2013

The Individual Mandate as Health Care Regulation: What the Obama Administration Should Have Said in NFIB v. Sebelius

Abigail R. Moncrieff
Cleveland State University College of Law, a.moncrieff@csuohio.edu

American Journal of Law & Medicine, 39 (2013): 539-572

The Individual Mandate as Healthcare Regulation: What the Obama Administration Should Have Said in *NFIB v. Sebelius*

Abigail R. Moncrieff[†]

CONTENTS

There was an argument that the Obama Administration's lawyers could have made—but didn't—in defending Obamacare's individual mandate against constitutional attack. That argument would have highlighted the role of comprehensive health insurance in steering individuals' healthcare savings and consumption decisions. Because consumer-directed healthcare, which reaches its apex when individuals self-insure, suffers from several known market failures and

[†] Peter Paul Career Development Professor and Associate Professor of Law, Boston University School of Law. I thank Hannah Fine, Sara Fiorillo, Sesi Garimella, and Amber Charles for outstanding research assistance, and I thank Einer Elhauge and the participants in the University of Pennsylvania and Boston University law school faculty workshops for their feedback.

because comprehensive health insurance policies play an unusually aggressive regulatory role in attempting to correct those failures, the individual mandate could be seen as an attempt to eliminate inefficiencies in the healthcare market that arise from individual decisions to self-insure. This argument would done a better job than the Obama Administration's of aligning the individual mandate with existing Commerce Clause and Necessary and Proper Clause precedent, and it would have done a better job of addressing the conservative Justices' primary concerns with upholding the mandate. This Article lays out this forgone defense of the individual mandate.

I. INTRODUCTION

There is one vision of health insurance—one among many that vie for dominance in law, economics, and policy[1]—that was missing from the debate over Obamacare's constitutionality.[2] That vision sees private health insurance not only as a contract or product but also as a regulator, which operates alongside public governance to steer individual behavior in the healthcare market.[3] This vision is not mere fantasy; health insurance has long served regulatory functions in the United States, manipulating enrollees' healthcare consumption.[4] Furthermore, comprehensive health insurance policies seem to be successful regulators with respect to goals of increasing health and longevity. Evidence suggests that individuals who carry comprehensive health insurance are, on average, healthier and longer-lived than individuals who carry limited or no insurance.[5] Although insurance imposes known regulatory costs by obfuscating prices and causing moral hazard,[6] it also has the significant regulatory benefit of improving beneficiaries' decisions about whether and where to consume medical care. But, of course, the regulatory reach of private insurance, unlike that of government, is limited by individuals' willingness and ability to enter insurance contracts. One of Congress's core goals in passing the Patient Protection and Affordable Care Act (not just the individual mandate but also the market reforms and subsidies) was to bring all of healthcare consumption under the regulatory umbrella of private insurance, eliminating the less-well-regulated market for self-insured[7] healthcare transactions.[8]

---

[1] *See, e.g.*, Kenneth Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653 (2013).

[2] *See* Nat'l Fed'n of Indep. Bus. (NFIB) v. Sebelius, 132 S. Ct. 2566 (2012); Florida v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011); Florida v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011).

[3] *See* Abraham, *supra* note 1, at 683-97.

[4] *See, e.g.*, KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 3, 57-58 (1986); Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 205 (2012).

[5] *See* RAND CORP., THE HEALTH INS. EXPERIMENT 3-4 (2006), http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf; JONATHAN GRUBER, KAISER FAMILY FOUNDATION, THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 8 (2006), http://kff.org/health-costs/report/the-role-of-consumer-copayments-for-health/.

[6] *See* Ben-Shahar & Logue, *supra* note 4, at 199-200; Uwe Dulleck et al., *The Economics of Credence Goods: An Experiment on the Role of Liability, Verifiability, Reputation and Competition*, 101 AM. ECON. REV. 526, 550 (2011).

[7] See *infra* Part II.C for full consideration of the difference between the terms "self-insured" and "uninsured."

[8] *See, e.g.*, Ben-Shahar & Logue, *supra* note 4, at 201; Abigail R. Moncrieff, *Obamacare's (3) Day(s) in Court*, 141 CHEST J. 1389, 1390-91 (2012).

My thesis in this article is twofold. First, the regulatory vision of health insurance and its relevance to the individual mandate's constitutionality are important for us to understand—not only as legal scholars and policy analysts but also as healthcare consumers and Americans. For that reason, it is a shame that the Obama Administration failed to include the regulatory vision in its highly publicized defenses[9] of Obamacare.[10] Second, this vision of the individual mandate would have strengthened the Administration's constitutional argument that the statute is permissible as a regulation of interstate commerce, not just as a tax. Although the arguments I lay out here might not have changed any of the Supreme Court Justices' votes on the Commerce Clause challenge, these arguments do provide better, stronger answers to some of the conservative Justices' chief concerns. And because the distinction between taxes and penalties matters to the statute's future enforceability (because Congress could have strengthened the mandate considerably if it were a penalty but cannot strengthen it much as a tax[11]), it is a shame that the Administration did not present this regulatory vision to the Supreme Court.

For the first part of the article's thesis, the chief question is what exactly private insurance companies do to improve their beneficiaries' healthcare consumption choices. What is the regulatory role of private insurance, and why does it matter? One obvious answer is that insurance, by decreasing the marginal cost of healthcare consumption, encourages policyholders to go to the doctor. But health insurance does not merely increase accessibility of care. It also imposes regulatory constraints on individual consumption decisions, steering beneficiaries toward particular doctors and hospitals and toward particular goods and services. Health insurers accomplish these regulatory manipulations with three basic tools: (1) they decrease the out-of-pocket cost not only of catastrophic care but also of routine care;[12] (2) they require beneficiaries to save while young for care they will consume when old;[13] and (3) they review beneficiaries' consumption choices before deciding whether and to what extent to indemnify losses, imposing different levels of cost-sharing depending on where the beneficiaries consume care and what kinds of care they consume.[14]

These manipulations serve as well-tailored corrections to three well-known cognitive distortions, which, in the absence of insurance's regulatory influence, harm the efficiency of healthcare consumption. When left to their own self-insured devices, healthcare consumers fall prey to optimism bias, hyperbolic discounting, and the credence goods problem.[15] Together, those failures cause individuals to save too little money for their future healthcare needs, consume too little preventive healthcare, and make poor decisions when choosing among doctors and hospitals. Insurance companies directly combat those behavioral inefficiencies by forcing individuals to save money and by steering individuals to prescreened healthcare

---

[9] The regulatory vision of insurance was missing not only from the Administration's legal defense of the statute in the *NFIB v. Sebelius* litigation but also from the Administration's political defense of the statute both before and after Obamacare's passage. *See, e.g.*, President Barack Obama, Remarks by the President on the Affordable Care Act and the New Patients' Bill of Rights (June 22, 2010), *available at* http://www.whitehouse.gov/the-press-office/remarks-president-affordable-care-act-and-new-patients-bill-rights.

[10] Patient Protection and Affordable Care Act of 2010 (ACA), Pub. L. No. 111-148, § 1(a), 124 Stat. 119 (2010).

[11] *See infra* Part III.C.

[12] *See* Moncrieff, *supra* note 8, at 1390.

[13] *See id.*

[14] *See id.*

[15] *See id.*

providers.[16] Part II of this article describes the cognitive failures that tend to harm the efficiency of the healthcare market and explains how the three manipulations of comprehensive insurance can correct those problems. In other words, Part II lays out the vision of health insurance as a regulatory tool.

Part III of the article turns to the second part of the thesis: the idea that this regulatory understanding of health insurance could have strengthened the Obama Administration's constitutional defense of the individual mandate. The first task in defending this idea is to situate Part II's vision of the mandate within existing Commerce Clause doctrine. Indeed, the narrative of the mandate—and of Congress's intent in passing it—that I lay out here fits comfortably in modern doctrine. Under the regulatory vision of insurance, the "end" that Congress had in mind was the elimination of self-insured healthcare transactions, and its chosen "means," the mandate, was an attempt to shift all consumers from that disfavored market to a perfect substitute market: the market for fully-insured healthcare transactions.[17] Under *Gonzales v. Raich*[18] and its many predecessors,[19] the "end" of eliminating disfavored commerce is clearly permissible. The only question, then, is whether Congress's chosen "means" is "reasonably adapted"[20] to the attainment of the end.

During oral arguments and in their opinions, the five conservative Justices of the Supreme Court (Chief Justice Roberts and Justices Scalia, Thomas, Kennedy, and Alito) voiced three concerns with the individual mandate as a means: the slippery slope problem, the novelty problem, and the bootstrapping problem. The slippery slope concern was that if Congress could stimulate the health insurance market by requiring individual purchases of insurance, then it could force individual purchases of any product whose market was suffering—such as American-made cars.[21] The novelty concern was that Congress had never before attempted to stimulate demand by legal fiat (as it seemed to be doing here), and novelty itself seemed suspicious to the Justices—if not outright disfavored.[22] The bootstrapping concern was that Congress should not have constitutional authority to fix a problem of its own (contemporaneous) creation, and the individual mandate, as the Justices saw it, was an attempt to fix market failures that Obamacare itself created—an attempt to avoid the cost-shifting and adverse selection that would arise from Obamacare's guaranteed issue and community rating requirements.[23]

---

[16] *See id.*

[17] *See generally* M'Culloch v. Maryland, 17 U.S. (4 Wheat.) 316, 421 (1819) ("Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.").

[18] 545 U.S. 1 (2005).

[19] *See, e.g.*, Wickard v. Filburn, 317 U.S. 111 (1942); United States v. Darby Lumber Co., 312 U.S. 100 (1941).

[20] *See Raich*, 545 U.S. at 37 (Scalia, J., concurring) (noting that the "relevant question [under the Necessary and Proper Clause] is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power" (citing *Darby*, 312 U.S. at 121)).

[21] *See* NFIB v. Sebelius, 132 S. Ct. 2566, 2588-89 (2012) (Roberts, C.J.); *id.* at 2650 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

[22] *See id.* at 2586 (Roberts, C.J.) ("Legislative novelty is not necessarily fatal; there is a first time for everything. But sometimes 'the most telling indication of [a] severe constitutional problem . . . is the lack of historical precedent' for Congress's action." (quoting Free Enter. Fund v. Pub. Co. Accounting Oversight Bd., 130 S. Ct. 3138, 3159 (2010))).

[23] *See* NFIB, 132 S. Ct. at 2587 (Roberts, C.J.) ("Construing the Commerce Clause to permit Congress to regulate individuals precisely *because* they are doing nothing would open a new and potentially vast domain to congressional authority."); *id.* at 2644 (Scalia, Kennedy, Thomas, & Alito,

All three of these concerns, however, hinged on a misconception—or at least a far-too-limited conception—of the individual mandate's intended ends. The conservative Justices saw the provision as nothing more or less than an attempt to create health insurance demand by dictate.[24] They entirely missed the role that insurance plays—and that the mandate therefore plays—in regulating healthcare and health. Of course, the Obama Administration's legal team did not entirely acquiesce in this misconception of Obamacare's intended ends,[25] but nor did they do everything they could to rebut it. In my view, the President's lawyers made two crucial mistakes. First, they did acquiesce a little bit in the conservative Justices' view. In countering the slippery slope concern, the government's briefs argued that, because of adverse selection, the insurance market has unique needs for legally-induced demand.[26] In other words, they admitted that the mandate was a bald attempt to induce demand, but they claimed that the insurance market was the only one in which demand-by-fiat would be constitutionally permissible. That concession to the Justices' view was unnecessary and potentially harmful. The second mistake was more severe. The Administration's attempt to identify the mandate's effects on health*care* regulation fell far short of its potential. The government focused solely on insurance's role as a payment structure for healthcare, noting that healthcare financing works better when consumers pay early and often for their inevitable medical consumption.[27] But that story says nothing about the long-term savings that mandatory insurance can accomplish by eliminating wasteful consumption and by improving Americans' overall health.[28]

II. HEALTH INSURANCE AS HEALTHCARE REGULATION

Health insurance is not ordinary insurance. To a greater extent than most kinds of private indemnity insurance (like car, home, life, and burial insurance), health insurance provides a robust incentive structure to steer beneficiaries' behavior in the insured market. This incentive structure emerges from three unusual features of health insurance: (1) it requires its beneficiaries to set aside money for all kinds of care (including routine maintenance and wear-and-tear); (2) it requires its beneficiaries to save while they are young for the inordinate costs of care when they are old; and (3) it reviews beneficiaries' consumption choices before indemnifying losses and manipulates the perceived costs of various kinds of care through differential cost-sharing and administrative obligations (especially copays and referrals).

Why is health insurance more intensively regulatory than other kinds of private insurance? For two reasons. First, healthcare is different (in degree, not kind) from other insured products. Medicine is still more art than science, and consumer-

---

JJ., dissenting) ("To be sure, *purchasing* insurance *is* 'Commerce'; but one does not regulate commerce that does not exist by compelling its existence.").

[24] *See, e.g.*, *id.* at 2590 (Roberts, C.J.) (arguing that "most of those regulated by the individual mandate are not currently engaged in any commercial activity involving health care . . . ."); *id.* at 2647-50 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

[25] *See* Reply Brief for Petitioners (Minimum Coverage Provision) at 35-36, Dep't of Health & Human Servs. v. Florida, 132 S. Ct. 2566 (2012) (No. 11-398); Brief for Petitioners (Minimum Coverage Provision) at 37-39, Florida v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011) (No. 11-398).

[26] *See* Reply Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 35-36.

[27] *See* Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 37-39.

[28] *See generally* Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 3; Reply Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 5.

directed care, which reaches its apex when individuals self insure, suffers from known market failures that are much less impactful for car and home repairs and for deaths and burials. Private health insurers, then, manipulate incentives for the same reason that government regulators do: to try to correct these market failures.[29] Second, both before and after Obamacare, there has been less public regulation of individual savings and consumption choices in healthcare than in car and home care, and there is less comprehensive social insurance available for healthcare than there is for deaths and burials.[30] Private health insurers therefore have bigger regulatory gaps to fill than private car, home, life, and burial insurers.

This Part first identifies the three behavioral market failures that are relevant to the regulatory story of private insurance generally (not just health insurance). It then elaborates the relevant vision of health insurance as a comprehensive regulatory tool, fleshing out the three unusual mechanisms that health insurers use to steer savings and consumption. It also explains, based on the relative gravity of the market failures and the relative absence of prior governmental intervention in healthcare, why private health insurance is more aggressively regulatory than private car, home, life, and burial insurance. This Part concludes with a brief note on the differences among the terms "self-insured," "uninsured," and "underinsured" in order to demonstrate that the usefulness of a comprehensive insurance policy does not depend on its coverage of all or even most of a given patient's healthcare expenditures, nor does its usefulness depend on its coverage of expenditures that the patient could not otherwise afford.

A. MARKET FAILURES

There are three market failures present to some degree in the markets for healthcare, car repairs, home repairs, deaths, and burials. This section provides a rough sketch of each: optimism bias, hyperbolic discounting, and the credence goods problem. The next section builds on these rough sketches to explain private health insurance companies' unusual aggression in regulating healthcare.

1. Optimism Bias

Optimism bias is a well-known cognitive failure that causes individuals to underestimate their personal risks of harm relative to the average risk of the general population.[31] This failure is sometimes deemed the Lake Wobegon effect,[32] after Garrison Keillor's Prairie Home Companion town "where all the women are strong, all the men are good-looking, and all the children are above average."[33] It is of

---

[29] *See* Ben-Shahar & Logue, *supra* note 4, at 201. As Ben-Shahar and Logue acknowledge, the notion that insurance regulates in ways that are similar to government is far from novel. *Id.* at 200. Legal and economics scholars have discussed the regulatory role and the regulatory potential of private insurance for decades. *See, e.g.*, ABRAHAM, *supra* note 4, at 10, 18. There have also been recent calls for private health insurance to play an even greater regulatory role for healthcare and medical safety. *See* Ronen Avraham, *Private Regulation*, 34 HARV. J.L. & PUB. POL'Y 543, 554-91 (2011).

[30] *See infra* Parts II.B.1-II.B.2; Ben-Shahar & Logue, *supra* note 4, at 220-25.

[31] *See* Neil D. Weinstein, *Reducing Unrealistic Optimism About Illness Susceptibility*, 2 HEALTH PSYCHOL. 11, 11-12 (1983); Neil D. Weinstein & William M. Klein, *Resistance of Personal Risk Perceptions to Debiasing Interventions*, 14 HEALTH PSYCHOL. 132, 132 (1995).

[32] *See* ELLIOT ARONSON ET AL., SOCIAL PSYCHOLOGY 150 (7th ed. 2010).

[33] *See A Prairie Home Companion with Garrison Keillor: The News from Lake Wobegon*, AM. PUB. MEDIA (Aug. 28, 2010), https://itunes.apple.com/podcast/apm-prairie-home-companions/id215352157?mt=2.

course statistically impossible for more than fifty percent of a population to be above average, but when polling a group with optimism bias, it is not uncommon for more than ninety percent of the group's individuals to claim above-average skills or below-average risks.[34]

Furthermore, information does not combat optimism bias.[35] Imagine, for example, a poll of obese teenagers. At the outset, the poll taker could give the subjects the statistical truth that the average obese individual is five times more likely to develop diabetes than the average normal weight individual.[36] The poll could then ask each member of the group whether he thought his own risk of developing diabetes was higher than, lower than, or the same as the statistical average. If the group suffered from optimism bias, more than fifty percent of them would report a lower-than-average individual risk of developing diabetes.[37] That is, the problem for optimism bias is not that individuals are ignorant of average or statistical risks; it is that they systematically overemphasize their positive risk factors and underemphasize their negative risk factors when comparing themselves to similarly-situated individuals.[38] One teenager who walks to school every day but eats only fried foods will overemphasize her exercise and underemphasize her diet while another who takes the bus but eats a lot of steamed vegetables will do the opposite.

2. Hyperbolic Discounting

The second market failure is hyperbolic discounting.[39] It is rational for individuals to apply a "discount rate" to future rewards, such that one might be willing to invest, say, $100 today to earn a reward of $150 a year from now. This kind of discounting is rational because of the time value of money, which might cause $100 today to be worth more than $150 a year from today. For example, instead of investing $100 in the $150 reward, the individual could invest the $100 in an interest-earning account that would grow by more than $50 in the intervening year, or she could buy goods and services today that would provide her with more than $150-worth of utility by the expiration of the year. Furthermore, there is a risk that the individual will increase her income in the intervening year so that her marginal utility of dollars decreases, making the extra $50 meaningless to her a year from today, and there is a risk that, in the intervening year, the individual will suffer some negative event, like death or disfigurement, that would decrease or even negate the utility of the extra $50. In short, discounting of future rewards is a pervasive and rational human behavior.

---

[34] *See, e.g.*, David M. DeJoy, *The Optimism Bias and Traffic Accident Risk Perception*, 21 ACCIDENT ANALYSIS & PREVENTION 333, 335-37 (1989).

[35] Weinstein & Klein, *supra* note 31, at 138-39.

[36] *See* News Release, Nat'l Inst. of Child Health and Human Dev., Many Obese Youth Have Condition that Precedes Type 2 Diabetes: Studies to Address Obesity-Linked Diabetes in Children (Mar. 13, 2002), *available at* http://www.nichd.nih.gov/news/releases/obese.cfm.

[37] *See* Cynthia T.F. Klein & Marie Helweg-Larsen, *Perceived Control and the Optimistic Bias: A Meta-Analytic Review*, 17 PSYCHOL. & HEALTH 437, 437-38 (2002).

[38] *See* Tali Sharot, *The Optimism Bias*, TIME, May 28, 2011, at 1-2, *available at* http://content.time.com/time/health/article/0,8599,2074067,00.html.

[39] *See, e.g.*, Uri Benzion et al., *Discount Rates Inferred from Decisions: An Experimental Study*, 35 MGMT. SCI. 270, 270 (1989); Peter Fishburn & Ariel Rubinstein, *Time Preference*, 23 INT'L ECON. REV. 677, 678 (1982); David Laibson, *Golden Eggs and Hyperbolic Discounting*, 112 Q.J. ECON. 443, 443-45 (1997).

But humans do not discount in a time-consistent and rational way. Instead of applying a constant discount rate with exponentially decreasing valuation of future rewards, which would match the behavior of currency over time, humans discount hyperbolically.[40] Relative to exponential discounting, hyperbolic discounting underestimates the present value of future rewards and overestimates the future value of present rewards. To return to the obesity example: imagine an obese teenager who understands that his obesity has increased his risk of developing diabetes later in life. He must now decide how much he is willing to pay today, in consumption of preventive care like diet, exercise, or even gastric bypass surgery, to capture the future reward of avoiding diabetes. Even if he correctly estimates the likelihood, magnitude, and accrual date of the future reward, hyperbolic discounting will cause him to underestimate the *present* value of that reward such that his willingness to pay today will be lower than optimal. Or, put another way, he will overvalue the present reward of eating steaks and watching TV relative to the future reward of avoiding diabetes.

Notably, the farther into the future a reward will accrue, the more pronounced this effect becomes. Under hyperbolic discounting, the discount factor increases with time, as it would under exponential discounting, but the discount *rate* decreases with time (rather than staying constant). As a result, the divergence between an individual's optimal and actual willingness to pay for a future reward grows as the lag between investment and reward grows.

3. Credence Goods

The final relevant market failure is the credence goods problem.[41] A credence good is one that consumers have a hard time evaluating both before and after consumption such that experience provides little if any help in determining one's willingness to pay for future consumption—even from the same provider.[42] This problem arises from three features of credence goods, which cause problems whether they exist alone or in combination. First, credence goods do not reveal their full value upon consumption.[43] A gastric bypass surgery, for example, usually has the observable benefit of making the patient skinnier, but it does not, without significant waiting time and further intervention like blood tests, reveal information about its success in decreasing the patient's diabetes risk. Second, some credence goods are simply of uncertain value.[44] Most dietary supplements, for example, have never been tested for long-term efficacy, so their true value to the consumer is simply unknown. Third, credence goods are subject to tremendous information asymmetry between consumer and provider.[45] For example, when a doctor tells her patient that his knee pain is due to a sprained medial collateral ligament (MCL), the patient rarely has enough independent information to verify or rebut the doctor's assessment (even if he has seen his diagnostic test results, such as images from magnetic resonance imagery (MRI)).

---

[40] Laibson, *supra* note 39, at 445-46.

[41] *See* Uwe Dulleck & Rudolf Kerschbamer, *On Doctors, Mechanics, and Computer Specialists: The Economics of Credence Goods*, 44 J. ECON. LITERATURE 5 (2006).

[42] *Id.* at 41.

[43] *Id.* at 7.

[44] *See* Peter W.B. Phillips & Grant Isaac, *GMO Labeling: Threat or Opportunity?*, 1 J. AGROBIOTECHNOLOGY MGMT. & ECON. 25, 26 (1998).

[45] *See* Dulleck & Kerschbamer, *supra* note 41, at 47.

Whether together or alone, these problems make it extremely difficult for an individual to determine his willingness to pay for any consumption at all, and they make it even harder for the individual to determine the right *differential* in willingness to pay for various substitute goods. Imagine, for example, that one of the obese teenagers is trying to decide between a diet pill and a gastric bypass surgery to combat his morbid obesity. To decide between the two options, he would want to know their relative prices as well as their relative efficacies for improving his appearance and health. If, for example, the pills cost $5,000 over a lifetime of use while the surgery cost $10,000 for the one-time intervention, the patient would need to know whether the surgery is sufficiently more efficacious than the pills to justify the $5,000 in additional cost. But both the pills and the surgery will have unknown efficacies before consumption and, in their abilities to improve long-term health, will have unknown efficacies *after* consumption. The teenager, thus, will be incapable of making an informed choice between the pills and the surgery. Neither the goods themselves nor the reports from friends who have consumed them will reveal full information about the goods' values relative to one another. In such a case, the patient is very likely to consult a doctor for advice and to rely on the doctor's presumably better-informed assessment, but the doctor's incentives are not perfectly aligned with the patient's. The doctor might recommend surgery simply because she will get paid for performing a surgery but not for prescribing a drug.

Together, optimism bias, hyperbolic discounting, and the credence goods problem create many difficulties in the markets for healthcare, as well as in the markets for home and auto repairs, deaths, and burials. The next section will discuss the various strategies that private insurers (and government regulators) have used to combat the inefficiencies that emerge from these failures. It will also explain why the failures have been worse for healthcare than for the other insured markets, forcing private health insurance companies to be more aggressively regulatory than other kinds of private insurance.

B. HEALTH INSURANCE'S CORRECTIONS

There are three regulatory features of health insurance that make it more aggressively regulatory than ordinary indemnity insurance, all of which are attempts to correct cognitive inefficiencies: preventive care coverage, forced lifetime savings, and relative cost manipulations. This section will flesh out each of those unique features in turn. In the process, it will also explain why these private market adaptations have been more necessary for health insurance than for car, home, life, and burial insurance, demonstrating that the cognitive failures are more impactful for healthcare and that public regulatory corrections are less pervasive in healthcare.

There is one general caveat that is worth identifying at the outset: all of these unusual features of health insurance are characteristic of comprehensive insurance products of the kind that will satisfy the individual mandate,[46] but they are not characteristic of all health insurance products that existed in the pre-Obamacare world. For example, high deductible health plans do not engage in the same level of incentive-setting for their beneficiaries. Nevertheless, these insurance features are all regulatory strategies that the private market adopted voluntarily, before Obamacare passed; they were not governmentally dictated in the first instance.

---

[46] *See* 42 U.S.C. § 5000A (Supp. IV 2010) (requiring individuals to carry "minimum essential coverage" and, inter alia, defining the kinds of health insurance plans that satisfy this requirement).

1. Comprehensive Coverage

The first unusual feature of private health insurance is that it covers all kinds of healthcare consumption, not just catastrophic loss. Car insurance won't cover an oil change or a tire rotation, but health insurance will cover a routine physical. If your doorknob falls off, you cannot file a claim with your homeowners insurance to replace it, but if you scrape your knee, your health insurance will cover a visit to the doctor to have the scrape cleaned and bandaged. This feature of private health insurance was nearly universal in the private market before Obamacare; even high deductible plans would count the costs of routine care against annual caps for out-of-pocket healthcare spending.[47]

Why does health insurance, unlike other kinds of insurance, cover non-catastrophic losses? The problem is that the relevant kinds of consumption—for routine maintenance and wear-and-tear—constitute present investments in future rewards, and they are therefore subject to hyperbolic discounting. The point of an annual checkup is to ensure that the patient is living a healthy lifestyle today, and to catch and prevent future medical problems before they arise. If individuals are not required to spend money on this kind of future-regarding care, they will consume systematically too little of it. Comprehensive health insurance corrects this under-consumption by forcing individuals to spend money on preventive care. The insurers bundle preventive coverage with catastrophic coverage, charging for preventive care in premiums rather than out-of-pocket payments, in order to lower the perceived marginal cost of investing in the future reward of good health. In other words, the marginal cost of an annual checkup with insurance coverage is only the time and opportunity cost of going to the doctor; the monetary cost is already paid.[48] This decrease in the perceived cost of today's investment in future health counteracts the systematic undervaluation of preventive care that results from hyperbolic discounting.

Of course, hyperbolic discounting similarly affects consumption of oil changes and tire rotations for a car and consumption of pest control and weather proofing in a home; those kinds of preventive care are also present investments in future value. So what's different about healthcare? Two things. First, the relevant timescale is much longer for human health than it is for cars or homes. The average length of ownership for the human body is 78.5 years in the United States;[49] you're stuck with your body for life. By contrast, the average length of ownership for both cars and homes is about 5 years,[50] and the Internal Revenue Service estimates the total useful life of cars[51] at 5 years[52] and the total useful life of residential properties at 27.5-40

---

[47] *See* Walecia Konrad, *Preventing Sickness, with Plenty of Red Tape*, N.Y. TIMES, Sep. 19, 2011, http://www.nytimes.com/2011/09/20/health/policy/20consumer.html?_r=0.

[48] Before Obamacare, many insurance policies charged a small copay, usually fifteen dollars or twenty dollars, for office visits like checkups. Under Obamacare, insurance may not charge a copay for any preventive care visits. *See What are My Preventative Care Benefits*, HEALTHCARE.GOV, https://www.healthcare.gov/what-are-my-preventive-care-benefits (last visited Sept. 16, 2013).

[49] *See FastStats: Life Expectancy*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchs/fastats/lifexpec.htm (last updated May 30, 2013).

[50] *See* Jason P. Schachter & Jeffrey J. Kuenzi, *Seasonality of Moves and the Duration and Tenure of Residence: 1996*, U.S. CENSUS BUREAU (DEC. 2002), http://www.census.gov/population/www/documentation/twps0069/twps0069.html; *Average Length of U.S. Vehicle Ownership Hit an All-Time High*, KELLEY BLUE BOOK (Feb. 23, 2012), http://www.kbb.com/car-news/all-the-latest/average-length-of-us-vehicle-ownership-hit-an-all_time-high/.

[51] These figures are relevant only to cars and homes that are used for business purposes, and they include high-use vehicles like rental cars and taxis and high-occupancy rental properties like

years.[53] One might think that these differences would make individuals more precautionary, not less, in taking care of their bodies since they are stuck with their bodies for longer (and cannot trade their current bodies for better ones when their current bodies degrade). But because of hyperbolic discounting, the longer timescale between present investment and future reward causes a bigger gap between optimal and actual present valuation. A young adult does not expect to accrue the full benefit of exercise for fifty-some years, but a car owner will accrue the full benefit of regular oil changes within 5 years. The irrationalizing effect of hyperbolic discounting is therefore more impactful for exercise than it is for oil changes.

Second, government has been far less interventionist in healthcare than it has been in car and home repairs. Except for vaccines,[54] there is no legal requirement that one consume preventive healthcare (or any other kind of healthcare). There are, however, requirements in every state that cars undergo and pass annual inspections,[55] that houses undergo and pass inspections whenever offered for sale,[56] and that all cars and homes meet a warranty of merchantability when traded.[57] All of those laws effectively require car and home owners to consume preventive care—to keep their cars and homes sturdy enough to pass inspections and to be resold. Because of those laws, private insurance policies for cars and homes have not needed to create strong incentives for consumption of preventive care; the government has already done so.

In short, private health insurance policies have long played a regulatory role in encouraging the currently young and apparently healthy to consume more preventive care than they would if left to their own (hyperbolically discounted) devices. Young people who self-insure forgo this regulatory intervention, and as a result, they very likely consume too little healthcare today relative to the optimum for their future health.

2. Community Rating

The second relevant feature of health insurance is that it requires individuals to save when they are young for healthcare that they will consume when they are old. Unlike other kinds of indemnity insurance, many health insurance policies do not set premiums according to individuals' actuarial risk.[58] Instead, they engage in community rating across age groups, despite the groups' differential health risks.[59] This feature of health insurance was less common among pre-Obamacare health

---

apartment buildings. The figures are therefore lower than they would be if they included owner-used cars and owner-occupied homes. *See* INTERNAL REVENUE SERV., DEP'T OF THE TREASURY, PUBL'N 946, HOW TO DEPRECIATE PROPERTY 62 (2013), http://www.irs.gov/pub/irs-pdf/p946.pdf.

[52] *Id.* at 104.

[53] *Id.* at 40-41 (giving residential rental properties a 27.5-year useful life under one system of depreciation but a forty-year useful life under a different system of depreciation).

[54] *State Vaccination Requirements*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/vaccines/vac-gen/laws/state-reqs.htm (last modified Sept. 30, 2011).

[55] 23 U.S.C. § 402 (2012).

[56] *Home Buyers: Home Inspection Information*, NAT'L ASS'N OF HOME INSPECTORS http://www.nahi.org/consumers/home-buyers (last visited Sept. 16, 2013).

[57] *Businessperson's Guide to Federal Warranty Law*, BUREAU OF CONSUMER PROT. BUS. CTR. (Dec. 2006), http://business.ftc.gov/documents/bus01-businesspersons-guide-federal-warranty-law#understanding.

[58] *See* Uwe E. Reinhardt, *Is 'Community Rating' in Health Insurance Fair?*, ECONOMIX (Jan. 1, 2010, 7:01 AM), http://economix.blogs.nytimes.com/2010/01/01/is-community-rating-in-health-insurance-fair/?_r=1.

[59] *Id.*

insurance policies than the comprehensive coverage described in the prior subsection, but community rating was not Congress's innovation in 2010. Many private health insurance policies, especially large group plans provided through employers, engaged in age-based community rating long before Obamacare.[60] (Indeed, the employer-provided plans that were most likely to have adopted this strategy pre-Obamacare are among the *least* regulated kinds of health insurance both before and after Obamacare.[61])

The benefit of this feature of health insurance is that it combats both hyperbolic discounting and optimism bias. The point about hyperbolic discounting is identical to the discussion above about comprehensive coverage except that it relates to pure financial investments in future health rather than healthcare investments in future health. Just as they will consume too little preventive care for the future reward of good health, individuals will put aside too little money for the future reward of high-quality care. Community rating combats that problem by forcibly smoothing individuals' monthly investments across their lives. From a systemic perspective, insurance requires those who are currently young to invest today in their future healthcare needs.[62]

The problem that arises from optimism bias has different origins but identical effects. Optimism bias causes individuals to assume that they will not need much healthcare in the future—that their risk of incurring high medical bills in later life is lower than average. This problem does not depend on any distortions in the valuation of present or future health; it is simply a universal sense that the future will be healthy and cheap. Of course, that sense is emphatically misguided. All individuals—not just currently high-risk individuals—will very likely need more and more expensive healthcare when they are old. Americans spend only one-third of their lifetime healthcare costs in their first fifty years of life; the remaining two-thirds accrues in middle and older age, in the last 20-30 years of life.[63] Put another way, the average thirty-year-old spends seven times less per year on healthcare than the average sixty-five-year-old,[64] and he spends nearly twelve times less than the average person over age eighty-five.[65] Notably, the average sixty-five-year-old does

---

[60] *Id.*

[61] *See* Russell B. Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 1 YALE J. HEALTH POL'Y L. & ETHICS 89, 92 (2005).

[62] One might object to this view on the ground that the money is not actually being invested for the future but rather is being immediately spent on the healthcare needs of the currently old. The system is admittedly one of immediate cross-subsidization rather than standard financial investment. But there is no meaningful difference in this context between quotidian investment and cross-subsidization; by supporting and maintaining an insurance system of cross-subsidization (by "investing" in the colloquial sense in a strong private insurance system), the currently young ensure that they will have access to dramatically discounted healthcare when they are old. Indeed, the colloquial investment in a cross-subsidizing insurance system may be more secure than a stock market investment to pay for future healthcare directly.

[63] Berhanu Alemayehu & Kenneth E. Warner, *The Lifetime Distribution of Health Care Costs*, 39 HEALTH SERVS. RES. 627, 636-38 (2004).

[64] These statistics may suffer a bit from the presence and operation of Medicare. It is possible that individuals could consume less medical care after age sixty-five than they currently do but that the generosity of Medicare creates a moral hazard that partially explains the statistical jump in spending at the Medicare age. Even looking at statistics from forty-year-olds, though, most of whom are not yet Medicare-eligible, it is clear that healthcare spending increases with age faster than income does. From age twenty to forty, healthcare spending increases 1.7 times and income increases only 1.3 times. *Compare id. with* U.S. CENSUS BUREAU, HISTORICAL INCOME TABLES: PEOPLE, http://www.census.gov/hhes/www/income/data/historical/people/ (last visited Aug. 31, 2013).

[65] Alemayehu & Warner, *supra* note 63, at 636-38.

not earn anything close to seven times more than the average thirty-year-old.[66] Even taking pre-retirement figures (i.e. looking at sixty-four-year-olds instead of sixty-five-year-olds), the average American male earns only 1.5 times more than he did at age thirty.[67] The average post-retirement male earns a mere 1.007 times more than he did at age thirty, and even at the peak of an individual's earning power, between ages 45-54, he earns only 1.53 times more than he did between ages 25-34.[68] The rational thirty-year-old therefore ought to save today for healthcare that he will need when he is old; starting around age fifty, he will need far more and far more expensive care than he will be able to afford.

But all of the medical problems associated with old age are subject to optimism bias. Young people systematically underestimate their risks of one day needing cancer treatments, cardiovascular interventions, hip replacements—and everything else. When young, we imagine that we will be the eighty-year-old we see on the ski slopes, not the one we visit in the nursing home—even though we know that there are far more eighty-year-olds in nursing homes than on ski slopes. As a result, Americans who self-insure save systematically too little. Community rating across age groups is a way to combat that error, ensuring that younger people pay too much today so that they can pay too little tomorrow.

As with under-consumption of preventive care, the under-consumption of savings is more of a problem for healthcare than it is for car and home repairs or for deaths and burials, again for the two reasons outlined above: the impactfulness of the cognitive failures and the lack of governmental intervention.

First, optimism bias is more impactful for healthcare than for car and home repairs (though about equally impactful as for deaths and burials). Optimism bias impacts humans' assessments of themselves and other humans. It might cause an individual to think that she is smarter, better-looking, and healthier than average, and it might cause her to think that her doctor, car mechanic, or home electrician is more skilled than average. But it does not make her think that her house's plumbing is sturdier than average or that her car will hold up better than average in a crash. If making decisions about how much money to save for future home and car repairs, then, an individual will not underestimate the likelihood of home or car deteriorations the same way that she will underestimate her likelihood of sickness and death.

That said, optimism bias *does* cause individuals to overestimate their own driving skills—an assessment of the human driver rather than the vehicle—and the bias thus causes individuals to underestimate their risks of collision.[69] This failure might cause individuals to save too little for future car repairs in the same way that it causes individuals to save too little for future healthcare; they simply do not believe that they will need to consume much in the future. But that brings us to the second difference between healthcare and car repairs—government's greater intervention—which is also the relevant difference between healthcare and deaths and burials: before Obamacare, government required more savings for cars, deaths, and burials than it did for healthcare.[70] All states require drivers to carry private car insurance so

---

[66] *See* U.S. CENSUS BUREAU, *supra* note 64.

[67] *Id.*

[68] *Id.*

[69] *See* DeJoy, *supra* note 34, at 333. To my knowledge, there has never been a similar finding of optimism bias in home repairs.

[70] There is no regulatory obligation to hold homeowners insurance, but most banks and lending institutions require mortgage holders to maintain such insurance until the loan is repaid.

that they have money set aside to repair collision damage.[71] For deaths and burials, the obligatory Social Security system of survivors' benefits[72] ensures that individuals save enough money to support their dependents—and to help their dependents pay for their burials—if they die younger than they were (optimistically) expecting. Admittedly, both before and after Obamacare, individuals are required to contribute to Medicare and Medicaid throughout their working lives, and they are thus required to save money for nursing home care,[73] hospitalization after age sixty-five,[74] and, to a lesser extent, outpatient care after age sixty-five.[75] But until Obamacare, the government had not required individuals to carry insurance—or otherwise to save money when young—for the increased healthcare that they will need between ages fifty and sixty-five. Private health insurance had to fill that gap, forcing young people to save for the fifteen-year period of high, pre-Medicare healthcare expenses by charging them too much today and allowing them to pay too little later.

3. Cost Manipulations

The final unusual feature of private health insurance is that it charges different out-of-pocket amounts and requires different administrative hurdles depending on where the beneficiary consumes care and what kinds of care he consumes. This differential cost-setting occurs through five related mechanisms: copays, networks, referrals, medical necessity review, and coverage exclusions. None of these mechanisms are common among car, home, life, or burial insurance.

First, imagine a patient who scrapes his knee over the weekend, when his usual doctor's office is closed. If he goes to the emergency room rather than a 24-hour urgent care facility, most private health insurance companies will charge him significantly more than they would have for the urgent care center. In health insurance terms, the companies set different copays for different kinds of care.

Second, imagine that the same patient went to an urgent care center, but he chose a center closer to his house rather than driving to the one affiliated with his regular doctor. If the closer facility did not have a relationship with the patient's insurance company, the insurance might cover significantly less of the cost than it would have for a visit to his usual doctor. In insurance terms, the company will cover less of the total cost for visits to out-of-network providers than for preferred or in-network providers.

Third, imagine that the patient instead scrapes his knee during regular business hours, but he goes straight to an orthopedist instead of visiting his primary care

---

[71] *See* Shamit Choksey, *Car Insurance Requirements by State*, CARS.COM (June 26, 2013), http://www.cars.com/go/advice/Story.jsp?section=ins&subject=ins_req&story=state-insurance-requirements.

[72] *See generally* SOC. SEC. ADMIN, SSA PUBL'N NO. 05-10084, SOC. SEC. SURVIVOR BENEFITS (2012), *available at* http://www.ssa.gov/pubs/10084.html.

[73] Medicaid covers long-term care for many elderly patients. *See* Nina Bernstein, *With Medicaid, Long-Term Care of Elderly Looms as a Rising Cost*, N.Y. TIMES, Sept. 6, 2012, http://www.nytimes.com/2012/09/07/health/policy/long-term-care-looms-as-rising-medicaid-cost.html?pagewanted=all&_r=0.

[74] Medicare Part A is obligatory for all Americans over age 65 and covers all hospitalization costs. *See What does Medicare cover (Parts A, B, C and D)?*, MEDICAREINTERACTIVE.ORG, http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=214 (last visited Sept. 22, 2013).

[75] Medicare Parts B, C, and D are optional and require additional (but highly discounted) premiums. They provide coverage for outpatient (i.e. non-hospitalized) care and for prescription drugs. *Id.*

doctor, thinking that he might have done structural damage to the knee's bones, tendons, or ligaments. Even if the orthopedist were a preferred or in-network provider, the patient's insurance might refuse to cover the visit altogether on the ground that the patient was required to see a primary care doctor before going to a specialist. In insurance terms, the company might require a referral for specialist visits.

Take a moment now to compare these three cost-manipulation strategies to other kinds of insurance. It is true that claims adjusters for car and home insurance companies will visit a damaged property to assess a claim's validity and to determine the magnitude of the loss, and the adjusters will set the indemnification amount by reference to market prices for the specific repairs that the damaged car or home requires. The insurance company might also provide the insured with a list of recommended mechanics or electricians in the area, similar to a health insurer's preferred provider network or referral requirement. But the car or home policy will *not* reduce the indemnifying payment amount if the insured visits a gas station mechanic rather than a dealership, say, or if he uses a dealership that does not appear on the list of recommended shops.

For the fourth cost-manipulation strategy of health insurance, imagine that the patient with a scraped knee visits his primary care doctor first, and his doctor notices that the knee also shows signs of structural instability. The doctor therefore refers the patient to an orthopedist, who diagnoses a ruptured medial collateral ligament (MCL) and recommends surgery. Most private insurance companies would demand medical evidence of a particular need for surgery before agreeing to cover the procedure, and they would refuse coverage if their employees determined, contrary to the doctor's assessment, that the MCL would respond adequately to physical therapy.[76] In insurance terms, the companies engage in medical necessity review before deciding whether to indemnify a recommended course of treatment.[77]

Fifth, imagine that the patient tore his anterior cruciate ligament (ACL) rather than his MCL and that ACL tears almost always require surgery. Imagine further, though, that the patient is terrified of surgery and that his orthopedist has recently invented a nonsurgical, injection-based repair technique for torn ACLs. Even if the doctor and patient both wanted to follow the nonsurgical route, the insurance company might refuse coverage on the ground that the technique is not sufficiently well-established as an effective alternative to surgery. In insurance terms, companies often deny coverage altogether for new or experimental medical procedures.[78]

Now compare these latter two cost-manipulation strategies to other kinds of insurance. Car and homeowners insurance policies usually provide indemnification against a proven loss without demanding anything at all, and certainly without demanding anything specific, by way of repairs.[79] In many states, a driver with a damaged car can pocket his insurance check without fixing the damage, and in states that require insurance beneficiaries to spend their payments on repairs of some kind, the insurance companies do not insist on any particular repair strategies.[80] The car

---

[76] *See generally* Michael Bihari, *Medical Necessity*, ABOUT.COM HEALTH INS., http://healthinsurance.about.com/od/healthinsurancetermsm/g/medical_necessity_definition.htm (last updated Aug. 5, 2013); *How to Treat an MCL Injury*, THE KNEE.COM, http://www.theknee.com/mcl-medial-collateral-ligament/how-to-treat-an-mcl-injury/ (last visited Sept. 21, 2013).

[77] Bihari, *supra* note 76.

[78] *Id.*

[79] *See* NAT'L ASS'N OF INS. COMM'RS, *Auto Insurance FAQs*, INSURE U ONLINE, http://www.insureuonline.org/consumer_auto_faqs.htm (last visited Sep. 16, 2013).

[80] *See id.*

owner and the mechanic are free to use non-recommended, experimental repair techniques without risking a decrease in the insurance reimbursement.

All of these unusual cost-manipulating features of health insurance serve to combat the credence goods problem. With the first three—copay manipulations, preferred provider networks, and referral requirements—insurance companies steer their patients to higher-value settings and doctors: those that will provide quality care at lower cost. Of course, self-insured patients, who pay out of pocket for their care, might make similar low-cost choices without the insurance company's manipulations. The problem, though, is that low cost is not the same thing as high value. A patient should not necessarily visit the cheapest possible facility or the cheapest possible doctor if that facility's or doctor's quality is significantly lower than higher-priced alternatives.[81] Indeed, the long-term consequences of choosing low-quality, low-cost care might include significantly higher overall healthcare spending if the low-quality providers make mistakes that require further treatment. But because of the credence goods problem, a patient cannot judge quality differentials with anything like enough precision to choose efficiently among care options. Insurance companies can correct that failure because they are much better-situated to observe an individual doctor's or an individual facility's quality by observing outcomes across many patients.[82] By creating a list of "preferred providers" that the insurance company assesses as high value and by disfavoring care settings that are systematically likely to be lower value (like emergency rooms and specialists), the companies can steer their patients to more efficient healthcare options.

With the other two cost-manipulation strategies—medical necessity review and evidence-based coverage decisions—health insurance companies directly combat the information asymmetry that is characteristic of credence goods. Take the example of MCL surgical repair: the orthopedist might have recommended surgery instead of physical therapy because she performs surgeries herself (and gets paid for doing so) but does not perform physical therapy.[83] But the patient might not know that. Most patients don't know the difference between an ACL and an MCL, much less whether a ruptured MCL requires the same surgical intervention as a ruptured ACL. (It usually does not.)[84] Insurance companies, with their medical staffs and expert claims processors, know that MCL tears usually respond adequately to physical therapy and that surgery would be an unnecessary expense for most patients with torn MCLs. By reviewing the individual patient's claim and the doctor's specific treatment recommendation, the insurance company can correct the element of the credence goods problem that arises from information asymmetry, preventing the doctor from abusing her superior information to extract greater profits.

Similarly, by denying coverage for new and experimental treatments, insurance companies combat the problem of actual uncertainty in the value of many medical interventions, which would otherwise allow doctors even greater leeway to abuse their superior information. Compare the torn MCL to the torn ACL: there is a degree

---

[81] This is why credence goods are often characterized by price inflation. Consumers attempt to judge quality by price, and providers respond by raising their prices to signify quality.

[82] *See generally* Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Could Be Good for Health Law*, 90 B.U. L. REV. 2323, 2359-60 (2010).

[83] The orthopedist in this example is also legally prohibited from taking a "kickback" for referring a patient to a particular physical therapist. *See* Anti-Kickback Statute, 42 U.S.C. § 1320a-7b (2006).

[84] *See Knee Sprain*, DRUGS.COM, http://www.drugs.com/health-guide/knee-sprain.html (last visited Sept. 21, 2013).

of actual uncertainty in both cases, but there is significantly more uncertainty for nonsurgical repair of an ACL. In the MCL case, medical science knows from long experience that most ruptured MCLs respond to physical therapy, but it also knows that some do not; some patients with ruptured MCLs do not recover from exercise alone and ultimately need surgery.[85] Each patient therefore experiences some uncertainty as to his prognosis from physical therapy, but the insurance company advocates well for the patient in requiring him to try the much cheaper and usually effective course of physical therapy before deciding on the more painful, more expensive option of surgery. In the hypothetical ACL case, by contrast, medical science would know far less about the patient's prognosis from the new, nonsurgical intervention simply because the science has had less opportunity to test the intervention's effectiveness. The uncertainty in that case would be not only particular to the individual patient but also general to the recommended treatment. That is, even if the nonsurgical injection technique had passed FDA clinical trials, the injections might be snake oil, or, like Vioxx, they might be hazardous.[86] Until more information is available, a rational patient might distrust a new medical procedure, but most patients would not know how new or untested a given procedure is. Informed consent rules[87] require a doctor to notify her patients of established risks, but they do not require her to notify her patients of general uncertainties.[88] This higher-order information asymmetry about the state of medical science allows doctors greater leeway to push risky but profitable care on their patients. Insurance companies combat that possibility by refusing coverage altogether until a medical innovation has established itself through longer and wider experience.

All told, insurance companies go to great lengths to combat the credence goods problem in healthcare. But why are private car and homeowners insurance companies so much less aggressive in this regard? The relevant goods in those markets are also credence goods; the long-term value of regular oil changes is difficult to assess both before and after consumption, and mechanics, plumbers, electricians, carpenters, and architects all benefit from information asymmetries. What, then, explains private health insurance's greater regulatory aggression? In this case, the difference is not that government has been less interventionist for healthcare. If anything, it has been more so. There are many state and federal laws that attempt to ensure the high quality of healthcare provided in the market (such as medical licensure[89] and medical malpractice rules[90]) and that attempt to prohibit unproven medical goods and services from being offered to unwitting patients (such

---

[85] *See* Jonathan Cluett, *Treatment of MCL Tears*, ABOUT.COM ORTHOPEDICS, http://orthopedics.about.com/od/kneeligamentinjuries/p/MCL-Treatment.htm (last updated May 15, 2012).

[86] *See* Snigdha Prakash & Vikki Valentine, *Timeline: the Rise and Fall of Vioxx*, NAT'L PUB. RADIO (Nov. 10, 2007, 2:40 PM), http://www.npr.org/templates/story/story.php?storyId=5470430.

[87] *See Informed Consent*, AM. MED. ASS'N, http://www.ama-assn.org//ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page (last visited Sept. 22, 2013).

[88] *See generally* FRANK H. KNIGHT, RISK, UNCERTAINTY, AND PROFIT (1971) (distinguishing between risk and uncertainty).

[89] *See Medical Licensure*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure.page (last visited Sept. 23, 2013).

[90] *See Medical Liability/Medical Malpractice Laws*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/banking/medical-liability-medical-malpractice-laws.aspx (last updated Aug. 15, 2011).

as FDA approval requirements[91] and informed consent laws[92]). The difference, then, is only that the credence good problem's impact is greater on healthcare than it is on car and home repairs.

Both the degree of uncertainty and the depth of information asymmetry are greater for healthcare than for the other markets. For example, I personally don't understand how my car's axles work, but many other people do, including many people who are not professional car mechanics. Furthermore, there are actual right answers about how axles work that will hold true for all axles of the same kind. If my mechanic tells me that I need to replace a boot on my axle, then, I can overcome my information asymmetry relatively easily by consulting others, including other mechanics as well as non-mechanic friends with expertise, to see if their answers line up. Indeed, these days, I can Google "axle boot replacement" to find information (including information on how to replace the boot myself).[93] If individuals without a direct profit motive contradict the initial mechanic's answer, I can find a different mechanic to repair the car.

Medicine is much finickier than that. Even in the MCL case, where there is a right answer for a majority of patients, there are some patients who continue to complain of knee instability after months of physical therapy. So if my doctor tells me that I look like a patient who will ultimately need surgery and that I might as well get the surgery now rather than trying physical therapy first, I cannot simply consult others—or Google "MCL rupture"—to beat the information asymmetry. Other medical experts, including those posting on sources available through Google searches,[94] will likely hedge on the necessity and value of surgery, telling me (honestly) that some patients do indeed fail to respond to physical therapy. Whether I am likely to be one of those patients might be an unanswerable question, or it might be a question that only someone observing me closely over time could answer. If so, then no amount of external research will help.

In short, there is more actual uncertainty—and thus less general information about the relative quality of care and greater opportunity for abuse of information asymmetry—in medicine than in home and auto repairs. Individuals who self-insure, and thereby attempt to navigate this uncertain market without the help of the objective, multi-patient perspective that insurance companies provide, are much more likely to visit low-value doctors and to get hoodwinked into spending money on unnecessary care.

C. SELF-INSURED, UNINSURED, OR UNDERINSURED

In the debates over the individual mandate, the Obama Administration and its allies tended to refer to those without comprehensive insurance as the "self-insured" while the plaintiffs and their allies tended to refer to the same population as the "uninsured."[95] The reason was purely rhetorical. Pro-mandate advocates wanted to

---

[91] *See* United States v. Rutherford, 442 U.S. 544, 552 (1979) (finding there is no exception for interstate shipment of unapproved pharmaceuticals under the Food, Drug, and Cosmetic Act).

[92] *See Informed Consent*, *supra* note 87.

[93] *See* Google Search for "axle boot replacement," GOOGLE, https://www.google.com/#q=axle+boot+replacement (last visited Sept. 27, 2013).

[94] *See, e.g.*, *Cluett*, *supra* note 85 ("Surgery for MCL tears is controversial . . . . Most surgeons agree that for patients who complain of persistent knee instability, despite appropriate nonsurgical treatment, surgery is reasonable.").

[95] *Compare* Reply Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 6 ("No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are

emphasize that those without comprehensive insurance were nevertheless active in the healthcare and health insurance markets—that they were making an active choice to "self insure"—while anti-mandate advocates wanted to emphasize the inactivity of simply forgoing insurance—of being "uninsured." Throughout this article, I use the term "self-insured" rather than "uninsured," but the reason is not at all rhetorical. There are real definitional differences in the terms "self-insured" and "uninsured," and the arguments throughout this article center on the self-insured, not the uninsured or underinsured.

By "self-insured," I mean anyone who plans to pay for his own healthcare needs out of his own pocket, whether or not he is actively saving money for healthcare. By "uninsured," I mean anyone who has zero liquidity available for healthcare purchases. Such people are extremely rare or non-existent; most people can afford a bottle of Advil, and those who cannot are eligible for Medicaid. By "underinsured," I mean anyone who can afford some healthcare but not all of the care he needs.

Of course, the vast majority of self-insured individuals are also underinsured. But there could be self-insured individuals who are rich enough to cover even the most expensive healthcare, such that they are neither uninsured nor underinsured. Nevertheless, those individuals are just as likely as the underinsured to suffer the cognitive limitations that cause under-consumption of preventive care and inefficient consumption of medical interventions. That is, a very wealthy self-insured patient will be just as likely to undervalue current investments in the future reward of good health and thus to consume too little preventive care; she will be just as likely to be overly optimistic about her future health and to consume too little preventive care for that reason; and she might be even *more* likely than the underinsured to consume high-price care that is not high-value, like an orthopedist visit for a scraped knee or a surgery for an MCL rupture. Of course, by hypothesis, this patient will be able to pay for the inefficient costs she incurs from future poor health and from high-price care, but she will unnecessarily and inefficiently consume scarce resources (like an orthopedist's time) in a zero-sum healthcare system.

There is also a flip side to this point, which is that the problem with self-insurance arises from the absence of an insurance company's manipulations, not from the mere fact of out-of-pocket spending. Individuals with comprehensive insurance policies remain free to spend extra-insurance money on healthcare. The MCL patient could get immediate surgery, notwithstanding his insurance company's refusal to cover the procedure, if he was willing to pay for it on his own. The usefulness of comprehensive insurance, though, does not depend on forcing individuals to consume healthcare efficiently; it is the manipulation of costs and incentives that make individuals *more likely* to consume healthcare efficiently. Insurance companies send valuable signals to their beneficiaries about the costs and benefits of various consumption choices, and those signals suffice to make comprehensive insurance a better, more efficient option than self insurance. In the end, then, some colloquially "uninsured" healthcare transactions—some transactions paid for without indemnification—are tolerable in the market as long as they are not made in the absence of a comprehensive insurance company's manipulations.

---

two forms of action for addressing the same risk . . . ." (quoting Thomas More Law Ctr. v. Obama, 651 F.3d at 529, 561 (6th Cir. 2011) (Sutton, J., concurring))) *with* NFIB v. Sebelius, 132 S. Ct. 2566, 2590 (2012) (Roberts, C.J.) ("The individual mandate's regulation of the uninsured as a class is, in fact, particularly divorced from any link to existing commercial activity.").

The problem that Obamacare sought to fix, then, is not just that the self-insured consume care they cannot afford; it is also that they do a bad job of consuming care they *can* afford.

III. HEALTH INSURANCE AS REGULATION OF INTERSTATE COMMERCE

This regulatory vision of health insurance—this notion that mandated insurance can improve individuals' healthcare consumption choices—could have changed the narrative in *NFIB v. Sebelius*, particularly adding a better narrative under the Commerce Clause and Necessary and Proper Clause. Rather than arguing, as they did, that the mandate is a means of correcting adverse selection and cost-shifting in health insurance or that the mandate is merely a required payment structure for inevitable healthcare purchases,[96] the Department of Justice (DOJ) lawyers could have argued that the mandate is a means of eliminating inefficiencies that arise from self-insured healthcare transactions.[97] By pointing out that individuals who consume healthcare without insurance make systematically less-efficient choices than those who consume care *with* insurance, the legal team could have refocused the debate on Congress's intent to use mandatory private insurance contracts as means of regulating all existing commerce in healthcare.[98]

This narrative would have had three concrete advantages over the one that the Obama Administration presented. First, it would have demonstrated that the individual mandate is a regulation of the healthcare market that corrects pervasive market failures in individual savings and consumption decisions; it is not just a stimulation of the health insurance market that solves problems arising from Obamacare's own provisions related to preexisting conditions and community rating.[99] Under this story, the point of the mandate is not to reimburse the health insurance companies for money that they will lose under Obamacare's market reforms;[100] it is to improve individuals' healthcare choices. Second, this story aligns the individual mandate with the prohibition of intrastate manufacturing of medicinal marijuana that the Court upheld in *Gonzales v. Raich*,[101] rather than casting it as a novel exercise of regulatory power to stimulate commerce. It establishes that one of Congress's goals with the mandate was to eliminate a disfavored set of commercial transactions—in this case, self-insured healthcare transactions[102]—and it casts the individual mandate as a rational means of accomplishing that uncontroversially legitimate goal. Third, because health insurance is more aggressively regulatory than other kinds of indemnity insurance, this narrative could have eased many of the

---

[96] *See NFIB*, 132 S. Ct. at 2610 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part); Brief for Respondents (Severability) at 33, NFIB v. Sebelius, 132 S. Ct. 2566 (Nos. 11-393, 11- 400); Reply Brief for Respondents (Severability) at 11, NFIB v. Sebelius, 132 S. Ct. 2566 (Nos. 11-393, 11-400).

[97] Brief for Abigail Moncrieff et al. as Amici Curiae Supporting Petitioners, at 20-21, NFIB v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11-398), *available at* http://ssrn.com/abstract=2070625 [hereinafter PPC Brief].

[98] *See* 42 U.S.C. § 18091(2)(E) (Supp. IV 2010) (Congress made this point explicitly in its findings, noting that "[t]he economy loses up to $207 [billion] a year because of the poorer health and shorter lifespan of the uninsured" and that near-universal coverage "will significantly reduce this economic cost.").

[99] *Cf. NFIB*, 132 S. Ct. at 2585 (Roberts, C.J.); *Id.* at 2645 (Scalia, J., dissenting).

[100] *NFIB*, 132 S. Ct. at 2613 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part); Reply Brief for Respondents (Severability), *supra* note 96, at 8-9.

[101] 545 U.S. 1, 1-2 (2005).

[102] *See* PPC Brief, *supra* note 97, at 4.

Justices' concerns about a slippery slope and a federal police power. If the mandate is a form of healthcare regulation, it is not a crass attempt to stimulate commerce by forcing people to buy things, and because health insurance is different from other kinds of indemnity insurance, Obamacare's mandate would not set a clear precedent even for a burial insurance mandate,[103] much less for a broccoli mandate.[104]

This Part first elaborates the regulatory narrative in doctrinal terms, explaining how the insurance-as-regulation argument would fit into existing Commerce Clause and Necessary and Proper Clause case law. Second, this Part elaborates on the three advantages of this argument over the one that the DOJ presented, focusing particularly on this narrative's ability to rebut the conservative Justices' three chief concerns about the mandate (novelty, slippery slope, and bootstrapping).

A. THE DOCTRINAL NARRATIVE

It is well established in constitutional law—and has been for decades[105]—that the Commerce Clause allows Congress to regulate individual intrastate economic activities that have substantial effects on interstate commerce.[106] There is disagreement among the current Justices as to whether the Commerce Clause authorizes that kind of intrastate regulation on its own or whether it does so only in conjunction with the Necessary and Proper Clause,[107] but there is no doubt that Congress has the power, under many circumstances, to regulate intrastate economic conduct.

In the lead-up to *NFIB*, there were only two questions about the individual mandate's constitutionality under this longstanding rule: whether the statute targets economic activity (clearly permissible) or inactivity (maybe impermissible) and whether the mandate's goal is to regulate existing commerce (clearly permissible) or to create new commerce (maybe impermissible).[108] These two questions are obviously interrelated, but they might be distinct in some circumstances; it might be possible to create new commerce by targeting activity or to regulate existing commerce by targeting inactivity. Using the behavioral economic analysis above, the Obama Administration could have cast the individual mandate quite solidly as a regulation of existing economic activity in the health*care* market rather than as a creation of new economic activity (or punishment of inactivity) in the health *insurance* market. The argument would have gone like this[109]:

There is no doubt that the United States healthcare market includes significant commercial activity in self-insured healthcare. About forty million Americans lack health insurance coverage at any given moment,[110] but those individuals do not

---

[103] *See NFIB*, 132 S. Ct. at 2593 (Scalia, J., dissenting); Transcript of Oral Argument at 7-8, Dep't of Health & Human Servs. v. Florida, 132 S. Ct. 2566 (2012) (No. 11-398).

[104] *See* Transcript of Oral Argument, *supra* note 103, at 13, 18, 77.

[105] *See* Wickard v. Filburn, 377 U.S. 111 (1942).

[106] *Raich*, 545 U.S. at 17 (citing Perez v. United States, 402 U.S. 146 (1971)); United States v. Morrison, 529 U.S. 598 (2000); United States v. Lopez, 514 U.S. 549 (1995); *Wickard*, 377 U.S. 111.

[107] *See Raich*, 545 U.S. 1, 2 (Commerce Clause alone); *id.* at 34 (Scalia, J., concurring) (Commerce Clause in conjunction with Necessary and Proper Clause).

[108] *See* Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1263-64 (11th Cir. 2011) *aff'd in part, rev'd in part sub nom. NFIB*, 132 S. Ct. 2566; Reply Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 16-17.

[109] *See* PPC Brief, *supra* note 97 (Together with five excellent coauthors, including four students, I presented this argument in full in an *NFIB* amicus brief.).

[110] April Fulton, *46 Million Uninsured: A Look Behind the Number*, NAT'L PUB. RADIO (Apr. 21, 2009, 12:36 PM), http://www.npr.org/templates/story/story.php?storyId=111651742.

abstain from consuming care. Importantly, the problem is not just that many Americans without health insurance consume interventionist medicine that they cannot afford—a point that the government made at length.[111] The problem has two additional dimensions as well. First, many self-insured Americans consume interventionist medicine that they *can* afford, but as discussed in the prior section, they do it badly. Second, on a nearly daily basis, everyone consumes "self-help" kinds of healthcare, and the self-insured do that badly, too. For someone with morbid obesity, for example, the decision to order a fish filet rather than a beef steak is an active healthcare choice, and for an otherwise healthy person with a scraped knee, the decision to apply drug store hydrogen peroxide and a Band-Aid is likewise. Notably, I am not referring here to healthcare inactivity, such as the mere decision to forgo an annual checkup, nor am I referring to arguably noneconomic or noncommercial activities akin to home-growing marijuana for personal use,[112] such as jogging during leisure time. I am referring to commercial transactions and economic activities related to quotidian healthcare: buying a bathroom scale rather than visiting a doctor's scale to monitor weight loss, purchasing low fat foods or dietary cookbooks without consulting a nutritionist, buying a heart rate monitor rather than getting a checkup to determine cardiovascular fitness for a new exercise routine, treating low-grade complaints with drug store visits rather than doctor visits. All such decisions might, if made badly, give rise to a need for more serious (and more expensive) medical intervention in the future, and all of them constitute active, commercial healthcare consumption today. In the end, the only way to avoid interacting with interventionist medicine is not only to be extremely lucky in avoiding sickness and accidents (as the government's briefs pointed out[113]), but also to be quite successful at self-help healthcare consumption throughout one's youth, including both preventive care and low-grade curative care. (Even living in a bubble will eventually drive you to a psychiatrist.)

The problem is that both self-help healthcare and interactions with doctors are predictably less efficient among the self-insured, even among the self-insured that can afford to pay their medical bills. As discussed above, patients left to their own devices make overly optimistic, hyperbolically discounted, and informationally-asymmetric choices about their daily healthcare needs. Those with comprehensive insurance do better.[114]

One of Congress's primary goals in passing the individual mandate was to eliminate the healthcare transactions that emerge from cognitively-limited, self-insured decisionmaking. By requiring all Americans to come under the regulatory umbrella of private insurance, Congress sought to move all healthcare transactions from the inefficient self-insured market to the more-efficient fully-insured market.[115] That is, one of the mandate's core goals is to take a patient who might have treated his own scraped knee at home and to make him systematically more likely to seek a doctor's help (using the insurance companies' bundled coverage for routine maintenance), just in case the patient actually did structural damage to the knee.

---

[111] *See NFIB*, 132 S. Ct. at 2611 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part); Reply Brief for Petitioners (Minimum Coverage Provision), *supra* note 25, at 2.

[112] *See Raich*, 545 U.S. at 43 (O'Connor, J., dissenting).

[113] *See* Memorandum in Support of Defendant's Motion for Summary Judgment, Florida v. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2010) (No. 3:10-CV-91-RV/EMT), 2010 WL 4564357.

[114] *See* RAND CORP., *supra* note 5, at 3-4.

[115] *See* 42 U.S.C. § 18091(2)(E) (Supp. IV 2010).

Simultaneously, the goal is to take a patient who might have gone straight to an orthopedist for a damaged knee and to make her systematically more likely to see a primary care doctor first (using the insurance companies' differential cost-setting and referral requirements), to avoid the lower-value setting of specialty care for mere scrapes. In other words, the statute's goal is to require every patient to make all medical decisions within the regulatory framework of comprehensive health insurance.

This vision of Obamacare's mandate is an easy fit for existing Commerce Clause doctrine. It is well settled that Congress's power to regulate existing commerce includes a power to prohibit disfavored commerce.[116] In *Raich*, for example, the difficult question was whether the power to eliminate the interstate market for recreational marijuana included a power to punish the purely intrastate growth and use of medicinal marijuana.[117] No Justice questioned whether Congress had power in the first place to punish—and thereby to try to eliminate—commercial transactions in recreational marijuana.[118] The dissenters merely questioned whether personal growth and use of medicinal marijuana had a big enough impact on the market for recreational marijuana to justify Congress's intervention.[119]

In this case, though, there is no doubt that the targeted intrastate behavior has a profound and immediate impact on the targeted interstate market. Individual decisions to self-insure (or, to use the *NFIB* dissenters' terms, individual decisions to remain inactive in the health insurance market[120]) are wholly responsible for the existence of self-insured healthcare transactions. If every individual in the United States obtained comprehensive health insurance of the kind that will satisfy the individual mandate, the inefficient self-insured transactions would definitionally disappear. The mere possession of a comprehensive insurance policy addresses the relevant inefficiencies. All of that is to say: applying the Commerce Clause test announced in *Lopez* and *Morrison* in conjunction with the economic analysis in Part II, there is simply no doubt that individual decisions to self-insure substantially affect interstate commerce in healthcare, sustaining the inefficient market for self-insured healthcare transactions, and the individual mandate, if everybody in the country complied with it, would cure the problem.

---

[116] *See Raich*, 545 U.S. at 9 (holding that applying the provisions of the Controlled Substances Act to intrastate marijuana production is a permissible exercise of Congress's power under the Commerce Clause); Garcia v. San Antonio Metro. Transit Auth., 469 U.S. 528, 528 (1985) (holding that the minimum wage provisions of the Fair Labor Standards Act applied to the transit authority's employees); United States v. Rutherford, 442 U.S. 544, 544 (1979) (finding there is no exception for interstate shipment of unapproved pharmaceuticals under the Food, Drug, and Cosmetic Act); Perez v. United States, 402 U.S. 146, 146 (1971) (holding that Congress's power under the Commerce Clause includes the ability to regulate local extortionate credit transactions); United States v. Darby, 312 U.S. 100, 113 (1941) (holding Congress had power under the Commerce Clause to regulate employment conditions including wages).

[117] *See Raich*, 545 U.S. at 4-5.

[118] *See id.* at 53 (O'Connor, J., dissenting) (noting, without questioning the broader constitutionality of the Controlled Substances Act (CSA), that "[t]here is simply no evidence that homegrown medicinal marijuana users constitute, in the aggregate, a sizable enough class to have a discernable [sic], let alone substantial, impact on the national illicit drug market—or otherwise to threaten the CSA regime"); *id.* at 59 (Thomas, J., dissenting) ("On this traditional understanding of 'commerce,' the Controlled Substances Act (CSA) . . . regulates a great deal of marijuana trafficking that is interstate and commercial in character.").

[119] *Id.* at 49 (O'Connor, J., dissenting).

[120] See *supra* Part II.C for a discussion of and differentiation among the terms "self-insured," "uninsured," and "underinsured." I use "self-insured" quite intentionally, not to align myself with proponents of the law, but to use the term that most accurately captures the problem of individual decisions to forgo comprehensive insurance coverage.

Under the Necessary and Proper Clause test, the question has an additional step, but the answer is equally clear. The Necessary and Proper Clause demands, first, that Congress pursue ends that are "legitimate" for the Federal Government to pursue under its enumerated powers and, second, that Congress choose rational, "reasonably adapted" means of attaining those ends.[121] The two-part question for the individual mandate is, first, whether Congress's goal of prohibiting self-insured healthcare transactions is a legitimate end and, second, whether the mandate's financial incentive for individuals to obtain and maintain comprehensive insurance coverage is a rational means of accomplishing that end. As noted above, Congress has clear authority to pursue the end of eliminating disfavored transactions in interstate commercial markets, so Congress's goal with the individual mandate is undoubtedly legitimate. The question under the Necessary and Proper Clause, then, is only whether an insurance purchase mandate is a rational and reasonably adapted means of accomplishing that goal. Given that mere possession of comprehensive health insurance seems to fix the market failures in self-insured decisionmaking, mandatory acquisition and maintenance of such insurance seems unambiguously rational and extraordinarily closely adapted.

All of that said, comprehensive health insurance of the kind that satisfies the mandate also adds inefficiencies. Most famously, insurance creates a moral hazard, which might cause individuals to engage in riskier behaviors, knowing that they can get the medical care they need. For example, obese individuals might become *less* likely to combat their obesity if they know that they will have coverage for their later diabetes. Insurance also obscures pricing for healthcare, which might cause individuals to demand care that is not cost-justified without realizing how expensive the care is. Of course, insurance companies are aware of these problems, and some of the manipulations identified in Part II exist to combat them;[122] medical necessity review, for example, does some work in correcting the problem of price obfuscation. But even if comprehensive insurance might create more inefficiencies than it corrects, that possibility does not matter to the constitutional analysis. In order to establish that the mandate is a permissible means of achieving a legitimate end, the government did not need to prove that the inefficiencies from self insurance are, in fact, worse than the inefficiencies from comprehensive insurance; the test is only whether Congress had a rational basis for believing they are.[123] Courts defer to legislatures' rational economic and policy assessments. Given the economic theory discussed in Part II, the existing data showing that the self-insured experience poorer health, shorter lifespans, and greater costs than the comprehensively insured,[124] and the lack of long-term data on costs or savings associated with consumer-directed health plans,[125] Congress had at least a rational basis for believing that patients with

---

[121] *See Raich*, 545 U.S. at 37 (Scalia, J., concurring) (noting that the "relevant question [under the Necessary and Proper Clause] is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power" (citing United States v. Darby, 312 U.S. 100 (1941)); Sabri v. United States, 541 U.S. 600, 605 (2004); M'Culloch v. Maryland, 17 U.S. (4 Wheat.) 316, 421 (1819) ("Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.").

[122] *See* Ben-Shahar & Logue, *supra* note 4, at 205.

[123] *See Raich*, 545 U.S. at 22 (defining the standard of review as "rational basis").

[124] *See* 42 U.S.C. § 18091(2)(E) (Supp. IV 2010).

[125] The trend of consumer-directed health plans, such as Health Savings Accounts and high deductible health plans, began in 2003. There was early evidence that those with consumer-directed plans spent less on healthcare than those with comprehensive insurance, but some or even most of those savings might have come from under-consumption of preventive care, which could result in

comprehensive insurance will perform better in the healthcare market than those without.

B. THE REGULATORY NARRATIVE'S THREE REBUTTALS

This narrative of the individual mandate's constitutionality has three concrete advantages over the story that the government told in the *NFIB* litigation, all of which center on the narrative's ability to rebut the conservative Justices' concerns about the mandate. Obamacare's opponents raised three core problems with the mandate's constitutionality: bootstrapping, novelty, and slippery slope.[126] All three arose from the opponents' misconception that the mandate is nothing more or less than an attempt to stimulate demand for health insurance by penalizing anyone who refuses to purchase it. Although the government's litigation briefs rebutted this misconception somewhat by pointing out that comprehensive health insurance is a more reliable and therefore more efficient payment structure than self-insurance, that defense did not do as much to address the opponents' core concerns as the regulatory vision could have done.[127]

First, the regulatory narrative responds to the conservative Justices' bootstrapping concern by focusing on the provision's responsiveness to preexisting problems in health*care* (rather than its responsiveness to, arguably, Obamacare-manufactured problems in health insurance). Second, this narrative responds at least somewhat to the conservative Justices' novelty concern by focusing on the mandate's attempt to prohibit disfavored commercial transactions, an attempt that not only aligns the provision with *Raich* but also aligns it with a long history of federal penal statutes that attempt to ban various practices and commodities. Third, this narrative does a better job than the government's of responding to the slippery slope concern, by focusing on the uniquely aggressive regulatory role of private health insurance companies and thereby distinguishing a health insurance mandate from a broccoli mandate.

This section elaborates each of these points in turn.

1. Bootstrapping

There was a sense among Obamacare's opponents that Congress had bootstrapped a power to mandate purchases out of a power to regulate insurance.

---

increased spending later in life. *See generally* Melinda Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, 25 HEALTH AFF. w516, w516 (2006) (finding that costs decreased among those with consumer-directed plans but that the data on quality of care and quality of consumption decisions were mixed); Amelia M. Haviland et al., *Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save $57 Billion Annually*, 31 HEALTH AFF. 1009, 1013 (2012) (finding that patients with consumer-directed health plans spend less money but that a nontrivial amount of the savings arises from patients' avoidance of recommended care like preventive care).

[126] *See* NFIB v. Sebelius, 132 S. Ct. 2566, 2573 (2012) (holding the Commerce Clause does not empower Congress to command individuals to purchase insurance); *id.* at 2586 (determining legislative novelty is not in it of itself fatal); *id.* at 2591 (Roberts, C.J.) (noting the Government's response to the concern that upholding the individual mandate would allow Congress to require individuals to purchase broccoli).

[127] *See id.* at 2593 (Roberts, C.J.) (determining that the individual mandate cannot be upheld under the Commerce Clause); *id.* at 2586 (holding legislative novelty is not in and of itself fatal, but a lack of historical precedent may be a telling indicator of a serious constitutional problem); *id.* at 2588 (fearing that the "Government's logic would justify a mandatory purchase to solve almost any problem").

Although it is not obvious that bootstrapping should be a concern at all,[128] the notion that the government was attempting to bootstrap a mandate power from a regulatory power made sense given the Obama Administration's defense of the ACA. The government's core argument was that Obamacare's market reforms necessitated an insurance mandate in order to curb problems of adverse selection and cost shifting that were sure to arise in the post-Obamacare world. The argument was that Obamacare's prohibition on preexisting condition exclusions and its requirement for community rating would cause rational consumers to wait until they were sick to buy insurance, and that phenomenon would, in the absence of a mandate, cause insurance markets to fail. On this account, the individual mandate is a core part of a comprehensive regulatory scheme (a good doctrinal argument under the Necessary and Proper Clause), required to ensure that the statute's market reforms will succeed as intended. But, of course, that argument casts the individual mandate as a fix to a problem of Congress's own contemporaneous creation. Assuming that Congress does not have authority to mandate purchases in the absence of justifying circumstances and assuming that Congress should not be allowed to mandate purchases if the justifying circumstances are of Congress's own creation (i.e., assuming that bootstrapping is a problem), the Obamacare mandate as the Justices perceived it—a demand-by-fiat attempt to bolster the insurance market—raised a reasonable bootstrapping concern.

Of course, the government did not limit its defense of the mandate to the argument that the provision is a necessary component of Obamacare's overall regulatory scheme. The DOJ lawyers also argued that the mandate's purpose was to designate one payment structure—insurance—as the required one for everybody's inevitable healthcare purchases. Although that argument does some work in addressing the activity/inactivity distinction that was central to the litigation,[129] it begs the question of why comprehensive insurance is a better payment structure than self-insurance, particularly for young and healthy consumers. The government's only attempt to address that question was its answer that the young and healthy will, quite rationally, engage in adverse selection once the guaranteed issue and community rating provisions make it possible for them to wait until they are sick to buy insurance.[130] That answer falls right back into the bootstrapping problem.

The regulatory vision of the mandate completely avoids this problem. If the individual mandate is an attempt to eliminate cognitively-distorted, self-insured healthcare transactions in favor of regulated comprehensively-insured transactions, then the provision is responsive to a series of pervasive inefficiencies that existed long before Obamacare was conceived. Indeed, under this vision, the mandate is responsive to market failures that would exist regardless of *any* prior governmental action. Hyperbolic discounting, optimism bias, and the credence goods problem would affect healthcare consumption choices even if no government existed. On this account, the constitutionality of the mandate does not depend on the existence or effects of any prior regulatory interventions. It is an attempt to fix pervasive

---

[128] For an argument that it is not, see Stuart Minor Benjamin, *Bootstrapping*, 75 L. & CONTEMP. PROBS. 115 (2012).

[129] *See NFIB*, 132 S. Ct. at 2589; Florida v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235, 1285 (11th Cir. 2011), *rev'd in part, aff'd in part sub nom. NFIB*, 132 S. Ct. at 2566; Florida v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1286 (N.D. Fla. 2011), *rev'd in part, aff'd in part Florida*, 648 F.3d 1235, *rev'd in part, aff'd in part sub nom. NFIB*, 132 S. Ct. at 2566; Transcript of Oral Argument, *supra* note 103, at 108-09.

[130] *See NFIB*, 132 S. Ct. at 2590 (Roberts, C.J.).

inefficiencies that will exist in any (regulated or unregulated) interstate market for healthcare.

2. Novelty

The second advantage of this narrative is that it helps to undermine Obamacare opponents' accusations of novelty. As with bootstrapping, it is not entirely clear that novelty should be a vice; presumably, with the world changing around us, regulatory innovation will be necessary. But the conservative Justices seemed to feel that novelty should be at least suspicious, if not disfavored, and the government's defenses of the individual mandate did not do much to reassure them.[131] If the individual mandate were merely an attempt to stimulate commerce in health insurance in order to avoid adverse selection and cost shifting, then the provision would seem to represent a new exercise of federal regulatory power. All prior purchase mandates, including those for health insurance,[132] have existed for other, narrower reasons. For example, the requirement that shipowners buy health insurance for their seamen and that seamen buy hospitalization benefits for themselves[133] were discrete solutions to the discrete problem of higher-than-usual rates of contagious disease and physical injury among sailors returning home. The founding-era requirement that all able-bodied men own and carry guns was a discrete solution to the discrete problem of our early nation's reliance on militiamen, who needed to be armed.[134] These prior purchase mandates were not broad-based attempts to stimulate markets by creating demand—as the Obamacare mandate seemed, to its opponents, to be. The conservative Justices were thus concerned that Congress was exercising a newly expansive power to mandate purchases for the sole purpose of stimulating demand.[135]

In addressing this novelty concern, the government's argument that Congress was merely dictating a payment structure for healthcare should have been somewhat reassuring. Although Congress has never mandated a particular payment type for a particular good or service—such as by requiring cash purchases for groceries or credit card payments for car repairs—it does frequently regulate methods of payment. The mortgage interest deduction, for example, creates an incentive for individuals to purchase homes with bank loans rather than cash,[136] and at least in formal legal terms, the Obamacare mandate is not that different. The so-called mandate is really just a tax incentive—and a fairly mild one, at that—for individuals

---

[131] *See id.* at 2625 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

[132] *See* Einer Elhauge, *If Health Insurance Mandates Are Unconstitutional, Why Did the Founding Fathers Back Them?*, NEW REPUBLIC (Apr. 13, 2012), http://www.tnr.com/article/politics/102620/individual-mandate-history-affordable-care-act [hereinafter Elhauge, *Unconstitutional Mandates*]; Einer Elhauge, *A Response to Critics on the Founding Fathers and Health Insurance Mandates*, NEW REPUBLIC (Apr. 19, 2012), http://www.tnr.com/article/politics/102739/individual-mandates-history-maritime-law [hereinafter Elhauge, *Response to Critics*].

[133] Elhauge, *Unconstitutional Mandates*, *supra* note 132; Elhauge, *Response to Critics*, *supra* note 132.

[134] Elhauge, *Unconstitutional Mandates*, *supra* note 132; Elhauge, *Response to Critics*, *supra* note 132.

[135] *See NFIB*, 132 S. Ct. at 2587 (Roberts, C.J.); *id.* at 2647-48 (Scalia, J., joined by Kennedy, Thomas, & Alito, J.J.); Transcript of Oral Argument, *supra* note 103, at 17.

[136] *See* Derek Thompson, *The Tiny Distinction that Saved Obamacare: Why the Penalty is a Tax*, ATLANTIC (June 28, 2012, 2:58 PM), http://www.theatlantic.com/business/archive/2012/06/the-tiny-distinction-that-saved-obamacare-why-the-penalty-is-a-tax/259140/.

to choose insurance as their means of financing healthcare.[137] The only difference is that the Obamacare provision is a negative incentive while the mortgage interest deduction is a positive one.

The regulatory vision, though, would have done even more to rebut the novelty concern and might have eased the suspicion of novelty even within the conception of the Obamacare mandate as a strict purchase mandate (not a mere tax incentive). The regulatory vision aligns the mandate better with the historical insurance and gun mandates as well as aligning the provision with countless other federal penal statutes that seek to prohibit disfavored commerce. Under the regulatory narrative, the individual mandate is a discrete correction to a discrete problem, and it is a correction to a problem that Congress undoubtedly has the power to solve, just like the founding-era mandates. Just as Congress has clear constitutional authority to enact maritime law and to regulate militias, so too does it have clear constitutional authority to prohibit disfavored commercial transactions in interstate markets.[138] And just as Congress has been allowed to regulate seamen's health and militias' strength through purchase mandates, so too should it be allowed to prohibit self-insurance through a purchase mandate. In short, under this conception of the mandate, upholding it does not create a new federal power to mandate purchases for the sake of mandating purchases; the decision would rest on the longstanding federal powers to prohibit commerce and to use purchase mandates to solve narrow problems of legitimate federal concern.

3. Slippery Slope

The final advantage of the regulatory vision is that it eases opponents' fears of a slippery slope.[139] The concern that the conservative Justices voiced most strongly in the oral arguments and in their opinions was that Obamacare's individual mandate would set a precedent for other purchase mandates. They focused particularly on hypothetical mandates for cars, broccoli, cell phones, and burial insurance.[140] As with the prior two concerns that opponents raised, it is not entirely clear that the slippery slope is something to fear.[141] The weightiness of the slippery slope hypotheticals should, perhaps, depend on whether doctrinal line drawing would be difficult once Congress held a general power to mandate purchases.[142] One severe problem with the government's defense of the Obamacare provision was that it did not create a clear sense of where the doctrinal line might lie—or even whether there was a doctrinal line at all.[143] In other words, the government's lawyers had a hard time articulating a "limiting principle" that would allow the Obamacare mandate to stand while other purchase mandates would fall.

---

[137] *See NFIB*, 132 S. Ct. at 2594 (Roberts, C.J.); Robert D. Cooter & Neil S. Siegel, *Not the Power to Destroy: An Effects Theory of the Tax Power*, 98 VA. L. REV. 1195, 1252 (2012).

[138] *See supra* Part III.A.

[139] *NFIB*, 132 S. Ct. at 2587 (Roberts, C.J.), 2647-48 (Scalia, J., joined by Kennedy, Thomas, & Alito, J.J.); Transcript of Oral Argument, *supra* note 103, at 11-13; *see generally* Ilya Somin, *A Mandate for Mandates: Is the Individual Health Insurance Mandate Case a Slippery Slope?*, 75 L. & CONTEMP. PROBS. 75, 75-76 (2012).

[140] *NFIB*, 132 S. Ct. at 2619-20 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part); Somin, *supra* note 139, at 85-86.

[141] *See* Frederick Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361, 381-83 (1985-1986).

[142] *See id.* at 378-81; ANDREW KOPPELMAN, THE TOUGH LUCK CONSTITUTION AND THE ASSAULT ON HEALTH CARE REFORM 99-100, 165 n.3 (2013).

[143] *See* Transcript of Oral Argument, *supra* note 103, at 5-9.

The problem for the government's conception of the mandate is that, if the provision is merely an attempt to correct adverse selection and cost shifting, then its justification rests solely on failures in the stimulated market and the need, in order to correct those failures, to increase demand within that market. Under that justification, Congress could force people to buy American-made cars when foreign imports started to threaten the stability of American manufacturers, and it could force people to buy broccoli if green beans or donuts or drought or poverty started to threaten the stability of broccoli farmers. Furthermore, Congress could pass purchase mandates for cell phones and burial insurance based solely on a congressional sense that those goods are under-demanded relative to optimum—a congressional sense that Americans should want more cell phones and burial insurance than they currently buy. Even if Congress could point to concrete costs that individuals without cars, broccoli, cell phones, or burial insurance imposed on the economy, the justification for the relevant mandates would rest entirely on the failure of some individuals to consume a useful commodity. The government's attempts to articulate a limiting principle to distinguish those hypothetical statutes from the Obamacare mandate centered only on the gravity of the market failures in health insurance and the magnitude of the costs associated with suboptimal demand in health insurance;[144] when pressed at oral argument, the Solicitor General was unable to provide a *theoretical* (as opposed to empirical) distinction between the Obamacare mandate and the hypothesized mandates.

The regulatory narrative of health insurance, by contrast, provides a theoretical distinction that is relatively easy for lawyers and judges to enforce. It does not require any judicial inquiry into empirical economics beyond the standard rational basis test for congressional intent. Under this vision of the mandate, the provision's goal is not to stimulate demand for the sake of stimulating demand nor is it to stimulate demand for the sake of preserving a failing market for the mandated commodity. Instead, the goal is to eliminate a disfavored commercial behavior by shifting consumers to a more efficient substitute. That is, the mandate's goal is to stop Americans from buying healthcare without insurance, and the requirement that all Americans carry insurance accomplishes that goal in one step. On this justification, a broccoli mandate would be constitutional only if broccoli were a perfect substitute for some other food that Congress disfavored—only if mandating broccoli purchases would naturally shift all compliant consumers away from a disfavored commodity. But, of course, mandating broccoli purchases would not, on its own, stop Americans from eating donuts. It might cause a marginal decrease in demand for donuts, but the effect would be tiny (especially since broccoli and donuts are not direct substitutes, much less perfect substitutes, in most Americans' diets). Similarly, a cell phone mandate would not, in one step, cause all compliant citizens to be more efficient in handling roadside accidents.[145] The complying individuals would need not only to buy a cell phone but also to use that cell phone correctly; simply owning the phone would not solve the perceived cost of delays in handling car accidents. These points matter tremendously to the Commerce Clause test announced in *Morrison*, which requires a challenged statute's "substantial effect" on interstate commerce to occur through a short causal chain.[146]

On the other hand, a mandate to purchase American-made cars might naturally shift compliant citizens away from the substitute good of a foreign import, which

---

[144] *See id.*; Reply Brief for Respondents (Severability), *supra* note 96, at 9-10.

[145] *Cf.* Transcript of Oral Argument, *supra* note 103, at 6, 16.

[146] *See generally* United States v. Morrison, 529 U.S. 598, 614-19 (2000).

might render the hypothesized car mandate constitutionally permissible under the limiting principle that I propose here. Importantly, however, the justification that Obamacare opponents have imagined in hypothesizing a purchase mandate for cars has not been the elimination of commerce in foreign-made vehicles. It has been the stimulation of demand for American-made cars, in order to save Chrysler and General Motors from bankruptcy. The conservative Justices have imagined a car mandate as an alternative to the 2009 bailouts of the failing auto industry.[147] That point might seem like a distinction without a difference, but there are actually two big differences between elimination and stimulation that should matter to Commerce Clause analysis.

First, Congress does not have undisputed authority to use regulatory power to stimulate markets.[148] It has undisputed authority to use the *taxing* power for that purpose (and has had such authority since long before *NFIB*, as the auto bailouts demonstrate and as the plaintiff-respondents gladly conceded throughout the litigation).[149] But Congress has not had undisputed authority to use *regulatory* power for market stimulation. By contrast, as noted above, Congress has long had authority to *eliminate* commerce through regulatory power.[150] The distinction between stimulation and elimination therefore matters tremendously to the raw doctrinal question (at least so long as precedent is valuable and novelty is suspicious).

Second, requiring Congress to demonstrate a rational basis for eliminating commerce places a much stronger political constraint on the mandate power than allowing it to demonstrate a rational basis for merely stimulating commerce. Imagine that Congress tried to mandate GM purchases, but instead of arguing that the mandate served the goal of saving Detroit, it argued that the mandate served the goal of eliminating the market for Toyotas. Toyota owners—and the Toyota corporation—would be outraged, much more so than they would be if Congress were merely trying to save GM. That outrage would be well-founded. If Congress's stated goal is to eliminate disfavored transactions in Toyotas and if the Court agrees that Congress has a rational basis for pursuing that goal, the next step after compelling GM purchases will be to fine or even imprison people for purchasing Toyotas. Americans who can afford to buy two cars might be okay with a requirement that one of those cars be a GM as long as the other can be a Toyota, but if they will be penalized just for buying a Toyota, they will be more concretely constrained. The elimination justification thus requires much more by way of political consensus; it requires consensus *against* the disfavored commerce rather than consensus in favor of the stimulated commerce. And many people who like Chevys don't hate Toyotas.

In the end, then, the only hypothetical mandates that present the same theoretical justification as the one that I propose here for the Obamacare mandate are those for other kinds of insurance. Those mandates, however, are empirically

---

[147] Robert Marko, Note, *Road Closed: The Inequitable Treatment of Pre-Closing Products Liability Claimants Under the Auto Industry Bailout*, 4 BROOK. J. CORP. FIN. & COM. L. 353, 354 (2010).

[148] *See* NFIB v. Sebelius, 132 S. Ct. 2566, 2573 (2012).

[149] *See* Transcript of Oral Argument, *supra* note 103, at 102-14; Jonathan Cohn, *The Sleeper Argument Before the Court*, NEW REPUBLIC (June 20, 2012), http://www.newrepublic.com/blog/plank/104176/supreme-court-obamacare-tax-precedent-revenue-balkin#; Felix Mormann & Dan Reicher, *How to Make Renewable Energy Competitive*, N.Y. TIMES, June 1, 2012, http://www.nytimes.com/2012/06/02/opinion/how-to-make-renewable-energy-competitive.html?pagewanted=all.

[150] *See NFIB*, 132 S. Ct. at 2573; Gonzalez v. Raich, 545 U.S. 1, 19 n.29 (2005).

different, which might or might not matter in a slippery slope debate. For the burial insurance mandate that Justice Alito mentioned at oral argument,[151] the identified problem was that individuals without such insurance must nevertheless be cremated or buried, and if they cannot afford cremation or burial out of Social Security survivors insurance or out of their own assets, then they must be cremated at taxpayer expense, shifting costs onto others. Furthermore, as mentioned above, those without burial insurance might save systematically too little to pay for their burials. The empirical difference, though, is that there are no market behaviors or active commercial transactions that are systematically less efficient when people engage in them without burial insurance. People without burial insurance are not more likely than those with it to make distorted, inefficient choices about their lives or deaths. Indeed, the survivors of people without burial insurance might make better environmental choices, opting for the cost-free alternative of scattering ashes rather than consuming land for burial and memorializing. The cost-shifting problem that a burial insurance mandate would seek to address, then, is much smaller than the systematic inefficiencies in medical consumption that a health insurance mandate seeks to address.

Of course, that empirical difference might not provide a doctrinal backstop for insurance mandates. Courts typically defer to Congress's assessments of economic need, so if Congress decided that the cost-shifting problem in burials was severe enough to mandate purchases of private burial insurance, the courts would likely defer to that assessment. As a result, if Congress had power to mandate health insurance purchases in order to eliminate self-insured healthcare transactions, then it probably could exercise the same power to mandate any similar kind of insurance for the same purpose. That is, the failure to save enough money for burials, though a minor problem, is one that Congress might rationally choose to address once it has the power to eliminate self-insured transactions in struggling markets. And if the Court wanted to invalidate a burial insurance mandate after upholding the Obamacare mandate, it would need to distinguish the two based on the depth of the market failures in deaths and burials and the aggressiveness of the corrections that private insurance provides—an empirical distinction that courts usually leave to legislatures.

This concession on burial insurance, however, does not undercut the idea that the slippery slope is less scary than the conservative Justices made it out to be—and that the regulatory vision of health insurance helps to establish that point. Indeed, the concession on burial insurance demonstrates an assertion that the Solicitor General tried to make at oral argument: that the limiting principle he sought would allow purchase mandates only for payment structures.[152] The regulatory vision of health insurance gives greater substance to that assertion and also further limits the limiting principle; under the regulatory vision of the Obamacare mandate, a decision upholding the mandate under the Commerce Clause would not set a precedent for mandating *any* payment structure—only those that are regulatory of consumer behavior. A credit card mandate or a cash mandate would not survive under this test because neither credit cards nor cash machines manipulate individuals' consumption choices.

In addition to raising the concern that the Court might set a precedent for demand-by-fiat purchase mandates, at oral argument, Justice Scalia raised a more

---

[151] *See* Transcript of Oral Argument, *supra* note 103, at 7-9.

[152] *See id.* at 17-18.

concrete slippery slope concern: that Congress might use the Obamacare precedent to pass a broccoli mandate or a gym membership mandate under a stated goal of improving health.[153] Under the regulatory vision of health insurance, this slippery slope might seem more troubling than the other. The virtue of health insurance's regulatory manipulations is that they improve individuals' health and longevity, much as eating broccoli or going to the gym might. But a broccoli mandate or a gym membership mandate, unlike a health insurance mandate, would fail the *Morrison* test for short causal chains between the statutes and their beneficial effects on commerce.[154] Under Justice Scalia's hypothesis, a broccoli mandate could be an attempt to eliminate the disfavored commercial activity of buying and consuming unhealthy foods, and the gym membership mandate could be an attempt to eliminate the disfavored commercial activity of watching TV. Both mandates might plausibly shift some consumers from the disfavored commerce to the favored commerce because broccoli might be a substitute for some unhealthy foods and exercise might be a substitute for some unhealthy leisure activity. But forcing people to buy broccoli does not, in itself, stop those people from buying donuts or hamburgers, and forcing people to buy gym memberships does not, in itself, stop them from lying on the couch to watch TV. Both mandates might have marginal impacts on the disfavored behaviors, but they will not definitionally eliminate the identified problems. The health insurance mandate, by contrast, definitionally eliminates the disfavored market for self-insured healthcare. Although inefficiencies arising from optimism bias, hyperbolic discounting, and the credence goods problem might remain at the margins, the mere existence of the health insurance contract creates the relevant incentives for beneficiaries to avoid those inefficiencies.

Because the narrative of insurance as regulation sustains the mandate under long established Commerce Clause precedent and because the narrative avoids or at least tempers the conservative Justices' concerns about bootstrapping, novelty, and slippery slopes, the Obama Administration's legal team might have had much greater success under the Commerce Clause by focusing on this argument than it had by focusing on the necessity of the mandate to combat adverse selection and cost shifting and on the nature of insurance as a payment structure. Particularly Chief Justice Roberts and Justice Kennedy might have become more inclined to accept a regulatory mandate under this narrative, and even Justice Scalia might have been moved by the analogy to *Raich*. At a minimum, all of the conservative Justices would have needed to figure out something wrong with the mandate other than its asserted problems of bootstrapping, novelty, and slippery sloping.

C. WHY IT MATTERS

In the end, of course, the Supreme Court upheld the individual mandate under the taxing power even while holding that the provision is not a legitimate exercise of the commerce power.[155] Given that the individual mandate survived the constitutional challenge intact, some readers might wonder why I care that the regulatory vision of health insurance was not part of the debate.

The problem with the holding under the taxing power is not for the statute's present; it is for the statute's future. Under the test for a constitutionally permissible tax, the financial consequence for refusing to buy insurance cannot be greater than

---

[153] *See id.* at 42.
[154] *See* United States v. Morrison, 529 U.S. 598, 614-19 (2000).
[155] *NFIB*, 132 S. Ct. at 2566.

the cost of compliance (i.e., the cost of an average insurance policy).[156] In economic terms, a regulatory tax must leave Americans indifferent between engaging in the incentivized behavior and paying the tax.[157] The individual mandate, then, can never force non-compliant Americans to pay more in tax penalties than the average cost of health insurance. Many Americans might therefore continue, quite rationally, to choose to pay the tax rather than coming under the regulatory umbrella of private health insurance.

Given that health insurance has such salutary effects, this constitutional limitation on the heft of the Obamacare tax seems a shame. It might be better in the long run if, once Americans get used to the idea that Obamacare is not socialized medicine, Congress could give the individual mandate stronger teeth. In passing Obamacare, Congress's ultimate goal was universal insurance coverage for all legal residents of the United States.[158] The stubborn among us might scuttle that effort if given a choice between paying $6000 to an insurance company or paying the exact same amount to the Federal Government. Anyone who places any positive financial value on avoiding a private insurance contract would be wise to pay the tax in order to remain self-insured. But if the Court had upheld the mandate as a regulation of interstate commerce, then the only constitutional limitation on the penalty's future heft would be the Eighth Amendment's prohibition on cruel and unusual punishment.[159]

Although Congress might never want to increase the penalty for self-insurance beyond the inflation-adjusted cost of an average insurance policy, it nevertheless seems significant that future congresses are constitutionally forbidden from doing so. Of course, the regulatory vision of health insurance that I lay out here might not have changed the outcome in the Supreme Court. But it might have helped and couldn't have hurt. It is therefore a shame that the government did not present the regulatory vision of health insurance in defending the statute against the Commerce Clause challenge.

IV. CONCLUSION

Legal scholars have long understood that insurance companies play a regulatory role in the markets they insure. Because the market for healthcare has deeper failures than other insured markets and because government has been relatively absent in regulating healthcare, private health insurance companies have been even more aggressively regulatory than other kinds of private insurance. One of Congress's core goals with Obamacare generally and with the individual mandate particularly was to bring all legal residents of the United States under the aggressively regulatory umbrella of private health insurance, eliminating the less efficient market for self-insured healthcare transactions. This story of the mandate's purpose and effect could have bolstered the government's case that the statute constitutes a permissible regulation of interstate commerce, rebutting the conservative Justices' misconception of the mandate as a bald attempt to create demand by fiat. Both for our own understanding of Obamacare and for the constitutional consequences of the

---

[156] *See* Bailey v. Drexel Furniture Co., 290 U.S. 20, 40-43 (1922).

[157] *See* Jonathan Gruber, *The Economics of Tobacco Regulation*, 21 HEALTH AFF. 146, 152-55 (2002).

[158] 42 U.S.C. § 18091(2)(D) (Supp. IV 2010).

[159] U.S. CONST. amend. VIII; *see generally* Wilkerson v. Utah, 99 U.S. 130, 134-35 (1878).

penalty's permissibility going forward, it is a shame that the government did not present this narrative in defending the statute against constitutional attack.