *RAND, CHOICE UNDER UNCERTAINTY AND THE DEMAND FOR HEALTH INSURANCE* (1986), <https://www.rand.org/content/dam/rand/pubs/notes/2007/N2516.pdf> [<https://perma.cc/SVC3-DVVU>]; Ray Briggs, *Normative Theories of Rational Choice: Expected Utility*, *STAN. ENCYCLOPEDIA OF PHIL.* (Aug. 8, 2014), <https://plato.stanford.edu/entries/rationality-normative-utility/> [<https://perma.cc/P3H8-Z2CL>].

145. See, e.g., Hoffman, *supra* note 16 (summarizing the large body of literature suggesting that patients do not act as neoclassical economics would predict).

146. See Maximiliane Hoerl et al., *Knowledge as a Predictor of Insurance Coverage Under the Affordable Care Act*, 55 *MED. CARE* 428, 430 (2017); *Knowledge About Health Insurance and Finance Linked to Higher Rates of Health Coverage*, *RAND* (Nov. 17, 2016), <https://www.rand.org/news/press/2016/11/17/index1.html> [<https://perma.cc/NTW8-LRQD>].

health insurance based on a straightforward economic analysis.<sup>147</sup>

A young healthy person calculating her weighted expected utility subject to risk tolerance may very well make the rational decision to not purchase insurance. This is particularly likely as premiums increase relative to a young person's relatively low expected health costs.<sup>148</sup> While society may have an interest in using insurance as a mechanism to redistribute income to sicker or poorer populations, it is not in the self-interest of individuals to subsidize the care of others.<sup>149</sup> Historically, when private goals have differed from broader social goals (like the desire for people to be insured), purchases have been made more attractive through various means. Part IV will suggest some ways to combat the cost objection to policy purchase. But first, the next Section explores reasons *other than cost* that individuals might choose not to purchase insurance, even when it might be in their rational self-interest to enroll.

## B. BEHAVIORAL ECONOMICS

Standard economic theory assumes that rational individuals make perfect decisions in their own self-interests, but insights from behavioral economics explain that people are only boundedly rational and self-interested.<sup>150</sup>

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147. See, e.g., David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 26 (2001) ("[T]he evidence is fairly clear that potential subscribers approach coverage decisions in traditional economic terms.").

148. "According to the U.S. Census, 55 percent of Americans without health insurance are under the age of 35. 72 percent are under the age of 45. It's these generally healthy people, in the first halves of their lives, who elect to go without insurance, because it is far too expensive, relative to their current health status." Avik Roy, *Putting the 'Insurance' Back in Health Insurance*, Forbes (May 21, 2012), <https://www.forbes.com/sites/theapothecary/2012/05/21/putting-the-insurance-back-in-health-insurance/#4143f9e86a4a> [<https://perma.cc/P6WU-EYB4>].

149. Of course, this is why the ACA included the individual mandate in the first place. Other mechanisms have also been used to try to make insurance purchase more financially attractive, including the use of tax incentives and employer subsidizing of costs. HOWARD C. KUNREUTHER ET AL., INSURANCE AND BEHAVIORAL ECONOMICS: IMPROVING DECISIONS IN THE MOST MISUNDERSTOOD INDUSTRY 4 (2013).

150. See Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CAL.

Numerous studies confirm that people have difficulty making the kinds of perfect decisions envisioned by neoclassical economics.<sup>151</sup> In many ways, health insurance is the poster child for behavioral economics because, as many have demonstrated, people are particularly likely to make poor decisions when it comes to matters of both health insurance and health care more broadly.<sup>152</sup> They do not really understand the choices and tradeoffs they are being asked to make in deciding between health plan options.<sup>153</sup> Principle-agent problems pervade the process because others (including employers) strongly influence the choices they are given.<sup>154</sup> Consumers lack the stable preferences that the law assumes they will draw upon in making decisions, and they suffer from a number of systematic decision-making biases.<sup>155</sup> “Difficulties are particularly likely when individuals are faced with decisions that involve uncertainty, tradeoffs between current and future costs and benefits, or significant complexity”<sup>156</sup>—all of which apply to the health insurance scenario.

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L. REV. 1051, 1054–55 (2000); Cass R. Sunstein, *Introduction* to BEHAVIORAL LAW AND ECONOMICS 1 (Cass R. Sunstein ed., 2000). *See generally* HERBERT A. SIMON, *MODELS OF MAN: SOCIAL AND RATIONAL* (1957) (containing mathematical essays on societal effects and rational human behavior).

151. *See* DANIEL KAHNEMAN & AMOS TVERSKY, *THE FRAMING OF DECISIONS AND THE RATIONALITY OF CHOICE* (1980) [hereinafter KAHNEMAN & TVERSKY, *FRAMING OF DECISIONS*]; *see also* Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 *ECONOMETRICA* 263 (1979) [hereinafter Kahneman & Tversky, *Prospect Theory*]. *See generally* Herbert A. Simon, *A Behavioral Model of Rational Choice*, 69 *Q.J. ECON* 99 (1955) (discussing “an ‘economic man,’ who, in the course of being ‘economic’ is also ‘rational’”).

152. *See, e.g.*, Jeffrey Liebman & Richard Zeckhauser, *Simple Humans, Complex Insurance, Subtle Subsidies*, in *USING TAXES TO REFORM HEALTH INSURANCE: PITFALLS AND PROMISES* 230, 232 (Henry J. Aaron & Leonard E. Burman eds., 2008); *see also* Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid’s Failure*, 90 *CORNELL L. REV.* 705, 719–22 (2005).

153. *See* Hoffman, *supra* note 16.

154. *Id.*

155. Wendy Netter Epstein, *Nudging Patient Decision-Making*, 92 *WASH. L. REV.* 1255 (2017).

156. *Lessons for Health Care from Behavioral Economics*, NBER (Oct. 7, 2019), <https://www.nber.org/aginghealth/2008no4/w14330.html> [<https://perma.cc/8RLA-MZZR>]; *see* Baicker et al., *supra* note 128, at 8 (“But while prices and information are undeniably key factors for understanding and achieving socially optimal health insurance coverage, they alone seem insufficient to explain observed patterns of coverage. There is mounting evidence that a third factor, the

There is strong evidence that people turn down policies even when they are affordable<sup>157</sup> and even when the expected utility model of choice under risk suggests that individuals should purchase policies.<sup>158</sup> For instance, many people do not sign up for Medicaid or other public benefits even if it would be virtually free to enroll.<sup>159</sup> Likewise, many people with access to subsidies that cover almost the entire price of the policy still do not sign up for a plan.<sup>160</sup>

So while prices and information are undeniably key factors in understanding insurance uptake, this Section explores various other reasons that individuals choose not to purchase insurance.

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psychology of individual decision making, plays a central role in driving coverage outcomes.”).

157. Baicker et al., *supra* note 128, at 113 (“Evidence suggests that the policies available are in fact affordable to many who turn them down, with estimates suggesting that policies are affordable to between 25 and 75 percent of the uninsured . . . . Even among households with incomes of \$75,000 or more, 8 percent of individuals are uninsured, and these people represent nearly 20 percent of the uninsured.”); *see also* M. Kate Bundorf & Mark V. Pauly, *Is Health Insurance Affordable for the Uninsured?* 25 J. HEALTH ECON. 650 (2006) (investigating the meaning of affordability in the context of health insurance); Helen Levy & Thomas DeLeire, *What Do People Buy When They Don't Buy Health Insurance and What Does That Say About Why They are Uninsured?* 45 INQUIRY 365 (2008) (comparing “household spending on different goods by insured versus uninsured households”). *See generally* DeNavas-Walt et al., *supra* note 137 (presenting data on income poverty, and health insurance coverage in the United States).

158. *See* Eric J. Johnson et al., *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture*, 8 PLOS ONE e81521 (2013) (finding that consumers chose the objectively better plan only half the time).

159. *See, e.g.*, Baicker et al., *supra* note 128, at 110 (“[O]f the nearly 7 million children lacking health insurance, approximately 65 percent are estimated to be eligible for Medicaid, CHIP, or both.”(citing GENEVIEVE M. KENNEY ET AL., GAINS FOR CHILDREN: INCREASED PARTICIPATION IN MEDICAID AND CHIP IN 2009 (2011))).

160. *See* Rachel Fehr et al., *How Many of the Uninsured Can Purchase a Marketplace Plan for Free?*, KAISER FAM. FOUND. (Dec. 11, 2018), <https://www.kff.org/health-reform/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free/> [<https://perma.cc/W7AC-9FHJ>]. The Medicaid anomaly might be explained by a philosophical protest to public benefits, but that seems less likely to be a rationale for refusing private, subsidized insurance.

## 1. Status Quo Bias

The status quo bias refers to the fact that people often prefer to leave things as they are—in other words, to stick with the *status quo*.<sup>161</sup> This bias has been demonstrated by extensive experimentation.<sup>162</sup> Perhaps the most famous example of the status quo bias, or inertia bias as it is sometimes called, concerns rates of organ donation, where rates vary tremendously between opt-in and opt-out regimes.<sup>163</sup> A difference in preferences does not explain the disparity. Rather, people just tend to stick with the default or to maintain the decision that has already been made.<sup>164</sup> Similar results have been confirmed in other contexts,

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161. Epstein, *supra* note 155, at 1294 (citing Eric J. Johnson & Daniel Goldstein, *Do Defaults Save Lives?*, 302 *SCI.* 1338, 1339 (2003)); *see also* Omri Ben-Shahar & John A. E. Pottow, *On the Stickiness of Default Rules*, 33 *FLA. ST. U. L. REV.* 651, 655 (2006) (reviewing the literature finding that individuals are biased to “stick” with the status quo).

162. *See, e.g.*, Katrin Burmeister & Christian Schade, *Are Entrepreneurs’ Decisions More Biased? An Experimental Investigation of the Susceptibility to Status Quo Bias*, 22 *J. BUS. VENTURING* 340 (2007) (finding “a status quo bias when investigating why pregnant women prefer the care they receive compared to other methods of care”); Raymond S. Hartman et al., *Consumer Rationality and the Status Quo*, 106 *Q.J. ECON.* 141 (1991) (finding electric power consumers to be status quo biased by studying decision behavior); Eric J. Johnson et al., *Framing, Probability Distortions, and Insurance Decisions*, 7 *J. RISK & UNCERTAINTY* 35 (1993) (studying the status quo manipulations on the choice of an insurance policy); Maureen Porter & Sally Macintyre, *What Is, Must Be Best: A Research Note on Conservative Or Deferential Responses to Antenatal Care Provision*, 19 *SOC. SCI. & MED.* 1197 (1984); Mercé Roca et al., *Ambiguity Seeking As a Result of the Status Quo Bias*, 32 *J. RISK & UNCERTAINTY* 175 (finding the status quo bias might even reduce most individuals’ aversion to ambiguity when the ambiguous option is the status quo); William Samuelson & Richard Zeckhauser, *Status Quo Bias in Decision Making*, 1 *J. RISK & UNCERTAINTY* 7 (1988).

163. *See* Johnson & Goldstein, *supra* note 161; *see also* Richard H. Thaler, *Opting in vs. Opting Out*, *N.Y. TIMES* (Sept. 26, 2009), <https://www.nytimes.com/2009/09/27/business/economy/27view.html> [<https://perma.cc/UE2F-SV4C>].

164. Samuelson & Zeckhauser, *supra* note 162, at 8.

including enrollment in retirement plans<sup>165</sup> and the choice to use green energy.<sup>166</sup>

There are various hypotheses about what drives the status quo bias. It might be laziness or an opposition to change.<sup>167</sup> Or people might defer to the policymaker who chose the default in the first place.<sup>168</sup>

As to health insurance, the default is generally *not* to have a policy.<sup>169</sup> Individuals have to go to quite a lot of effort to sign up—obtain information on policies, compare the options, deal with the administrative hurdles of actually applying, and so forth.<sup>170</sup> These burdens are disproportionately high for those living in poverty for whom the time and effort required to access health insurance can truly be an impediment.<sup>171</sup> In general, the

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165. John Beshears et al., *Public Policy and Saving for Retirement: The Autosave Features of the Pension Protection Act of 2006*, in BETTER LIVING THROUGH ECONOMICS 274, 287 (John J. Siegfried ed., 2010) (finding clear evidence that automatic enrollment increased savings and financial well-being); Alexander Kempf & Stefan Ruenzi, *Status Quo Bias and the Number of Alternatives: An Empirical Illustration from the Mutual Fund Industry*, 7 J. BEHAV. FIN. 204 (2006); see also, e.g., Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior* (Nat'l Bureau of Econ. Res., Working Paper No. 7682, 2000), <https://doi.org/10.3386/w7682> [<https://perma.cc/EJ5C-D945>] (finding that employers' retirement savings plan defaults shape employees' enrollment decisions).

166. Daniel Pichert & Konstantinos V. Katsikopoulos, *Green Defaults: Information Presentation and Pro-Environmental Behaviour*, 28 J. ENVTL. PSYCHOL. 63, 67–69 (2008) (discussing the results of a study offering participants the choice between two suppliers—one default, the other alternative—which showed sixty-eight percent of participants chose the default supplier).

167. See Dylan Walsh, *The Power of Doing Nothing*, STAN. BUS. (Jan. 22, 2018), <https://www.gsb.stanford.edu/insights/power-doing-nothing> [<https://perma.cc/P7QV-TJJA>]; see also Baraka Kambi, *Status Quo Bias: Is it Human Habit to Prefer the Current Situation and Abhor Changes?*, 4 RES. HUMAN & SOC. SCI. 1, 3 (2014).

168. See JASON CAMPBELL ET AL., SOC'Y OF ACTUARIES, MODELING OF POLICYHOLDER BEHAVIOR FOR LIFE INSURANCE AND ANNUITY PRODUCTS, (2014).

169. *But see supra* Part II.D (discussing re-enrollment on the Exchange).

170. See, e.g., *Ways to Apply For 2019 Health Insurance*, HEALTHCARE.GOV, <https://www.healthcare.gov/apply-and-enroll/how-to-apply/> [<https://perma.cc/W6AZ-FNM4>].

171. Shanoor Seervai, *It's Harder for People Living in Poverty to Get Health Care*, COMMONWEALTH FUND (Apr. 19, 2019), <https://www.commonwealthfund.org/publications/podcast/2019/apr/its-harder-for-people-living-poverty-to-get-health-care> [<https://perma.cc/7CGF-2J9U>].

status quo bias suggests that some people might not sign up for insurance because *not* having insurance is the default choice.<sup>172</sup>

The status quo bias has been shown to be stronger in certain contexts,<sup>173</sup> but studies have confirmed the existence of the status quo bias in health insurance.<sup>174</sup> The high coverage rate for employer-sponsored insurance has been explained, in part, by a preference for the status quo.<sup>175</sup> The choice of the default is therefore very important to decision-making.<sup>176</sup>

## 2. Misperception of Risk and Optimism Bias

Individuals make systematic mistakes in evaluating probabilities and assessing the true risk of an outcome.<sup>177</sup> These difficulties with probabilities likely impact health insurance purchase decisions.<sup>178</sup> Individuals tend to give too much weight to events that are unlikely to occur (like a plane crash) and too little weight to high probability outcomes.<sup>179</sup> And people tend to be overly optimistic when it comes to their assessment of risk.<sup>180</sup>

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172. Skinner & Volpp, *supra* note 97 (discussing the inertia bias in health care).

173. See Samuelson & Zeckhauser, *supra* note 162 (finding the more options that were included in the choice set, the stronger the relative bias for the status quo based on the survey results).

174. *Id.*; Benjamin R. Handel, *Adverse Selection and Switching Costs in Health Insurance Markets: When Nudging Hurts* (Nat'l Bureau of Econ. Res., Working Paper No. 17459, 2011), <https://doi.org/10.3386/w17459> [<https://perma.cc/29CS-DVEW>].

175. Baicker et al., *supra* note 128, at 119 (“[T]he relatively high coverage rates for employer-sponsored insurance are likely due in part to such factors.”).

176. *Id.* (“[T]he main consequence for take-up is to reinforce the power of the institutional features that determine the status quo.”).

177. Liebman & Zeckhauser, *supra* note 152, at 4–5.

178. Johnson et al., *supra* note 162, at 36; Liebman & Zeckhauser, *supra* note 152, at 4–5.

179. Kahneman & Tversky, *Prospect Theory*, *supra* note 151, at 286. These may point in different directions for insurance decisions. Concern over low-probability events may cause over-insurance, whereas too little concern over high-probability ones may result in under-insurance. The latter seems likely to be more pervasive. Susan K. Laury et al., *Insurance Decisions for Low-Probability Losses*, 39 J. RISK & UNCERTAINTY 17 (2009).

180. See Baker & Siegelman, *supra* note 15, at 79 (describing the operation of the optimism bias in the same context); see also Neil D. Weinstein, *Unrealistic Optimism About Future Life Events*, 39 J. PERSONALITY & SOC. PSYCHOL. 806 (1980) (explaining that people discount the likelihood of adverse outcomes).



For instance, people believe that they are less likely to be affected than their peers by poor health outcomes from asthma, drug addiction, and lung cancer, even when it is not true.<sup>181</sup> This phenomenon is referred to as the optimism bias.<sup>182</sup>

A related bias is the illusion of control bias—people believe they have more control over outcomes than they do in reality.<sup>183</sup> Consider the individual who believes she will not need to access the health care system because she eats healthy and exercises regularly. She may be overly optimistic about her chances of staying in good health, particularly when there is a significant degree of chance involved.

While many young and healthy people might be making welfare-enhancing decisions in not purchasing insurance, many actually would be better off *with* insurance, but choose not to purchase it because they are overly optimistic about their prospects of staying healthy. According to the U.S. Census, fifty-five percent of Americans without health insurance are under the age of thirty-five.<sup>184</sup> Many may be overly optimistic about their prospects of staying healthy and not needing insurance. Young people may believe that by paying premiums, they are really just throwing away money because there is such a small likelihood that they will need it—even if that is not an accurate assessment of their risk.<sup>185</sup>

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181. See Derek E. Bambauer, *Shopping Badly: Cognitive Biases, Communications, and the Fallacy of the Marketplace of Ideas*, 77 U. COLO. L. REV. 649, 709 (2006).

182. See Baker & Siegelman, *supra* note 15, at 468–69 (surveying evidence that young people in particular do not purchase health insurance because of optimism bias, resulting in the moniker “young invincibles”).

183. *How the Illusion of Control Bias Impacts Investing*, HIT INVESTMENTS, <https://www.hitinvestments.com/illusion-of-control/> [<https://perma.cc/PF5P-5U74>]. Ramon Salinas, *There's a Reason Why You Have Coverage and Your Buddy Doesn't: Cognitive Bias and the Insurance Market*, FIN. SERV. (Apr. 16, 2018), <https://www.continuuminnovation.com/en/how-we-think/article/theres-a-reason-why-you-have-coverage-and-your-buddy-doesnt> [<https://perma.cc/V3LA-FNGZ>] (“Probably the most predominant of optimistic biases is a misguided tendency to overestimate one’s capacity to influence the outcome of certain events.”).

184. See U.S. CENSUS BUREAU, *supra* note 12.

185. Another related bias is the anecdotal fallacy. People give greater weight to their knowledge of isolated examples, particularly when those examples are negative. Stories of insurers not paying claims despite individuals having paid

### 3. Hyperbolic Discounting and Regret Bias

Time-inconsistent preferences also likely affect insurance decision-making. Hyperbolic discounting refers to the tendency for people to choose immediate gratification over longer-term benefits, even when the longer-term benefits will be greater.<sup>186</sup> Young people are particularly susceptible to this bias.<sup>187</sup> Indeed, it is a common problem when it comes to prompting individuals to receive preventive health care, which requires some inconvenience and possibly pain or discomfort in the near-term in exchange for the prospect of avoiding an illness that one may or may not develop in the future.<sup>188</sup> Regret-aversion bias refers to the related concern that people fear that they will later regret a decision that they make in the present.<sup>189</sup> People therefore tend to avoid making decisions.<sup>190</sup>

The nature of insurance requires people to part with their money now based on the prospect that they might incur health care expenses later. Parting with premiums in the present is more painful than having to pay health care costs later. When

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premiums, for instance, are rare. But an individual who gives that story disproportionate weight because of their personal knowledge of it might choose not to purchase insurance for that reason.

186. David Laibson, *Golden Eggs and Hyperbolic Discounting*, 112 Q.J. ECON. 443 (1997); see Baicker et al., *supra* note 128, at 117 (“People sometimes postpone activities with immediate costs and tend to give too much weight to losses and gains in the present versus similar losses and gains in the future. This type of present-biased preference implies that people will delay incurring costs even if doing so will reduce their welfare in the long run.”).

187. See RICHARD H. THALER, *THE WINNER’S CURSE* 93–94 (1992); Cass R. Sunstein, *Lives, Life-Years, and Willingness to Pay*, 104 COLUM. L. REV. 205, 252 (2004).

188. Ateev Mehrotra et al., *Impact of a Patient Incentive Program on Receipt of Preventive Care*, 20 AM. J. MANAGED CARE 494, 495 (2014) (“When making the choice to receive preventive care, patients balance the inconvenience of receiving preventive care with distant and often intangible benefits. Humans generally discount such future benefits and therefore it may not be surprising that many patients do not seek preventive care.”).

189. See *The Behavioral Biases of Individuals*, FIN. STROKES, <http://www.financestrokes.com/wp-content/uploads/2012/12/The-Behavioral-Biases-of-Individuals.pdf> [<https://perma.cc/Y4XB-827L>] (“Regret-aversion bias is an emotional bias in which people tend to avoid making decisions that will result in action out of fear that the decision will turn out poorly.”); see also Nafez Al Tarik, *Regret Aversion Bias*, PROF. FIN. STUD., <https://www.pfsbd.net/regret-aversion-bias/> [<https://perma.cc/546U-6UUH>].

190. See *The Behavioral Biases of Individuals*, *supra* note 189.

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this is coupled with the fact that consumers will avoid making a choice if they fear it will be a bad one, individuals may choose not to purchase insurance even if it would be in their rational self-interest to do so. Individuals' underweighting of future benefits is an important component of insurance decision-making.<sup>191</sup>

#### 4. Framing Effect

The decision about whether or not to buy insurance may also be subject to the framing effect. While traditional economic theory assumes that people have stable preferences and make decisions with reference to those preferences, studies have shown that individual preferences may indeed not be stable.<sup>192</sup> Rather, results differ when identical decision choices are simply framed differently.

For instance, in a famous study, Amos Tversky and Daniel Kahneman offered participants two identical choices.<sup>193</sup> But they framed one choice as saving 200 lives (out of 600 lives) and the other as allowing 400 people to die.<sup>194</sup> Seventy-two percent of people chose the option that was framed in the positive (saving 200 lives) while only fifty percent of people made the same choice with the negative framing (400 people will die).<sup>195</sup>

Consideration might be given to how the choice to purchase an insurance policy is framed and what effect that frame might have on individual decision-making. In fact, the framing of the individual mandate as a penalty—people must purchase insurance to avoid a penalty—conjures a negative framing.<sup>196</sup> This framing might have impacted take-up of insurance even when the mandate was in effect.

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191. This bias is also sometimes referred to as "present bias." Jason Abaluck & Jonathan Gruber, *Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*, 101 AM. ECON. REV. 1180 (2011).

192. See generally KAHNEMAN & TVERSKY, FRAMING OF DECISIONS, *supra* note 151.

193. *Id.*

194. *Id.* at 3–4.

195. *Id.*

196. See *Affordable Care Act Tax Penalty Calculator*, MED. MUTUAL, <https://www.medmutual.com/for-individuals-and-families/health-insurance-education/health-insurance-basics/penalty-estimator.aspx> [https://perma.cc/TF7X-2UCG].

## 5. Choice Overload and Complexity

Finally, while it was traditionally assumed that more choices were always preferable to fewer ones, studies have now shown that individuals actually suffer from choice overload.<sup>197</sup> That is, when too many choices are offered, individuals will become overwhelmed and will refrain from making the choice at all.<sup>198</sup>

Again, the retirement plan context is illustrative. There, a study found that the more retirement plan options an employer provided, the greater the likelihood was that the employee would choose no plan at all.<sup>199</sup>

In general, there is much evidence that when individuals are given too many choices, they decide not to make purchases.<sup>200</sup>

Complexity is a related problem. The more complex and therefore overwhelming a decision, the more an individual pre-

197. See Chernev et al., *Choice Overload: A Conceptual Review and Meta-Analysis*, J. CONSUMER PSYCHOL. 333–58 (2015).

198. BARRY SCHWARTZ, THE PARADOX OF CHOICE — WHY MORE IS LESS (2004); Benjamin Scheibehenne et al., *Can There Ever Be Too Many Options? A Meta-Analytic Review of Choice Overload*, 37 J. CONSUMER RES. 409 (2010); Steve Chapman, *The Return of Old-Fashioned Paternalism: Will Limiting Our Choices Save Us From Ourselves?*, REASON (Aug. 7, 2008), <https://www.reason.com/2008/08/07/the-return-of-old-fashioned-pa> [<https://perma.cc/Q9ZJ-MG49>].

199. Sheena Sethi-Iyengar et al., *How Much Choice is Too Much? Contributions to 401(k) Retirement Plans*, in PENSION DESIGN AND STRUCTURE: NEW LESSONS FROM BEHAVIORAL FINANCE 83–95 (Olivia S. Mitchell & Stephen P. Utkus eds., 2004).

200. See, e.g., Tori DeAngelis, *Too Many Choices?*, 35 MONITOR ON PSYCHOL. 56, 56 (2004) (“[T]oo many choices can overwhelm us to the point where we choose nothing at all.”); Barry Schwartz, *More Isn’t Always Better*, 84 HARV. BUS. REV. June 2006, at 22 (“Research now shows that there can be too much choice; when there is, consumers are less likely to buy anything at all.”); Amos Tversky & Eldar Shafir, *Choice Under Conflict: The Dynamics of Deferred Decision*, 3 PSYCHOL. SCI. 358, 358 (1992) (arguing that “people are more likely to defer choice when conflict [i.e. differing options] is high than when it is low”). But see Jesse Marczyk, *Is Choice Overload a Real Thing?*, PSYCHOL. TODAY (Feb. 5, 2016), <https://www.psychologytoday.com/us/blog/pop-psych/201602/is-choice-overload-real-thing> [<https://perma.cc/MC4N-U6UU>] (arguing that recent studies “cast doubt on the phenomenon” of “choice overload as being a real thing”).

fers not to have to make the decision—and the poorer the decision-making process if the individual does choose to participate.<sup>201</sup>

Choice of a health plan is a complex endeavor, even with the ACA's attempts to simplify the process.<sup>202</sup> Aside from the standard decision inputs of premium cost and risk of certain health outcomes, choosing a policy requires an understanding of a complicated list of benefits. Individuals must understand the terms “deductible,” “co-pay,” “co-insurance,” “out-of-pocket maximum,” and must be able to understand the import of in-network and out-of-network care.<sup>203</sup> An individual's preferred provider may be in-network on one plan but out-of-network on another. Certain policies may cover particular pharmaceuticals that others do not.<sup>204</sup> And the list of decision inputs goes on. The process of actually applying for benefits can also be complicated.<sup>205</sup>

While there has been limited study of this issue in the context of health insurance specifically,<sup>206</sup> it is not hard to imagine

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201. See Liebman & Zeckhauser, *supra* note 152, at 237–39 (“[C]onsumers have trouble making wise decisions when faced with such complex consumption choices.”); cf. *The Importance of The Decision Making Process*, EVERYDAY HEALTH, <https://www.everydayhealth.com/neurology/importance-decision-making-process/> [<https://perma.cc/KFF5-LTYR>] (last updated Nov. 15, 2017) (advocating step-by-step, reasoned decision making).

202. See, e.g., *The ‘Metal’ Categories: Bronze, Silver, Gold & Platinum*, HEALTHCARE.GOV, <https://www.healthcare.gov/choose-a-plan/plans-categories/> [<https://perma.cc/94WY-AVYL>] (detailing the robustness of the differing healthcare policies by classifying them as “metals” (bronze, silver, gold, or platinum)).

203. See *Health Insurance Basics: The 101 Guide to Health Insurance*, POLICYGENIUS, <https://www.policygenius.com/health-insurance/learn/health-insurance-basics-and-guide/>, [<https://perma.cc/4BPC-PT5H>].

204. See Elissa Suh, *Why Prescription Drug Coverage Matters*, POLICYGENIUS (Aug. 13, 2019), <https://www.policygenius.com/health-insurance/prescription-drug-coverage/> [<https://perma.cc/V35B-927N>].

205. See, e.g., KETCHUM & LAKE RESOURCE PARTNERS, *supra* note 141, at 11–13 (detailing barriers to Medicaid and CHIP access); Anna Aizer, *Public Health Insurance, Program Take-Up, and Child Health*, 89 REV. ECON. & STAT. 400, 412 (2007) (conducting empirical study relating to Medicaid barriers); see also Baicker et al., *supra* note 128, at 111 (“For example, lengthy applications and complex eligibility rules appear to depress enrollment in Medicaid, and assistance with enrollment can improve participation.”); Stuber et al., *supra* note 141, at 18 (identifying barriers and confusions hindering Medicaid enrollment).

206. For some of the limited examples available linking choice overload theory to health insurance, see Jennifer L. Matjasko et al., *Applying Behavioral*

how choice overload and complexity may depress rates of insurance enrollment.

With these reasons why individuals choose not to purchase health insurance in mind, the next Part proposes a menu of private law solutions intended to address purchase deterrents.

#### IV. SURVEY OF SOLUTIONS

Policymakers seeking to change consumer behavior generally have two options: command-and-control regulation<sup>207</sup> or the use of incentives or “nudges” to make choices more attractive to consumers.<sup>208</sup> Given the backlash against the mandate as being too coercive—even though it might be more properly categorized as an incentive—this final Part surveys ways to increase insurance uptake in the vein of incentives and nudges. These solutions are largely ones that insurers could implement with limited government intervention.<sup>209</sup> They are alternative methods

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*Economics to Public Health Policy: Illustrative Examples and Promising Directions*, 50 AM. J. PREVENTIVE MED. S13, S15, S17 (2016) (advocating for “nudges” that reduce choice selection for “markets such as . . . health insurance in which choices are numerous, complex, and hard to compare”); J. Michael McWilliams et al., *Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making*, 30 HEALTH AFF. 1786, 1786 (2011) (finding that Medicare Advantage enrollment rates initially increased with a number of plan options, but fell after passing a threshold); see also Salinas, *supra* note 183, at 2 (identifying “a series of cognitive biases” and “why people choose, over and over, not to pay for insurance”).

207. See Daniel Schweppenstedde et al., *Regulating Quality and Safety of Health and Social Care: International Experiences*, 4 RAND HEALTH Q. 1 (2014), ncbi.nlm.nih.gov/pmc/articles/pmc5051969 [https://perma.cc/6FNB-WCF7] (“Command and control: implies direct enforcement by government (eg licensing professionals and facilities, enforcing performance standards).”).

208. See RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH AND HAPPINESS* 4–6 (2008) (describing a nudge as something that “alters people’s behavior in a predictable way without . . . significantly changing their economic incentives”); Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1161–62 (2003) (describing “libertarian paternalism” as a system that “steer[s] people’s choices in directions that will improve the choosers’ own welfare” without choosing for them with “nudges”). Taxation may be considered a third category of policymaking options. See, Brian Galle, *Tax, Command . . . or Nudge?: Evaluating the New Regulation*, 92 TEX. L. REV. 837, 841–42 (2014) (distinguishing nudges, even when made by taxing, from traditional regulation through tax).

209. See, e.g., Andrew G. Simpson, *9 Alternatives to Individual Health Insurance Mandate; Will They Work?*, INS. J. (Mar. 29, 2011), https://www

to prompt insurance enrollment in a world with no mandate<sup>210</sup> and without universal coverage, and they address several of the barriers to enrollment described in Part III.<sup>211</sup>

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.insurancejournal.com/news/national/2011/03/29/192080.htm [https://perma.cc/6C3N-ZZ2R] (“Most experts . . . agree that if the mandate is stripped from the law, then an alternative method or combination of methods to expand coverage will be needed if the rest of the healthcare reform is to work.”).

210. Only one post-ACA policy proposal has gained any significant traction as a mandate alternative—the “continuous coverage” proposal. See *The Future of U.S. Health Care: Replace or Revise the Affordable Care Act*, RAND HEALTH CARE, <https://www.rand.org/health-care/key-topics/health-policy/in-depth.html> [https://perma.cc/G5JA-9RK7] (outlining the “continuous coverage” proposal); see also U.S. DEP’T OF HEALTH & HUMAN SERVS., U.S. DEP’T OF THE TREASURY & U.S. DEP’T OF LABOR, REFORMING AMERICA’S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION (2018), <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf> [https://perma.cc/ER6W-DUCH] (arguing for “better value through choice and competition”). The basic premise of the proposal is that individuals have to be continuously insured without a significant break in coverage. See RAND HEALTH CARE, *supra*. If they are, then the protections in the ACA of guaranteed issue and community rating continue to apply. See *id.* Depending on the version of the proposal, lapses could justify insurance companies in denying coverage entirely or in charging significantly higher rates. See American Health Care Act of 2017, H.R. 1628, 115th Cong. § 133 (2017) (passed by the House of Representatives on May 5, 2017, but failed to pass in the Senate); see also Leigh Ann Caldwell, *Obamacare Repeal Fails: Three GOP Senators Rebel in 49–51 Vote*, NBC NEWS (July 28, 2017, 12:45 AM), <https://www.nbcnews.com/politics/congress/senat-gop-effort-repeal-obamacare-fails-n787311> [https://perma.cc/5F3X-8M5N]. One problem is that the proposal penalizes individuals for the decision to reenroll and not the decision to let their insurance lapse in the first place. See RAND HEALTH CARE, *supra*. While continuous coverage may deter lapses, it more strongly deters individuals from purchasing insurance if they have lapsed, when it would be more desirable to encourage reenrollment as soon as possible.

211. See *supra* Part III. Prior to the ACA, Paul Starr proposed an interesting legislative alternative to the mandate. See Paul Starr, *The Opt-Out Compromise: How to Let Individuals Out of the Insurance Mandate and Improve the Odds of Health-Care Reform*, AM. PROSPECT (Mar. 9, 2010), <https://prospect.org/article/opt-out-compromise-0> [https://perma.cc/EWP9-KPBF] (describing a two-part system that first “let[s] people opt out of the new insurance system if they sign a form on their tax return waiving their right to federal health-insurance subsidies for a fixed period—five years. The second part of the proposal is to raise the annual penalties for those of the uninsured who want to keep open the possibility of buying coverage at any time”). One more possibility worth mentioning is the adoption of individual mandates by some states. See *Study: State-Level Individual Mandates Would Reduce Number of Uninsured by Nearly 4 Million in 2019; Health Plan Premiums Would Fall 12 Percent*, COMMONWEALTH FUND (July 18, 2018), <https://www.commonwealthfund.org/press>

This Part starts first with a discussion of insurer-focused solutions such as offering new products that might be attractive to younger and healthier policyholders: low introductory rate, long-term insurance contracts; return of premium-style policies; further simplified plan offerings; and experimenting with a generosity frame for insurance purchases. It then moves on to a discussion of the automatic enrollment option. No one option is the silver bullet that will turn our market-based system into one of universal coverage. But particularly if used in combination, or targeted correctly based on an individual's reason for being uninsured, they may significantly improve upon the status quo.

A. PREDATORY TO SALUTARY: CO-OPTING PREVIOUSLY MALICIOUS PRACTICES FOR GOOD

One of the important reasons that young, healthy people currently do not buy policies is because premium rates are too high relative to their predicted expenses (or too high generally).<sup>212</sup> Although there is always risk that a young and healthy person may have an unexpected change in health status that would cause significantly higher than predicted expenses, for most people in this risk category, they *will* be paying more than their fair actuarial share.<sup>213</sup> This reality is hard to counteract because it requires individuals to make decisions (at least seemingly) against personal interest.<sup>214</sup> However, for ACA markets to work, healthy individuals must enroll in policies.<sup>215</sup> And there is broader societal benefit to enrolling larger numbers of these individuals. Arguably, there is also individual benefit in a healthy person having insurance in that it protects against the parade of

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-release/2018/study-state-level-individual-mandates-would-reduce-number-uninsured-nearly-4 [https://perma.cc/RPN9-JNAC] (arguing that other states would benefit by mimicking Massachusetts and New Jersey's health insurance mandates); see also Shane Hoffman, Comment, *Individual Mandates, Take Two: Incentivizing State-Based Individual Health Insurance Mandates Under the Spending Power*, 2011 WIS. L. REV. 827, 829 (suggesting conditioning Medicaid funding on state adoption of an individual mandate).

212. See Rivkin Jr., *supra* note 10, at 94.

213. *Id.*

214. However, the reason that insurance exists in the first place is that it is near impossible to know in advance who will need the insurance and who will not.

215. See *supra* notes 95–98 and accompanying text.



horribles that ensues should they unexpectedly incur high medical costs.<sup>216</sup>

This first proposal suggests looking to industry practices that have successfully prompted consumers to make decisions against interest: offering low introductory rates and then locking consumers into long-term contracts with limited exit rights. These commercial practices work in part because they exploit known consumer biases.

Consider a ten-year policy with a low introductory rate that applies for the first three years, with a schedule of reasonable rate increases pre-disclosed for years four through ten.<sup>217</sup> Low introductory rates have proven enticing to consumers, in part because of hyperbolic discounting.<sup>218</sup> In studies where it would be more financially advantageous for individuals to choose a constant rate, they have nonetheless chosen an option with a lower introductory rate that later increases, even when it results in them paying more over the life of the policy.<sup>219</sup> This may be be-

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216. See *supra* Part II.C.3.

217. A five-year policy is also worth considering.

218. Consider, for example, how cable companies successfully encourage sign up by offering special discounts at the start. See, e.g., *You May Be Qualified to Save More on Your Cable Bill*, TECH., <https://www.inmyarea.com/resources/cable-tv/cable-provider-discounts-might-not-know> [<https://perma.cc/4PB4-SSFJ>] (“Cable TV providers are constantly coming out with new deals and promotions to bring in more customers. Just turn on the TV, open a newspaper, or simply visit their website, and you’ll find ads for different packages at reduced prices.”).

219. See, e.g., Patrick M. Corrigan, “Abusive” Acts and Practices: Dodd-Frank’s Behaviorally Informed Authority over Consumer Credit Markets and Its Application to Teaser Rates, 18 N.Y.U. J. LEGIS. & PUB. POL’Y 125, 170–74 (2015) (describing Shui & Ausubel’s credit card study to show “that consumers misunderstand the teaser rate offers” (citing Haiyan Shui & Lawrence M. Ausubel, *Time Inconsistency in the Credit Card Market* (Jan. 30, 2005) (unpublished manuscript), <http://www.ausubel.com/creditcard-papers/time-inconsistency-credit-card-market.pdf> [<https://perma.cc/3EGT-RZMU>])); see also GREGORY ELLIEHAUSEN, FED. RESERVE BD. & GEO. WASH. UNIV., IMPLICATIONS OF BEHAVIORAL RESEARCH FOR THE USE AND REGULATION OF CONSUMER CREDIT PRODUCTS 2 (2010), <https://www.federalreserve.gov/pubs/feds/2010/201025/201025pap.pdf> [<https://perma.cc/J6CP-JBYD>] (“Consumers simplify, take shortcuts, and use heuristics, which may not always be optimal.”).

cause of calculation difficulties or it may be simply because consumers prefer the lower price now (instant gratification) even if they know that it means a higher price down the road.<sup>220</sup>

Actuarially, a low introductory price model might be designed to be equivalent to a single, higher rate averaged over ten years, but it is more attractive to consumers framed as a low-entry rate with pre-disclosed, planned rate increases.<sup>221</sup> This pricing scheme also has the advantage of likely better mapping onto ability to pay over time, particularly as individuals move from their twenties into their thirties. Therefore it addresses not only hyperbolic discounting but also affordability issues.

Many industries have previously designed contracts that exploit the hyperbolic discounting phenomenon—consider subprime mortgages that offered low initial rates that increased over time or consumer credit cards that draw in customers with promises of low introductory rates that later increase.<sup>222</sup> Generally, regulators have viewed such “traps” unfavorably as consumer irrationality regarding these products has led to both individual and societal harms.<sup>223</sup> The subprime mortgage crisis can be explained, in part, by consumers being enticed to get

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220. Genevieve Selden, *Time Inconsistency*, INTELLIGENT ECONOMIST, <https://www.intelligenteconomist.com/time-inconsistency/> [<https://perma.cc/K9TC-7DZS>] (last updated May 3, 2019) (“Decision-makers are often biased toward their present selves and thus put a greater weight on the choice that will currently benefit them. Those people discount the benefits of choices increasingly with time . . . [T]hey put less . . . weight on the benefits of a choice the farther out into the future that choice gets.”).

221. See *supra* notes 219–20 and accompanying text.

222. See, e.g., Oren Bar-Gill & Omri Ben-Shahar, *Exit from Contract*, 6 J. LEGAL ANALYSIS 151, 151–52 (2014) (describing “longstanding concern about possible abuse in consumer contracts”).

223. See, e.g., *CFPB Finalizes Rule to Stop Payday Debt Traps*, CONSUMER FIN. PROT. BUREAU (Oct. 5, 2017), <https://www.consumerfinance.gov/about-us/newsroom/cfpb-finalizes-rule-stop-payday-debt-traps/> [<https://perma.cc/N558-B49K>]; Oren Bar-Gill, *Seduction by Plastic*, 98 NW. U. L. REV. 1373, 1375 (2004) [hereinafter Bar-Gill, *Seduction*] (describing consumer irrationality or, as Bar-Gill says, “imperfect self-control”); Oren Bar-Gill, *The Law, Economics and Psychology of Subprime Mortgage Contracts*, 94 CORNELL L. REV. 1073 (2009) [hereinafter Bar-Gill, *Subprime Mortgage*] (“[T]he welfare loss to borrowers [from the subprime mortgage crisis]—substantial in itself—is compounded by much broader social costs.”).

mortgages that they could not afford when rates later ballooned.<sup>224</sup>

But the problem in those scenarios is that consumer biases led to bad outcomes, both as an individual matter and as a matter of public good. In fact, the mechanism was quite successful at achieving its commercial purposes.<sup>225</sup> Here, in the case of health insurance, a low introductory rate, when combined with clear disclosure of subsequent rates, may serve an important, *positive* purpose.<sup>226</sup> In addition to exploiting hyperbolic discounting to prompt sign-up, it has the added consumer benefit of locking in a rate when rate increases can otherwise be unpredictable year-to-year. The mechanism of low introductory rates is still deployed in many commercial contexts. Cable companies, for instance, still routinely use this tactic to bring in new customers.<sup>227</sup>

A long-term insurance contract with a lock-in mechanism—such as an early termination penalty—is essential to the model.<sup>228</sup> An early termination fee would deter early exit, with certain necessary exceptions such as for people who move outside the state or obtain employer-sponsored insurance.<sup>229</sup> Without a lock-in penalty, consumers could take advantage of low

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224. See Bar-Gill, *Subprime Mortgage*, *supra* note 223, at 1079 (“[T]he design of these [subprime mortgage] contracts can be explained as a rational market response to the imperfect rationality of borrowers.”).

225. *Id.* at 1130 n.198 (“The success of such advertising proves the imperfect information, imperfect rationality of borrowers, or both.”).

226. Consider the incentives with life insurance—if you sign up early, you get a lower price. See Zack Sigel, *Life Insurance Rates By Age*, POLICYGENIUS (Sept. 18, 2019), <https://www.policygenius.com/life-insurance/life-insurance-rates-by-age/> [<https://perma.cc/XXM4-L669>] (noting that if you sign up early for life insurance, you get a lower rate). Life insurance has nonetheless had difficulty attracting younger policyholders. See, e.g., Volker Meier, *Why the Young Do Not Buy Long-Term Care Insurance*, 18 J. RISK & UNCERTAINTY 83 (1999).

227. See *supra* note 218.

228. Other countries use lock-in systems like this. For instance, it is common in Switzerland to sign five-year contracts that cannot be broken unless the insured moves out of the country. See Avik Roy, *Why Switzerland Has the World's Best Health Care System*, FORBES: APOTHECARY (Apr. 29, 2011), <https://www.forbes.com/sites/theapothecary/2011/04/29/why-switzerland-has-the-worlds-best-health-care-system/#3c9274a67d74> [<https://perma.cc/4PD3-B5PW>].

229. There might be some gaming of the system at the margins by people who purposely move to get out of a contract. If people obtain employer insurance to get out of a contract, though, on the whole that would be a good outcome.

prices and then move to a different insurer before prices go up.<sup>230</sup> And insurers would have to price policies higher to account for this possibility. Lock-in mitigates these problems, allowing insurers to plan on most insureds staying with the plan for its full length.

Both longer-term contracts and lock-in would be a departure from the industry norm, and arguably from the law. Currently, policies are written for single, calendar years.<sup>231</sup> The ACA is structured so that there is a yearly “open enrollment period,” where insurers sell policies for a “benefit year,”<sup>232</sup> which is defined as “a calendar year for which a health plan provides coverage for health benefits.”<sup>233</sup> Nothing in federal law seems to require yearly contracts for employer-sponsored insurance. Nonetheless, there would be a strong industry norm to overcome, with annual open enrollment periods being typical of employer markets. The historical reason for one-year policies is likely that it allows insurers to adjust rates year-to-year in response to actual costs and that costs can be difficult to predict over longer time horizons.<sup>234</sup> From the consumer perspective, one-year policies are good because they foster competition. An insurer understands the possibility of insureds switching carriers at the end of the term and must (theoretically) deliver good service to prompt re-enrollment.

But longer-term policies with lock-in also have a number of important advantages to consider over one-year plans.<sup>235</sup> Per-

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230. See Bar-Gill & Ben-Shahar, *supra* note 222, at 153 (describing business luring away customers with special rates).

231. An exception being so-called “short-term” insurance plans currently favored by the Trump Administration. See Andrew M. Harris & John Tozzi, *Trump Win on Health Plans Advances Effort to Undo Obamacare*, BLOOMBERG (July 19, 2019), <https://www.bloomberg.com/news/articles/2019-07-19/trump-s-short-term-health-insurance-rule-survives-lawsuit> [<https://perma.cc/7QC7-F93D>].

232. 45 CFR § 155.410(e) (2018).

233. *Id.* § 155.20 (2018).

234. Cf. Neil A. Doherty & James R. Garven, *Insurance Cycles: Interest Rates and the Capacity Constraint Model*, 68 J. Bus. 383, 383, 395 n.19 (1995) (discussing the annual insurance writing process). This was even more important when insurance companies could use information learned about the policyholder in the prior year to adjust rates, which is no longer possible with community rating. See *supra* note 36 and accompanying text.

235. Guaranteed-renewable insurance is another option, however, it is not

haps most importantly, they give the insurer an incentive to prioritize an insured's long-term health. Now, insurers know the insured may be another carrier's problem the next year.<sup>236</sup> The insurer's incentive with a one-year contract is to focus only on short-term health, not long-term health.<sup>237</sup> And from an insurer perspective, long-term policies address the problem that people will buy flood insurance right after a flood but let it lapse if they do not experience a flood for a few years.<sup>238</sup> A longer-term contract, simply speaking, guarantees customers for longer periods.

There are nonetheless challenges to this model. Longer-term policies mean less competition and perhaps lower quality

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as helpful as long-term policies because consumers can still leave early, so insurers would still need to set rates higher to account for that possibility. See Roy, *supra* note 148 (“[F]orcing insurers to cover everyone with pre-existing conditions drives premiums upward. If you know you can buy insurance after you’re sick, you have every incentive to drop out of the system now, and wait until you’re sick to buy.”).

236. *Id.* (“Under a five-year contract, the insurer has a much greater incentive to make sure you stay healthy, because it will be more liable for the bills if your health deteriorates. One-year contracts, on the other hand, incentivize an insurer to simply hope that you don’t get sick, with little eye to the long term.”). Short-term insurance contracts, for example, are a contributing factor to the opioid crisis. See Joy Stephenson-Laws, *Payors Share Responsibility for the Opioid Epidemic*, BUS. L. TODAY, (Oct. 18, 2018), <https://businesslawtoday.org/2018/10/payors-share-responsibility-opioid-epidemic/> [<https://perma.cc/V6EV-N799>].

237. See, e.g., John H. Cochrane, *Time-Consistent Health Insurance*, 103 J. POL. ECON. 445, 447 (1995) (“But suppose that the consumer gets a long-term illness. He is now a long-term liability of the insurer, so the insurer has a strong incentive to get rid of him.”). There is a vast literature discussing the problem of insurer incentives in short-term contracts. See, e.g., Alain C. Enthoven et al., *Going Dutch — Managed-Competition Health Insurance in the Netherlands*, 357 NEW ENG. J. MED. 2421 (2007); John H. Goddeeris, *Insurance and Incentives for Innovation in Medical Care*, 51 S. ECON. J. 530 (1984); George Loewenstein et al., *Behavioral Economics Holds Potential to Deliver Better Results for Patients, Insurers, and Employers*, 32 HEALTH AFF. 1244 (2013); James C. Robinson, *Payment Mechanisms, Nonprice Incentives, and Organizational Innovation in Health Care*, 30 INQUIRY 328 (1993); Harold Schmidt et al., *Carrots, Sticks, and Health Care Reform — Problems with Wellness Initiatives*, 362 NEW ENG. J. MED. E3(1) (2010); Kevin G. Volpp et al., *Redesigning Employee Health Incentives — Lessons from Behavioral Economics*, 365 NEW ENG. J. MED. 388 (2011).

238. See Daniel Schwarcz & Peter Siegelman, *Law and Economics of Insurance*, in 2 THE OXFORD HANDBOOK OF LAW AND ECONOMICS 481, 490–91 (Francesco Parisi ed., 2017).

of service.<sup>239</sup> But this problem may be limited in a world where interests are, to a degree, aligned. The insured wants coverage to stay healthy, and the insurer also benefits from keeping insureds healthy and therefore lowering longer-term claims costs.

Lock-in contracts also come with their own challenges and have typically been criticized because they reduce competition and consumer choice.<sup>240</sup> The reaction against cell phone companies that used to offer “free” phones in exchange for customers committing to a contract with an early termination fee is instructive.<sup>241</sup> But as Omri Ben-Shahar and Oren Bar-Gill note, early termination fees (ETFs) are not *necessarily* bad for consumers. They explain:

ETFs are part of lock-in contracts, in which consumers enjoy up-front discounts and sellers assume up-front losses. There is no a-priori reason to think that higher up-front prices and lower ETFs are better, for consumers, than lower up-front prices and higher ETFs. And it is misguided to argue that back-end ETFs overcompensate sellers, without considering the up-front discounts that cut into sellers’ profits.<sup>242</sup>

There might be valid reasons that a consumer might freely choose a lock-in option, for instance in order to get a lower rate. The biggest concern is that consumers might fail to see the trade-offs in agreeing to a long-term contract with limited exit rights. But this *concern* leads to people being insured for ten-year periods (or even three-year periods), and on that basis, it might be less objectionable.

Some other challenges merit note, but are not insurmountable. For instance, consumers may view the individual market

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239. See Bar-Gill, *Seduction*, *supra* note 223, at 1401 n.130, 1430 (“Competition is powerless in fighting lock-in.”).

240. See Xingzhu Liu et al., *Contracting for Primary Health Services: Evidence on Its Effects and a Framework for Evaluation*, PHRPLUS 7–8 (2004), <https://www.who.int/management/resources/finances/ContractingPrimaryHealthServicesEvidence.pdf> [<https://perma.cc/2K55-XKP4>] (“[T]he pitfalls critics have cited” include that “[t]he health sector has high asset specificity, which creates conditions and incentives for parties to act opportunistically . . . . Providers have a strong interest in seeing their contracts renewed, and purchasers may be locked into an unsatisfactory contract[] . . . particularly if there are no alternative choices.”). This might be a deterrent to sign-up that the low introductory rate would have to counteract.

241. Bar-Gill & Ben-Shahar, *supra* note 222, at 164 n.12 (describing “bill shock” of cell phone early termination fee plans: “nearly half of cell phone users . . . do not know the amount of fees they are accountable for”).

242. *Id.* at 155.

as transitional—somewhere to get insured temporarily while hoping to again get an employer-sponsored policy. Ultimately it is an empirical question how many consumers would be interested in a long-term plan, but the growth of the gig economy and of independent contractor-type positions suggests that there may be considerable demand. Another challenge is that it will be difficult for insurers to accurately estimate costs over a longer-term policy rather than a shorter-term one, and they may be tempted to inflate prices because of uncertainty. To deal with future uncertainty, insurers might set premiums quite high in the later years of the 10-year term. But it can be done. The long-term care insurance market, for instance, while rarely touted as a success story, has settled into more stable rates after an initial period of much volatility.<sup>243</sup> Also, the switch from an actuarial fairness model to community rating that has already occurred under the ACA makes the rate-setting process simpler. And if a ten-year policy is too long a time horizon, a five-year policy might be more palatable.

Another important hurdle to insurers experimenting with an offering like this, however, is the changes that might be required to the ACA, which now only allows insurers to charge younger insureds one-third the price of older insureds, and which seems to require plans that cover a one-year benefit period.<sup>244</sup> However, given that a low-rate, long-term plan with a

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243. See Cheryl W. Munk, *What You Need to Know About Hybrid Long-Term-Care Insurance*, WALL ST. J. REP.: RETIREMENT (Nov. 20, 2018), <https://www.wsj.com/articles/what-you-need-to-know-about-hybrid-long-term-care-insurance-1542645000> [<https://perma.cc/BM4J-8JPA>] (describing the long-term-care market as “roiled by huge premium increases on policies priced several years ago,” but also noting that hybrid policies, which have grown more popular recently, “have been more stable over time”). Nonetheless, the long-term care market is rarely considered a model of success as rates continue to be high relative to perceived value. See *id.*

244. See Hoffman, *supra* note 45, at 65–67 (“[T]he Health Reform Law [] allows older insured to be charged 3 times as much as younger insured.”). Others have suggested that younger people would be better off just getting catastrophic coverage, which is the lowest-priced. See, e.g., Aly Keller, *Everything You Need to Know About Catastrophic Health Insurance*, STRIDE (Nov. 30, 2018), <https://blog.stridehealth.com/post/everything-about-catastrophic-health-insurance> [<https://perma.cc/P5JL-7LW6>] (“If you’re young and healthy, you may find it hard to justify the cost of health insurance . . . . That’s where catastrophic health insurance comes in.”). But catastrophic coverage is very unsat-

termination fee might address affordability concerns by taking advantage of time inconsistent preferences, it is worth further exploration.<sup>245</sup>

#### B. RETURN OF PREMIUM POLICIES

Another possibility addresses the optimism bias problem by borrowing a product idea from the life insurance sphere. Some life insurance companies sell “return of premium” term life insurance.<sup>246</sup> The idea is that many young people are hesitant to purchase term life insurance. Statistically, a young person’s chances of dying in a typical life insurance term of fifteen to thirty years are low. People worry that they are just throwing away their money in buying a policy, even though rates are appropriately lower for younger, and therefore lower-risk, people.<sup>247</sup> Alternatively, although risk of death is low probability, the consequences of early death for surviving loved ones can be very high.

Life insurance companies designed a product intended to address these concerns.<sup>248</sup> Individuals agree to pay higher than average premiums for a policy. In exchange, if they are still living at the end of the term, the insurance company agrees to return the premiums the individual has paid. The insurance company

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isfying for young people looking to feel like they have gotten something in exchange for their investment. Cf. Timothy F. Harris & Aaron Yelowitz, *Nudging Life Insurance Holdings in the Workplace*, 55 *ECON. INQUIRY* 951, 958–59 (2017), <https://onlinelibrary.wiley.com/doi/full/10.1111/ecin.12390> (noting a 17% drop in under-35 life insurance purchases in the study).

245. Cf. Oren Bar-Gill, *The Behavioral Economics of Consumer Contracts*, in N.Y.U. CTR. L. & ECON, *Consumer Contracts: Behavioral Economics vs. Neoclassical Economics: An Exchange Between Oren Bar-Gill and Richard A. Epstein* 10–12 (N.Y.U. L. & Econ. Working Papers No. 91, 2007) (noting that low teaser rates attract consumers, even if the long-term rates are not in their best interests (citing Shui & Ausubel, *supra* note 218)); Richard A. Epstein, *The Neoclassical Economics of Consumer Contracts*, 92 *MINN. L. REV.* 803, 823–26 (2008) (describing market based mechanisms that influence rational consumers).

246. See Amy Danise, *How Return-of-Premium Life Insurance Works*, NERD-WALLET (Feb. 23, 2016) <https://www.nerdwallet.com/blog/insurance/return-of-premium-life-insurance/> [<https://perma.cc/YVJ8-C6BU>].

247. See, *supra* notes 148–49 and accompanying text.

248. See Baker & Siegelman, *supra* note 15, at 82 (discussing the rise of the “tontine life insurance” that paid life insurance survivors after a defined term).



benefits from being able to invest the higher-than-average premiums for the fifteen- to thirty-year policy.<sup>249</sup> The individual benefits from having coverage in case of early death and in getting premiums back in the event they live. Individuals who are at a very low risk of dying are basically giving a long-term loan to insurance companies. But the framing of the return of premium policy, addressing the hyperbolic discounting, optimism, and regret bias concerns, prompts people to sign up who otherwise would not have done so.

The hesitation of young people to buy life insurance in many ways parallels the issues with health insurance. Tom Baker and Peter Siegelman made a similar connection almost ten years ago, noting that traditional health insurance does not appeal to “young invincibles” who view it as “a way to spend money for something the customer thinks he does not need.”<sup>250</sup> The return of premium concept addresses the concern by promising to return the premiums paid in by insureds who do not use the benefits.

Some modifications would need to be made to adapt the concept to the health insurance market. For instance, it is not desirable to tie the return of premium to \$0 consumed in health care expenses. It would be a problem if return of premium policies deterred people from getting care even when it would benefit their longer-term health. So perhaps the premium return would be tied to expenses staying below a threshold. Insurers would still commit to pay for preventive care—vaccines, and the routine and recommended screenings like mammograms and colonoscopies.<sup>251</sup> And using *those* benefits would not impact the return of the premium. Depending on policy length, an insurer might even be prompted to require preventive health to reduce long-term expenses. The model might be that a certain percentage of

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249. See *Compare, Buy, & Learn About Return of Premium Life Insurance*, POLICYGENIUS, <https://www.policygenius.com/life-insurance/return-of-premium-life-insurance/> [https://perma.cc/EAV4-4QN5] (suggesting that return of premium policies generally contain an approximately 30% mark-up in premium rates over traditional term policies).

250. Baker & Siegelman, *supra* note 17, at 83.

251. For the most part, the ACA requires these services to now be offered free of cost anyway. See 42 U.S.C. § 300gg-13(a) (2012) (“Coverage of preventive health services.”).

premiums gets returned if health expenses stay below a threshold and preventive care is obtained, rather than returning the entirety of premiums as is typically the case with life insurance.<sup>252</sup>

Baker & Siegelman make their own analogy to the life insurance context, going back to a popular mid-nineteenth century offering called “tontine life insurance,” which “paid a deferred dividend to policyholders who timely paid their life insurance premiums for a specified period[.]”<sup>253</sup> A traditional tontine does not guarantee the amount of the dividend (nor in some instances, the timeframe in which it will be paid). Rather, members of the risk pool who out-survive others split available funds and therefore receive a sort of “prize.” In the health insurance context, Baker & Siegelman suggest that “[t]he young invincibles who in fact turn out not to use very much insurance would share the dividend, while those who use more insurance would get their benefits from the policy exclusively in the form of the covered health care they received.”<sup>254</sup>

The return of premium concept builds in many ways on the tontine idea in that it also attempts to address the same optimism bias problem. Both approaches share the benefit of not requiring government subsidy, instead relying on private insurers to prompt insurance uptake.

There is a key difference between the return of premium concept and the tontine idea, however. For the tontine, the amount of the dividend is (generally) not fixed in advance whereas in the return of premium model, the amount to be returned is predefined.<sup>255</sup> There are pros and cons to both scenarios. An optimistic consumer might assume that an unspecified dividend payout will be higher than it actually will be. And the insurer bears less risk if it does not pre-commit to the dividend. On the other hand, the guarantee in the return of premium

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252. This idea is similar in intent to Baker and Siegelman’s proposal to encourage healthy people to buy insurance by bundling it with a prize if they do not need to use the insurance. Baker & Siegelman, *supra* note 15, at 89–91.

253. *Id.* at 85.

254. *Id.* at 89.

255. *Id.* at 89 (distinguishing tontines from endowment life insurance, in which the amount of the deferred dividend was fixed in advance). Baker and Siegelman, however, are open to whichever option market research suggests would be more effective. *Id.*

model might be more motivating for consumers, particularly those who do not trust insurers to determine the amount of the prize. And the framing of the ability to get premiums back might be particularly attractive to young people whose primary objection is having to pay the premiums in the first place. Further study would be required to assess which model would prompt more insurance purchase.

Both ideas are worth further exploration. If these policies could prompt healthy people who would not ordinarily enter the risk pools at all to contribute premiums, even if essentially in the form of a loan, it would be beneficial. And having access to a policy that would provide preventive care is important to individual health.

There are some additional downsides to acknowledge. The tontine and return of premium solutions do not address the affordability issue. In fact, they may exacerbate that problem in the short term in that return of premium policies must charge somewhat higher-than-average premiums.<sup>256</sup> The return of premium concept is also at odds with the earlier stated assumption that younger people prefer lower rates in the short-term. (Although there is nothing stopping an insurer from crafting a return of premium style policy with rates that increase over a specified term.) And it adds complexity where simplification is preferred.

For those who do not purchase insurance because they cannot afford it, this solution would not be the right fit. But insurers have the benefit of data collection and segmented marketing. For reasons discussed earlier, many who can afford insurance still choose not to buy it.<sup>257</sup> Addressing affordability would not prompt insurance enrollment for that group; rather, this solution may be more attractive. Because the styling of these plans seems to address some of the key reasons that people currently give for not enrolling, it is worthy of experimentation.<sup>258</sup>

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256. See Danise, *supra* note 246.

257. See *supra* Parts I.B, II.C–D, III.A–B.

258. According to Baker & Siegelman, tontines were once quite popular. Baker & Siegelman, *supra* note 15, at 89; see also Howard Kunreuther & Mark Pauly, *Insurance Decision-Making and Market Behavior*, 1 *FOUNDATIONS & TRENDS MICROECONOMICS* 63, 91–92 (2005) (demonstrating consumer preference for insurance offering rebates).

## C. FURTHER SIMPLIFIED PLAN OFFERINGS

A third possibility is to address issues of choice overload and complexity<sup>259</sup> in the current system by simplifying offerings or making default plan selections. To a degree, the ACA already tried to simplify choices by putting plans in a metallic category (platinum, gold, silver, bronze) according to their actuarial value.<sup>260</sup> It is a shorthand for the degree of coverage a plan offers, with platinum plans offering more robust coverage and fewer out-of-pocket expenses and bronze plans covering less of the out-of-pocket costs.<sup>261</sup> But studies of the metal labels have found that they do little to elucidate choice for consumers.<sup>262</sup>

And more generally, it is still incredibly challenging to understand and navigate health insurance choices, to the point that it may be deterring individuals from participating in the system at all.<sup>263</sup> Charts of benefits are complicated and require understanding terminology about co-insurance, deductibles, copays, out-of-pocket maximums, and so forth.<sup>264</sup> Many individuals do not understand the terms and most have difficulty calculating

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259. See, e.g., Cathy Schoen et al., *Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to Ten Other Countries*, 32 HEALTH AFF. 2205, 2206 (2013) (“[T]he United States is unique in its complexity of health insurance designs . . .”).

260. See Sarah Sullivan, *ACA Plan Metal Levels – What They Are, How They Work*, HEALTHDEALS (June 26, 2019), <https://www.healthdeals.com/blog/aca/obamacare-metal-plans/> [<https://perma.cc/4ZX5-9C5M>]; see also *Metal Categories*, *supra* note 202.

261. Sullivan, *supra* note 260.

262. See, e.g., Saurabh Bhargava et al., *The Costs of Poor Health (Plan Choices) & Prescriptions for Reform*, 3 BEHAV. SCI. & POL'Y 1, 1 (2017) (finding that “labels that more sensibly reflect the factors consumers ought to consider—for instance, labels that emphasize gradations in the need for health care—do lead to significant improvements in the efficiency of plan choices”).

263. See Baicker et al., *supra* note 128 (surveying evidence).

264. See, e.g., *Deductibles, Copayments, and Coinsurance*, MEDICA, <https://www.medica.com/-/media/documents/individual/member-tip-sheets/ifb-member-tips-deductibles-copays-coinsurance-ifb10082.pdf> [<https://perma.cc/WF8N-T7PW>]; *Health Insurance Plan Comparison Chart*, OPTIMA HEALTH, <https://www.optimahealth.com/health-insurance-101/health-insurance-plan-comparison-chart> [<https://perma.cc/94VA-VM7Y>].

the expected costs of their care.<sup>265</sup> The simple length of a benefit plan deters reading and understanding it.<sup>266</sup>

Some insurers are already beginning to experiment with simplified offerings. A new health plan called “Humana Simplicity” does away with deductibles and co-insurance entirely and uses a copay-only model.<sup>267</sup> Covered services are subject to one of six copay amounts, making it easier for insureds to know how much they will owe in various scenarios.<sup>268</sup> A study of the copay-only model found that the simplified offerings improved plan choice—although the study did not consider the effect of simplification on the decision to enroll in the first place.<sup>269</sup>

Another option is to simplify the process of plan selection through the use of artificial intelligence. For example, the Maya Intelligence platform is being marketed as using machine learning to help individuals choose the best health insurance coverage option based on their individual needs.<sup>270</sup> In other words, it takes the individual out of the complicated decision-making process. One could even imagine a scenario where a simple algorithm could select the best plan option as an individual’s default.<sup>271</sup> This might work well with the auto-enrollment idea discussed further below.

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265. Baicker et al., *supra* note 128 at 116.

266. Lauren Woods, *Health Insurance Plans ‘Too Complicated to Understand,’* UCONN TODAY (Apr. 5, 2017), <https://today.uconn.edu/2017/04/health-insurance-plans-complicated-understand/#> [<https://perma.cc/DS76-95ML>] (“[T]oday’s complex insurance plans, with intricate cost calculations and complicated language and terminology, can be very difficult to understand, even for people with a college education.”).

267. *Behavioral Economics*, *supra* note 70.

268. *Id.* (describing the Humana Simplicity plan as having “six categories of copayments” and “[i]nstead of having a 70-page guide to benefits, everything fits on a page and a half”).

269. See Loewenstein et al., *Consumers’ Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 856–60 (2013).

270. See *Abbott Launches Its AI Based Personal Assistant, MAYA*, ET HEALTHWORLD (Feb. 20, 2019), <https://health.economictimes.indiatimes.com/news/health-it/abbott-has-launched-its-ai-based-personal-assistant-maya/68063221> [<https://perma.cc/84VQ-6H7L>]. Tools like this have the potential to exacerbate adverse selection concerns, but might at least help people over the hurdle of not purchasing insurance at all.

271. In other work, the author has explored the possibility of choosing treatment defaults for patients to address issues of flawed decision-making. See Epstein, *supra* note 155, at 1255. Choice of health plan could be done similarly.

Simply reducing the number of plan offerings by each insurer may also be advantageous in addressing choice overload. And to the extent that plans are more standardized, it would mitigate the effects of adverse selection where sicker people choose more robust plans, which then have to charge higher premiums, and healthier people choose skinnier coverage.

Not everyone is in favor of simplification, though. Large insurer Aetna, for instance, has opposed standardized plan designs on the basis that it would stifle their ability to create innovative plans.<sup>272</sup> Indeed, some of the innovations urged in sections A and B above might add complexity in the form of more choices for the consumer. Choices could be offered on a more targeted basis, so that each individual consumer does not get overloaded with options, but that requires confidence that the data is driving the right matching.

At bottom, more study needs to be done to determine whether complexity is deterring enrollment or just causing poor decision-making. If either is true, however, the case for simplification is strong.

#### D. GENEROSITY FRAMING

Another option could take advantage of framing effects to prompt enrollment. Health insurance is currently marketed as a way to insure against individual risk.<sup>273</sup> Any individual might incur health care costs that exceed premiums in a given period. Purchasing insurance and agreeing to pay premiums is supposed to be a rational economic choice to mitigate that risk. However, one of the problems, as previously discussed, is that many young and healthy individuals do not purchase insurance because they do not view it as a “good deal.”<sup>274</sup> They believe that they will spend less in out-of-pocket health care costs than they would in premiums. And many of them are correct. After all, the reason that the risk pools require the addition of less expensive insureds is precisely *to* subsidize the cost of sicker insureds. In the current

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272. Herman, *supra* note 62.

273. See *Risk Pooling: How Health Insurance in the Individual Market Works*, AM. ACAD. ACTUARIES (July 2017), <http://www.actuary.org/files/publications/RiskPoolingFAQ071417.pdf>.

274. See Baker & Siegelman, *supra* note 15 at 96–97.

framing of the decision, perhaps it is not a surprise that many healthier individuals are opting out of insurance.

At the same time, though, the prohibition on pre-existing conditions exclusions and the community rating provisions are highly popular because Americans view them as moral imperatives.<sup>275</sup> People do not like the thought, and rightly so, that a child born with a disorder due to no fault of her own can be denied insurance because she is expensive to insure.<sup>276</sup> One possibility, then, is to change the framing of the insurance purchase decision. One might purchase insurance not merely to insure against her future risk, but also explicitly to fund the care of sicker people in need of insurance coverage.

The importance of framing to decision-making as a general matter was discussed above.<sup>277</sup> We know that how a decision is framed can have a significant impact on decision-making outcomes.<sup>278</sup> But another fundamental conceit of the behavioral economics literature is equally relevant to this solution—namely, that individuals do not always act strictly in their own self-interest.<sup>279</sup> Individuals are also generous and altruistic.<sup>280</sup>

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275. Brietta Clark, *A Moral Mandate & the Meaning of Choice: Conceiving the Affordable Care Act After NFIB*, 6 ST. LOUIS U. J. HEALTH L. & POL'Y 267, 316 (2013).

276. See Poll: *The ACA's Pre-Existing Condition Protections Remain Popular with the Public, Including Republicans, as Legal Challenge Looms This Week*, KAISER FAM. FOUND. (Sept. 5, 2018), <https://www.kff.org/health-costs/press-release/poll-acas-pre-existing-condition-protections-remain-popular-with-public/> [<https://perma.cc/E9YJ-9542>] (“[Seventy-two percent of Americans] say it is ‘very important’ to retain ACA provisions that prevent insurance companies from . . . charging sick people more.”).

277. See discussion *supra* Part III.B.4.

278. See TVERSKY & KAHNEMAN, *FRAMING OF DECISIONS*, *supra* note 151.

279. See Sendhil Mullainathan & Richard H. Thaler, *Behavioral Economics: How Behavioral Economics Differs from Traditional Economics*, LIBR. ECON. & LIBERTY, <https://www.econlib.org/library/Enc/BehavioralEconomics.html> [<https://perma.cc/3482-VBVY>].

280. See Summer Allen, *The Science of Generosity*, GREATER GOOD SCI. CTR. 2 (May 2018), [https://ggsc.berkeley.edu/images/uploads/GGSC-JTF\\_White\\_Paper-Generosity-FINAL.pdf](https://ggsc.berkeley.edu/images/uploads/GGSC-JTF_White_Paper-Generosity-FINAL.pdf) [<https://perma.cc/H74M-LQ7J>] (“[G]enerosity has its roots not just in our individual development but also in our very biology and evolutionary history.”); Jessica L. Collett & Christopher A. Morrissey, *The Social Psychology of Generosity: The State of Current Interdisciplinary Research*, SCI. GENEROSITY (Oct. 2007), [https://generosityresearch.nd.edu/assets/11794/social\\_psycho/social\\_psychology\\_of\\_generosity.pdf](https://generosityresearch.nd.edu/assets/11794/social_psycho/social_psychology_of_generosity.pdf) [<https://perma.cc/X9UE-ETMQ>]; Jill Suttie, *Can You Incentivize Generosity?*, GREATER GOOD MAG.

In the real world, millennials in particular have demonstrated strong altruistic tendencies.<sup>281</sup> Millennials, who are mostly young and healthy, are the most sought-after population for purposes of insurance risk pools. Perhaps for this reason, products tying their sales to social movements and to themes of generosity have been particularly successful in recent years.<sup>282</sup>

Consider the example of TOMS shoes.<sup>283</sup> TOMS markets their shoes by telling consumers that for every pair of shoes the company sells, it will donate a pair to children in need.<sup>284</sup> In order to be able to donate shoes, TOMS must be charging customers more for a pair of shoes than it would without the donation commitment. People could buy other similar shoes for less money. But TOMS is explicitly trading on individuals' altruistic tendencies. And the business model seems to be working, primarily in selling to the younger population.<sup>285</sup> In fact, other companies have followed suit. Bombas socks, for instance, has a similar business model.<sup>286</sup>

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(June 23, 2016), [https://greatergood.berkeley.edu/article/item/can\\_you\\_incentivize\\_generosity](https://greatergood.berkeley.edu/article/item/can_you_incentivize_generosity) [<https://perma.cc/KW5S-W4BW>].

281. See NAT'L CHAMBER FOUND., *THE MILLENNIAL GENERATION: RESEARCH REVIEW 4* (2012), <https://www.uschamberfoundation.org/sites/default/files/article/foundation/MillennialGeneration.pdf> [<https://perma.cc/VXN9-GBTV>] ("Popular opinion is that Millennials are more caring, community oriented, and politically engaged than previous generations."); Wes Gay, *Millennials Are Effecting Change with Social Responsibility*, FORBES (Aug. 11, 2017), <https://www.forbes.com/sites/wesgay/2017/08/11/millennials-social-responsibility/#1cb0f49117d8> [<https://perma.cc/536W-L7BB>] ("Millennials are an idealistic, altruistic generation.").

282. Jorie Goins, *How Millennials Are Changing Corporate Generosity*, CHI. TRIBUNE (June 24, 2019, 12:59 PM), <https://www.chicagotribune.com/business/success/tca-success-how-millennials-are-pushing-corporate-generosity-20190624-story.html> [<https://perma.cc/N5VY-5MXL>].

283. See TOMS, <https://www.toms.com/> [<https://perma.cc/ZX8L-T6GZ>].

284. *Id.* ("Your purchases have helped give 86 million pairs of shoes to children in need. And they still do today. Shop the shoe that started the movement.").

285. See Leigh Buchanan, *What's Next for Toms, the \$400 Million For-Profit Built on Karmic Capital*, INC., <https://www.inc.com/magazine/201605/leigh-buchanan/toms-founder-blake-mycoskie-social-entrepreneurship.html> [<https://perma.cc/L59D-R2JF>] (describing TOMS' philanthropic efforts and strategic focus on young people who care about their impact as reasons for its commercial success).

286. See BOMBAS, <https://bombas.com/pages/giving-back> [<https://perma.cc/F2BW-77KB>] ("[D]onated over 18 million clothing items through more than 1,700 Giving Partners across the country."); see also SOAPBOX, <https://>



Drawing on these lessons, health insurance companies could change the decision frame for purchasing health insurance. Rather than just framing the decision as one of self-interest, insurers could be explicit that a young and healthy policyholder who purchases a policy helps to fund insurance coverage for an individual with a pre-existing condition. This combats the negative frame of “I’m paying too much for coverage relative to my own risk” and replaces it with a positive frame of “I’m doing a good thing in getting health insurance because I’m enabling a sick person to be able to get care.” And of course there is also still the individual benefit that the insured is covered in the event of high, unexpected medical costs.

Just as with many attempts to nudge consumers into decisions that a choice architect seeks, this framing may yield undesired results or may fail to accomplish its purpose.<sup>287</sup> For instance, a consumer can purchase a pair of TOMS shoes for a lot less money than a year of health insurance premiums. It is possible that altruistic millennials are only willing to be generous up to a certain threshold, particularly as they often have more limited means than older consumers. And it could deter some consumers who purchased policies as the rational economic choice.

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[www.soapboxsoaps.com/](http://www.soapboxsoaps.com/) [<https://perma.cc/FFC4-RQT5>] (donating more than 2,995,037 bars of soap); TWICE AS WARM, <https://twiceaswarm.com/> [<https://perma.cc/2V78-TBR4>] (“With each purchase, a new winter clothing item is given to a person in need: Wear One, Give One.”). For a list of similar business models donating with each purchase, see Shawn Donnelly, *16 Brands That Use the TOMS Model of One-for-One Giving*, INSIDEHOOK, (Nov. 28, 2016, 5:00 AM), <https://www.insidehook.com/article/food-and-drink/16-brands-use-toms-model-one-one-giving/> [<https://perma.cc/9222-8APJ>].

287. Successful results from incentivizing generosity typically rely on public trust. See Herrington J. Bryce, *The Public’s Trust in Nonprofit Organizations: The Role of Relationship Marketing and Management*, NPQ (Jan. 11, 2016), <https://nonprofitquarterly.org/the-publics-trust-in-nonprofit-organizations-the-role-of-relationship-marketing-and-management/> [<https://perma.cc/CZ9N-4EYZ>] (discussing the role of trust in relationships between consumers and charity); see also *America’s Least-Respected Industries: How Does Insurance Fare?*, INS. BUS. (June 16, 2015), <https://www.insurancebusinessmag.com/us/news/breaking-news/americas-least-respected-industries-how-does-insurance-fare-16552.aspx> [<https://perma.cc/FJ9H-2E62>] (citing Harris Poll finding out of 2,250 surveyed adults, only 7% trust their health insurance company).

Also, while TOMS shoes began from day one by marketing itself as a company that sought to do good, individuals may already be highly skeptical of the motivations of insurance companies, which are mostly viewed as greedy and self-serving.<sup>288</sup> One could see skepticism about whether funds are really being used for the sick or rather to pad the salaries of overpaid insurance company CEOs.<sup>289</sup> Perhaps a newly formed, non-profit insurance company would be more successful in changing the framing than a large, well-known, profit-driven company.<sup>290</sup> But at the very least, this generosity frame seems worthy of experimentation.<sup>291</sup>

#### E. AUTOMATIC ENROLLMENT WITH OPT-OUT

Finally, the concept of automatic enrollment is not a new one, but it merits serious new consideration. Individuals may not be enrolling in insurance plans because the status quo is *not* to be enrolled. An individual has to take affirmative action and wade through all of the choices and all of the complexity involved in making a decision about whether to purchase a policy.

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288. See *Healthcare System*, GALLUP, <https://news.gallup.com/poll/4708/healthcare-system.aspx?version=print> [<https://perma.cc/Q7XV-YYB9>] (finding 48% of Americans have a very/somewhat negative view of the healthcare industry and a 2009 poll finding 13% of Americans believe the biggest problem with healthcare in the U.S. is insurance companies' greed).

289. If insurance companies move to a non-profit or mutual status, then they could potentially ameliorate public skepticism and distrust. See Bryce, *supra* note 287 (outlining steps that non-profits can take to restore public trust and image).

290. This might be a good role for a Certified B Corporation, for instance. See CERTIFIED B CORP., <https://bcorporation.net/> [<https://perma.cc/45HH-W7NT>].

291. There might be other frames also worthy of experimentation. Consider, for instance, a personal responsibility frame—in the context that human beings are personally responsible for maintaining insurance so as not to impose negative externalities on the rest of society. See, e.g., Brownell et al., *Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue*, 29 HEALTH AFF. 379, 382 (2010) (advocating “[t]he use of collective action to support personal responsibility” as a way to address the obesity crisis). Perhaps ironically, Governor Mitt Romney successfully sold the individual mandate to Massachusetts using the value of personal responsibility. When he introduced his proposal for Massachusetts in 2005, he stated: “It’s the ultimate conservative idea . . . that people have responsibility for their own care, and they don’t look to government . . . when they can afford to take care of themselves.” Martha Bebinger, *Personal Responsibility: How Mitt Romney Embraced the Individual Mandate in Massachusetts Health Reform*, 31 HEALTH AFF. 2105, 2109 (2012).

One way then to address the status quo, or inertia, bias and the concerns about complexity is to automatically enroll individuals in plans, but then allow them to opt-out if they desire.<sup>292</sup> There is now evidence from a wide variety of sectors that many people will simply stick with decisions that have been made for them.<sup>293</sup> Perhaps the most analogous example to the insurance enrollment context is the studies about employee participation in 401(k) plans. Enrollment in such plans dramatically increases when employers automatically enroll employees but allow them to opt out.<sup>294</sup>

The ACA, as enacted, contained an automatic enrollment provision for large employers.<sup>295</sup> The concept was that employers would automatically enroll employees in one of the employer-sponsored plans and give them the right to change the selection or opt out entirely. The idea was to increase participation in employer-sponsored insurance.<sup>296</sup> But its implementation was postponed and ultimately it was repealed in 2015.<sup>297</sup>

The employer automatic enrollment provision never got off the ground for a number of reasons. First, businesses generally opposed it.<sup>298</sup> They viewed automatic enrollment as administratively difficult and costly to execute. Second, some businesses

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292. See Adams, *supra* note 96; *An Alternative to the Individual Mandate*, FLEX (Sept. 21, 2017), <https://www.flexiblebenefit.com/blog/alternative-individual-mandate> [<https://perma.cc/5DMU-YEMQ>]; Lanhee J. Chen & James C. Capretta, *Republicans Need a Nudge to Lower Health Care Costs*, N.Y. TIMES (Feb. 12, 2018), <https://www.nytimes.com/2018/02/12/opinion/health-care-automatic-enrollment.html>.

293. See, e.g., Carlos Alós-Ferrer et al., *Inertia and Decision Making*, 7 FRONTIERS PSYCHOL. 1, 2 (2016); see also discussion *infra* Part III.B.1.

294. Madrian & Shea *supra* note 165, at 1176.

295. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1511, 124 Stat. 252 (2010) (codified at 29 U.S.C. § 218A (2012) (repealed 2015)) (mandating that large firms must automatically enroll new employees into employer-provided health plans).

296. Timothy Jost, *Budget Legislation Would Repeal Auto-Enrollment Requirement for Large Employers*, HEALTH AFF. BLOG (Oct. 27, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20151027.051444/full/> [<https://perma.cc/Y2MZ-JF5N>] (describing employer automatic enrollment provision as a “nudge” that was “intended to reverse the course of inertia and encourage enrollment in coverage by employees who might otherwise forgo doing so if they had to initiate enrollment on their own”).

297. Bipartisan Budget Act of 2015, Pub. L. No. 114-74, 129 Stat. 584 (2015).

298. See, e.g., Letter from Various Businesses, Trade Associations, and Organizations to Johnny Isakson, Senator, U.S. Senate (July 22, 2014),

said that they feared “unnecessary hardship” on employees who were automatically enrolled in a plan but did not wish to be.<sup>299</sup> Third, many employers were already automatically re-enrolling employees during open enrollment, so the provision was limited in effect to new employees, a small group that perhaps did not merit the costs entailed.<sup>300</sup> Finally, the automatic enrollment provision was considered duplicative of the individual mandate. If a penalty for failure to enroll was providing incentive to enroll, then it was not also necessary to automatically enroll people in plans.<sup>301</sup>

But in a world where there is no longer an individual mandate penalty, automatic enrollment deserves further consideration—and not just for employer-sponsored health insurance, but also for the individual market. If it were possible for the government to identify the twenty-seven million people who do not have insurance and to automatically enroll them in a plan, it could significantly increase rates of insurance.

There are a number of downsides to consider, though. The first and perhaps most important concerns data difficulties. While employers could automatically enroll new employees and their uninsured beneficiaries, it is harder to identify the uninsured who lack an employer-sponsored insurance option. One suggestion is to design a process that could be implemented through the DMV or for states to require some sort of information collection on insurance status. The government has information on who is enrolled in Medicare, Medicaid, or who has coverage through the Veterans Administration, and through the IRS, employer coverage could also be determined. The uninsured could largely be identified by process of elimination.<sup>302</sup>

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<https://www.shrm.org/ResourcesAndTools/hr-topics/benefits/Documents/S2546EmployerSupportLetter.pdf> [<https://perma.cc/3CT2-S4M4>] (more than one hundred businesses writing in favor of the Auto Enroll Repeal Act).

299. *Id.*

300. *Id.* (“[T]he automatic enrollment requirement is redundant, expensive and unnecessarily burdensome for employers without increasing employees’ access to coverage.”).

301. *Id.* (“[E]mployers that are subjected to the [Automatic Enrollment for Employees of Large Employers provision] are already bound by the health care law’s Shared Responsibility for Employers provision, which requires an offer of coverage to these same employees . . .”).

302. The government also has historical evidence on which individuals did not have insurance previously and therefore paid the individual mandate tax.

Another possible stumbling block to automatic enrollment concerns the paternalistic nature of the strong nudge in favor of insurance. The paternalism concern is perhaps even heightened when the direction of the nudge may benefit the public, but is not necessarily in the individual's self-interest.<sup>303</sup> Typically, nudges are designed to move individuals toward decisions that would be in their rational self-interest, not decisions that might be contrary to that interest.<sup>304</sup> Political opposition to a strong nudge like automatic enrollment may be problematic. Notably, while many countries have successfully adopted opt-out organ donation regimes, the United States has continued to resist what might arguably be a less controversial nudge than automatic insurance enrollment.

But this need not be paralyzing. Because of the right to opt-out, any coercion is minimal.<sup>305</sup> And even if an individual might be paying more than actuarially necessary, having health insurance is arguably still an individual benefit and is certainly a public benefit.

Consideration would also need to be given to billing mechanisms and enforcement. With employer automatic enrollment, funds can be deducted from wages to cover the cost of insurance. With private insurance, however, companies would have to bill consumers and hope that they pay. Or perhaps there is a way to invoke the tax system, but then automatic enrollment starts to sound like the repealed mandate.

The next question concerns what plan to automatically enroll people in, given that the "best" plan for an individual is typically viewed as a personal decision. Some options are that a default plan could be established (by the employer or by the state),

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303. See Jacob Goldin, *Which Way to Nudge? Uncovering Preferences in the Behavioral Age*, 125 *YALE L.J.* 226, 233 (2015).

304. See *Paternalism*, *STAN. ENCYCLOPEDIA PHIL.* (Feb. 12, 2017), <https://plato.stanford.edu/entries/paternalism/#DefiIssu> [<https://perma.cc/8359-YBWD>] ("There are nudges which are not paternalistic (on [Sunstein and Thaler's] definition) because the aim is to promote the general good—even if the chooser is not benefitted. Nudging building managers to put in elevators with braille buttons, influencing people to contribute to Oxfam by putting up pictures of starving infants, are examples where the good to be promoted is the welfare of people other than those being influenced.")

305. See, e.g., Wendy Netter Epstein, *The Health Insurer Nudge*, 91 *S. CAL. L. REV.* 593, 650 (2018) (discussing objections to paternalistic nudges).

or the individual could be enrolled in the lowest-cost plan.<sup>306</sup> Indeed, automatic enrollment seems most likely to be successful if individuals can be enrolled in plans with very low cost.<sup>307</sup> For those who are eligible for subsidies and are simply not accepting those subsidies, this seems possible. But for higher income individuals, even the lowest-cost plans may still be pricey.

The success of automatic enrollment is also predicated on an assumption that status quo bias explains why so many are uninsured. If, instead, most people are making a conscious choice not to enroll in insurance, then automatic enrollment would just add unnecessary cost in the form of forcing large numbers of people to opt out. While there is sufficient data to be optimistic,<sup>308</sup> ultimately, the degree of inertia exhibited depends largely on context, and some limited experimentation could provide helpful data.

### CONCLUSION

There is much excitement on the political left about the possibility of moving to a single-payer, universal-coverage model in health care. And there is excitement on the right about doing away with the ACA and moving to a more market-driven approach to health care. But there are serious stumbling blocks in

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306. In a future world, big data and artificial intelligence can play a part in selecting the right plan for the right individual.

307. Goldin, *supra* note 303 at 233; *see also* Wesley J. Smith, *Obamacare Repeal: The NEJM Starts to Panic*, *FIRST THINGS* (Feb. 17, 2011), <https://www.firstthings.com/blogs/firstthoughts/2011/02/obamacare-repeal-the-nejm-starts-to-panic> [<https://perma.cc/Y8RV-4722>] (“Inertia alone may not be a sufficiently strong force to get younger, healthier workers to stay insured, given high and rising insurance premiums.” (quoting Jonathan Oberlander, *Under Siege—The Individual Mandate for Health Insurance and Its Alternatives*, 364 *NEW ENG. J. MED.* 1085, 1086 (2011))).

308. *See* Benjamin R. Handel, *Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts*, 103 *AM. ECON. REV.* 2643 (2013) (finding evidence of status quo bias in health insurance in that people tend to stick with their original choice of health insurance policy even if another option would be better for them); *see also* James Marton et al., *Medicaid Program Choice, Inertia and Adverse Selection*, 56 *J. HEALTH ECON.* 292 (2017) (finding inertia effect in Medicaid plan choice); Keith M. Marzilli Ericson, *Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange*, 6 *AM. ECON. J. ECON. POL’Y* 38 (2014) (finding inertia effect in Medicare Part D choice); Gordon B. Dahl & Silke J. Forbes, *Doctor Switching Costs in Health Insurance* (unpublished manuscript), [http://faculty.weatherhead.case.edu/forbes/Dahl\\_Forbes\\_Draft.pdf](http://faculty.weatherhead.case.edu/forbes/Dahl_Forbes_Draft.pdf) [<https://perma.cc/96CJ-Z8A4>].

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the way. With a politically-divided Congress, any major changes are not imminent. It is time to deal with the current situation—with the ACA that is still in place, but now lacking the individual mandate penalty. This change is almost certain to result in a significant increase in uninsured Americans, which in turn will raise the rates on premiums and further destabilize individual insurance markets (even if they are not likely to crash). More globally, it is time to explore ways to address the seemingly intractable problem of high rates of uninsured. Options exist to prompt health insurance enrollment, perhaps even ones that could garner support across a broad swath of interests. Many of these options are ones that insurance companies could experiment with, without needing major legal changes to do so. Although no single option is perfect, there is reason for optimism. Private law alternatives to the individual mandate could mitigate a host of negative consequences that will flow from the mandate's repeal if no substitutes are implemented.