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P H Y S I C I A N S[®]



Obamacare's (3) Day(s) in Court

Abigail R. Moncrieff, JD

Before the oral arguments in late March, the vast majority of legal scholars felt confident that the Supreme Court of the United States would uphold the individual mandate against the constitutional challenge that 26 states have levied against it. Since the oral arguments, that confidence has been severely shaken. This article asks why legal scholars were so confident before the argument and what has made us so concerned since the argument. The article posits that certain fundamental characteristics of health insurance, particularly its unusual role in steering health-care consumption decisions, which distinguishes health insurance from standard kinds of indemnity insurance, should make the constitutional question easy, but the Obama Administration's legal team was understandably hesitant to highlight those unique characteristics in its arguments. Because the Supreme Court justices seemed not to understand the uniqueness of health insurance without the government's help and because the justices seemed unusually willing to adopt a new constitutional constraint in this case, the individual mandate appears to be in far greater jeopardy than we legal scholars anticipated.

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Abbreviations: ACA = Patient Protection and Affordable Care Act

It took 6 h, spread over 3 days, for the Supreme Court to canvass the legal issues involved in the constitutional challenge to the Patient Protection and Affordable Care Act (ACA).¹ Six hours of lawyers' presentations and justices' questions, and they were considering a case that most legal scholars thought would be simple.^{2–8} Predicting outcomes from oral arguments is a dangerous game, but one thing became clear during the course of those 6 h: The case will not be simple. This article asks and answers two questions: (1) Why were (most) legal scholars so confident that the Supreme Court would find the individual mandate constitutional? (2) What did we miss?

Part of the answer to these questions is straightforward. We were confident because we understood the existing law and assumed that the Supreme Court would abide by its precedents. We missed the possibility, which now seems significant, that the Supreme Court would change the law, distinguishing its pre-

cedents, in order to find the individual mandate unconstitutional.

Part of the answer, though, is subtler. Part of the problem is that the relevant lawyers and legal scholars simultaneously understood too much and too little about American health care. We understand, in a way that the Supreme Court justices apparently do not, that health insurance is not normal insurance, that in addition to aggregating risk like ordinary indemnity insurance, health insurance provides a robust incentive structure to steer health-care consumption. We do not understand, however, something that seems crucially important to the litigation: that, because health insurance steers consumption, a health insurance mandate feels like a substantial infringement on personal freedom in a way that other kinds of purchase incentives do not. This article fleshes out those points in two parts, the first exploring the reasons for confidence before the argument and the second exploring the reasons for concern afterward.

PREARGUMENT CONFIDENCE

Before the oral argument, there was broad consensus among legal academics (not unanimous^{9–12} but close) that the constitutional challenge to the individual mandate was meritless. Even after five federal

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judges in the trial and appellate courts argued that the individual mandate was unconstitutional,¹³⁻¹⁵ legal scholars remained confident that the Supreme Court would uphold the provision. Why? What was the source of this widespread confidence?

The simple answer is that the invalidating judges on the lower federal courts had deviated from longstanding precedent, and legal scholars thought it unlikely that the Supreme Court justices would do the same. The challenge to the individual mandate centers primarily on the Commerce Clause,¹⁶ the provision of the Constitution that allows Congress to regulate interstate and foreign commerce. Since the Supreme Court's famous 1942 opinion in *Wickard v Filburn*,¹⁷ the Commerce Clause has empowered Congress to regulate not only actual interstate commerce (the movement of goods across state lines) but also individual intrastate activity that substantially affects interstate commerce (in *Wickard*, a farmer's decision to grow his own wheat instead of buying it from the interstate commercial market). Under this longstanding conception of the commerce power, the legal question for the individual mandate should be simply whether individual decisions to self-insure substantially affect interstate commerce.

In more recent Commerce Clause cases, the Supreme Court has clarified that the *Wickard* rule allowing regulation of intrastate activity applies only to economic activity. In *United States v Lopez*,¹⁸ the Court invalidated a statute that prohibited individuals from carrying guns in school zones, arguing that carrying a gun (as opposed to making, buying, or selling a gun) is not an economic activity, and in *United States v Morrison*,¹⁹ the Court invalidated a provision of the Violence Against Women Act²⁰ on the ground that acts of domestic violence are not economic acts. Even though the presence of guns in schools and the prevalence of domestic violence in society might have substantial effects on interstate commerce, the Court held, Congress could not use its commerce power to punish what amounted to immoral or simply disfavored behavior. The impact on commerce was too remote. Under these more recent, refined precedents, then, the question for the individual mandate should be whether the decision to self-insure is an economic activity (rather than simply an immoral choice) that substantially affects interstate commerce.

And this is where it became a problem, at least for predicting the Supreme Court's reaction, that the relevant legal scholars know too much about health care. The answer we gave was that self-insurance is obviously an active economic choice that substantially affects interstate commerce. But both parts of that statement, both the notion that self-insurance is an economic act and the notion that it affects com-

mercial markets, depend on the understanding that health insurance is not ordinary insurance.

When an individual chooses not to buy health insurance, he is not simply deciding to bear his own risk, as he would if he chose not to buy homeowner's insurance, for example. Nor is he simply deciding to bear the risk that he poses to himself and others, as he would if he chose not to buy car, life, or burial insurance. He is choosing both to bear his own risk and to set his own incentives for health-care savings and consumption, to rely solely on his own purse strings to guide his purchase choices. He is rejecting the rarefied incentive structure that health insurance companies provide to their insured.

Health insurance performs three important functions beyond mere risk distribution. First, health insurance forces individuals to save money for all kinds of health care (including routine maintenance and wear-and-tear, which car insurance, for example, never covers) in a market in which optimism bias causes individuals to save systematically too little (a cognitive failure that does not exist for other insured items like cars and homes).^{21,22} Second, health insurance in the ACA world of community rating forces individuals to smooth their health-care savings over the course of their lives so that, from an actuarial perspective, they pay too much when young and too little when old, a feature that most kinds of insurance need not include because the risk associated with cars and homes does not vary so dramatically with the age of the insured. Finally and most importantly, health insurance administrators set differential cost-sharing obligations, attempting to channel their beneficiaries toward preventive care, primary care, and generic pharmaceuticals (away from emergent care, specialty care, and brand-name drugs), and insurance companies engage in medical necessity review to try to curb wasteful spending on unnecessary care. Standard indemnity insurance does not do that. Car insurance and homeowners' insurance do not manipulate incentives to improve consumption decisions; they often do not even require the beneficiary to spend his indemnifying payment on repairs.

Self-insurance for health care, then, is not simply a failure to buy insurance. It is a continuing economic activity of setting and following one's own incentives with respect to health-care consumption rather than becoming subject to the insurance company's salutary manipulations. (Insurance also causes inefficiencies, most notably the moral hazard that causes excessive consumption of costly care. Under the constitutional test, though, Congress's policy choices do not need to be right or perfect; they need only be rational. And Congress rationally could believe that moral hazard costs less than underconsumption of preventive and primary care.) In addition, the

effect of self-insurance on the health-care market is not just that a depression in the quantity demanded for insurance causes inefficiently high prices (the theory that Justice Antonin Scalia posited during argument²³). Instead, self-insurance substantially affects the health-care market by allowing individuals to make less-efficient choices about health-care purchasing, driving up health-care costs for everyone even if all self-insured health care is fully bought and paid for.

In the end, among those who understand the unique interrelationship of the health insurance and health-care markets, there is no room for doubt that the individual mandate is a regulation of economic activity that substantially affects interstate commerce.

POSTARGUMENT CONCERNS

If the question is so easy under current doctrine and with a basic knowledge of health insurance functioning, why did the oral arguments go so badly awry? The problem arose almost immediately in the justices' questions and in Solicitor General Donald Verrilli's responses: Everybody in the room either failed to grasp the interrelationship of health insurance and health care or was unwilling to admit that health insurance manipulates savings and consumption incentives. That is, the legal scholars who were so confident before argument had understood something that the justices and advocates did not, but we had also failed to understand an important political constraint on what the government was willing to argue.

Of course, Solicitor General Verrilli repeatedly asserted that health care is unique.²⁴ But his point was not that health insurance is unusual insurance with a unique relationship to its subject market, health care. His point was just that everyone will someday need health care, that no one can predict when, that the cost is likely to be prohibitive, and that the cost will shift to others if it is not covered by third-party insurance.²⁵ The problem with that argument is that it simply identifies the risk that self-insured individuals are choosing to bear. That risk may be greater than or slightly different from ordinary risks in ordinary insurance markets, but the notion that self-insurance is a decision to bear one's own risk, and even that self-insurance can expose others in the market to cost shifting, is identical in all insurance contexts, as Justice Samuel Alito pointed out early in the argument with a question about burial insurance.²⁶ In short, the government's entire "health care is unique" argument identified a mere portion, and the least important, least unique portion, of what health insurance provides.

At one point in the argument, Justice Scalia asserted, "These people [the currently uninsured] are not stupid. They're going to buy insurance later. They're young and need the money now. When they think they have a substantial risk of incurring high medical bills, they'll buy insurance, like the rest of us."²⁷ This argument gave Solicitor General Verrilli a clear opening to discuss health insurance's function of smoothing health-care savings across patients' lives and to discuss the incentives that health insurers create for the currently young and apparently healthy to consume preventive care. But Solicitor General Verrilli forwent the opportunity, answering Justice Scalia with the same narrow kind of response that he had given in asserting that health care is unique. He said that waiting to buy insurance is the core problem in a system with guaranteed issue because it causes prices to rise and, ultimately, insurance markets to fail.²⁸ He is right, of course, that adverse selection in health insurance is part of the problem, but that point does not help establish that health insurance and health care are unique. Adverse selection (and the information asymmetries between insurance companies and their customers as to their customers' risk profiles, which allow adverse selection to occur) is a pervasive problem in insurance markets. To establish that self-insurance for health care is an economic activity with substantial effects on interstate commerce, in a way that self-insurance for burials, cars, and homes is not, Solicitor General Verrilli needed to say much more.

But this is where the scholarly critique shows too little understanding about health care. Solicitor General Verrilli undoubtedly knew that he was identifying a small portion of the relevant arguments. It is simply implausible that the solicitor general of the United States, who knew that this case would be the biggest of the year and perhaps of his career, had not learned enough about health insurance to be able to discuss the salutary influences of cost-sharing manipulations, optimism bias corrections, medical necessity review, and referral requirements. So why did he not discuss them?

The problem is that there is a deeply felt political constraint that motivates a unique kind of skepticism toward a health insurance mandate, preventing the Obama Administration's lawyer, in the middle of an election year, from admitting the true efficiencies of health insurance: Americans do not want to be manipulated in their health-care consumption choices. Purchase incentives for mortgages (such as the mortgage interest deduction) are fine; purchase incentives for fuel efficient cars (such as tax credits and carpool lane access for hybrids) are fine; the states' purchase mandates for car insurance are fine. But a purchase mandate for health insurance, justified by reference

to insurance's incentive structure for health-care consumption? That sounds like rationing. Solicitor General Verrilli did not want to be heard as saying, "We didn't include a government death panel, don't worry. We'll just make you enter into a private, contractual death panel—a health insurance policy that will steer your consumption decisions to improve the market's efficiency." It was politically safer to say that we all pay for each other's health care already and that those without insurance free ride on cross-subsidized emergency rooms, even if those points fail to distinguish health insurance from other kinds of insurance.

Importantly, I am not mocking the Tea Party here or disparaging the solicitor general's performance. Direct government rationing of health care might in fact be unconstitutional,²⁹⁻³⁰ and there is certainly a strong political constraint that prevents regulatory rationing from becoming law. Of course, the perception that health insurance is the same thing as a death panel or that a purchase mandate for such insurance approaches a constitutionally problematic line is alarmist and misguided. But that perception is also pervasive.

Fortunately, the Supreme Court is not going to adopt an alarmist account of the individual mandate, holding that the ACA amounts to unconstitutional rationing. So how will the justices escape, if they do, the precedent that allows Congress to regulate intrastate economic activity that substantially affects interstate commerce? Again, predicting outcomes from oral arguments is dangerous, but the theory that the conservative justices seemed to be pursuing was that there is a constitutionally important distinction between regulating commerce that exists in the world and creating commerce where none existed before.³¹ This distinction would be brand new to American constitutional law and it might threaten the many provisions of the United States Code that attempt to stimulate commerce by providing positive incentives for individuals to buy things (tax deductions and credits), in addition to invalidating the negative incentive in the ACA's penalty for failure to buy health insurance. But the Court seems tempted to draw this new line, holding at a minimum that Congress may not use penalties to stimulate markets.

Such a holding would misunderstand the purposes of the individual mandate and of health insurance generally. But you cannot really blame the Supreme Court or even President Obama's legal team. Americans are not ready to accept that we need help, beyond our doctor's, in making medical decisions.

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