1-13-2012

Brief Amici Curiae of Prescription Policy Choices, Professors of Law, and Professors of Health Policy in Support of Petitioners on the Minimum Coverage Provision in Department of Health & Human Services v. State of Florida

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BRIEF AMICI CURIAE OF PRESCRIPTION POLICY CHOICES, PROFESSORS OF LAW, AND PROFESSORS OF HEALTH POLICY IN SUPPORT OF PETITIONERS ON THE MINIMUM COVERAGE PROVISION IN DEPARTMENT OF HEALTH & HUMAN SERVICES V. STATE OF FLORIDA

Boston University School of Law Working Paper No. 12-26
(May 22, 2012)

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No. 11-398

In The Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

v.

STATE OF FLORIDA, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF *AMICI CURIAE* OF PRESCRIPTION POLICY CHOICES, PROFESSORS OF LAW, AND PROFESSORS OF HEALTH POLICY IN SUPPORT OF PETITIONERS ON THE MINIMUM COVERAGE PROVISION

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QUESTION PRESENTED

One purpose of the individual mandate is to eliminate the market for self-insured healthcare transactions. It is well-established in this Court's precedent that the elimination of an interstate commercial market is a constitutionally legitimate end for Congress to pursue under the Commerce Clause. Under the Necessary and Proper Clause, Congress may use any reasonably adapted means to accomplish constitutionally legitimate ends. The individual mandate is not only reasonably adapted but is quite elegant as a means of eliminating the market for self-insured healthcare transactions. The provision effectively encourages individuals to shift from the inefficient market for self-insured care to its more efficient substitute market for fully-insured care.

The question presented is whether the minimum coverage provision is a valid exercise of Congress's powers under Article I of the Constitution.

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INTEREST OF *AMICI CURIAE*[1]

Prescription Policy Choices is a nonprofit educational and public policy organization providing objective research and expertise on prescription drug policy. Our mission is to serve as an independent voice in educating and providing advocacy services to stakeholders and consumers on issues relating to access to safe, effective, and affordable prescription drugs in the U.S. The Patient Protection and Affordable Care Act (ACA) will further our goal to effectively reduce prescription drug prices and increase access to medications and comprehensive health care.

Professors of Law and **Professors of Health Policy** are experts in the fields with particular interest in this case. The professors supporting this brief, with their student research assistants, include: **Paula Berg**, J.D., Professor of Law, City University of New York Law School; **Alexander Capron**, LL.B., Scott H. Bice Chair in Health Law, Policy and Ethics, Gould School of Law, Professor of Law and Medicine, Keck School of Medicine, University of Southern California; **Alan B. Cohen**, Sc.D., Professor of Health Policy and Management, Boston University School of Management; **Marsha Garrison**, J.D., Suzanne J. & Norman Miles Professor of Law, Brooklyn Law

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[1] This brief is submitted with the consent of the parties, as lodged with the Clerk per the Docket Sheets. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party. Expenses of *amici* have been borne by their own resources, without support from any party.

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SUMMARY OF THE ARGUMENT

The Eleventh Circuit and the parties failed to identify one of Congress's most important goals in passing the individual mandate: eliminating the market for self-insured healthcare transactions. The parties have considered only Congress's goals of correcting adverse selection and reducing cost-shifting in the health insurance market, overlooking the additional goal of eliminating the market for self-insured care.

Regardless of whether the individual mandate is a necessary or proper means of stimulating the market for health insurance, Congress's goal of eliminating the self-insured market is undoubtedly a legitimate exercise of congressional power, and the individual mandate is a reasonably adapted means of accomplishing that goal. Congress has well-established authority to ban an interstate commercial market or otherwise to prohibit interstate commerce, as well as clear concomitant authority to accomplish such bans by penalizing intrastate behavior. Because the market for self-insured healthcare is a national market, Congress may try to eliminate it.

Furthermore, Congress chose an eminently rational and minimally intrusive means of accomplishing its ban: a small financial incentive for individuals to choose fully-insured care over self-insured care, where fully-insured care is a sufficient substitute that is demonstrably more efficient. The market for self-insured care is inefficient because individuals systematically underestimate their need to save for future medical care, due to proven tendencies to underestimate personal health risks and to undervalue long-term healthcare costs. Insurance corrects these inefficiencies through payment structures that encourage patients to consume preventive care and that guarantee sufficient savings for future costs. Shifting individuals into the fully-insured market also introduces other efficiencies that underscore the rationality of Congress's scheme.

———♦———

ARGUMENT

I. THE INDIVIDUAL MANDATE IS A RATIONAL MEANS OF ELIMINATING THE INTERSTATE MARKET FOR SELF-INSURED HEALTHCARE TRANSACTIONS.

Throughout this litigation, the parties and the courts have treated the individual mandate, 26 U.S.C.A. § 5000A, of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111–148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029, as though its only goals are to combat adverse selection in the health insurance market and to reduce cost-shifting in the healthcare market. See *Florida ex rel. Att'y Gen.* v. *U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1284-85 (11th Cir. 2011). So characterized, the mandate seems to raise a difficult question of whether Congress may require individual purchases in order to stimulate commerce.

But a different and equally valid characterization of the mandate presents a much easier – indeed, a well-settled – constitutional question: whether Congress may regulate intrastate behavior not to stimulate a market but to *eliminate* a market.[2] One of

[2] Petitioners raise issues related to inefficiencies of self-insured healthcare transactions, and they recognize that Congress may attempt to eliminate the entire self-insured market rather than penalizing only individuals who consume uncompensated care. *See* Brief for Petitioners (Minimum Coverage Provision) at 43-44, 50-51, *Dept. of Health & Human Servs. v. Florida* (2012) (No. 11-398). We present a full constitutional and economic defense of Congress's elimination goal and mandate strategy.

Congress's most important goals in passing the individual mandate was not to improve the market for insurance but to eliminate the market for self-insured[3] healthcare,[4] shifting individuals out of that market by requiring them to obtain insurance. Regardless of

[3] We refer to the market for "self-insured" rather than "uninsured" care because "uninsured" is both under-inclusive and over-inclusive of the problems Congress addressed. First, although it is true that most self-insured individuals are underinsured or uninsured for the care they need, even those with sufficient savings cause inefficiencies by paying out-of-pocket. Third-party insurance is more efficient than self-insurance for all consumers because insurers add bulk purchasing discounts, quality screening, and medical management. *See* Part II, *infra*. Congress therefore reasonably sought to eliminate the whole market for self-insured care, not just the market for uncompensated care. Second, some uninsured transactions are unproblematic but are not meaningfully "self-insured." For example, elective surgeries (e.g. cosmetic surgery) and extra diagnostics (e.g. non-indicated mammography) are common healthcare purchases that insurance rarely covers. But individuals needn't be insured against healthcare costs that are neither medically necessary nor time-sensitive. Elective healthcare purchases are not "self-insured" any more than the patient's last DVD purchase was "self-insured." Because these kinds of elective costs present few inefficiencies, Congress didn't intend to eliminate the market for uninsured *elective* care that is bought and paid for. The target market, then, is for self-insured healthcare: healthcare that is medically necessary but lacks coverage by a third-party insurer.

[4] Importantly, the market that Congress targeted is not the market for self-insurance itself – which is not a true market given that individuals don't buy or sell anything to self-insure – but rather the market for self-insured healthcare transactions. Healthcare purchases have different characteristics when made without third-party insurance, sufficiently so that self-insured and fully-insured transactions constitute separate markets.

whether Congress's goals of curing adverse selection and reducing cost-shifting are proper exercises of Congress's powers, the additional goal of eliminating a national market in self-insured healthcare transactions is clearly legitimate.

Furthermore, a small financial incentive for individuals to choose fully-insured[5] healthcare over self-insured healthcare – where the two options are near-perfect substitutes – is an eminently rational and minimally intrusive means of accomplishing that goal. The individual mandate is therefore a rational means of achieving the constitutionally legitimate end of eliminating the market for self-insured healthcare. Even if the mandate is not necessary or proper as a means of stimulating the insurance market, its constitutionality as a means of eliminating the self-insured market is sufficient to sustain the provision. We urge the Court to reverse the Eleventh Circuit's holding to the contrary.

A. Eliminating The Market for Self-Insured Care Was One of Congress's Central Goals in Passing The Individual Mandate.

According to Congress's legislative findings, the purpose of the individual mandate is to regulate not

[5] We use "fully-insured" as an antonym for "self-insured," to refer to all those who carry third-party insurance. Fully-insured individuals, by this definition, have to pay applicable copayments and deductibles but are "fully-insured" in the sense that they are insured against most conceivable healthcare-related losses.

only "when health insurance is purchased" but also "how and when health care is paid for." 42 U.S.C.A. § 18091(a)(2)(A). Although some of Congress's findings address only adverse selection or cost-shifting, four of the ten findings speak to an additional goal of eliminating the market for self-insured care.

First, Congress asserted in two findings that the individual mandate would "increase the number and share of Americans who are insured," 42 U.S.C.A. § 18091(a)(2)(C), and would achieve "near-universal coverage," § 18091(a)(2)(D). The next finding noted 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." 42 U.S.C.A. § 18091(a)(2)(E). Even without the explicit acknowledgement in § 18091(a)(2)(E) that Congress's goal is to eliminate self-insurance, the stated goal of near-universal coverage in §§ 18091(a)(2)(C)-(D) supports the notion that Congress sought to eliminate the self-insured market. Universality is neither necessary nor sufficient to avoid last-minute enrollments in particular insurance pools (adverse selection), and cost sharing depends on the health and wealth characteristics of the individuals in a given pool, not on the absolute number of people carrying insurance or on the percentage of the national population carrying insurance. Indeed, *merely* increasing the "number and share of Americans" participating in the insurance market accomplishes very little for the efficiency of that market, particularly when the market is

structured such that individuals can move among discrete insurance pools. The virtue of universal coverage, then, rests in the notion that near-universal insurance *definitionally* decreases – almost to the point of elimination – the market for self-insured care.[6] As the self-insured procure insurance, the market for medically necessary care purchased without third-party coverage will dwindle until it is virtually nonexistent. Congress made this point explicit in § 18091(a)(2)(E) by highlighting the overall cost of inefficiencies in the self-insured market and noting that the individual mandate sought to reduce that cost by reducing the market.

In the fourth relevant finding, Congress wrote: "62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the [individual mandate] requirement . . . will improve financial security for families." 42 U.S.C.A. § 18091(a)(2)(G). This finding relates exclusively to the inefficiencies of the market for self-insured care – the problem that self-insured individuals frequently save too little to pay for the care that they inevitably consume. Furthermore, Congress made explicit here its conclusion that shifting individuals into the near-perfect substitute market for fully-insured care would solve the inefficiency of

[6] Fully-insured individuals are free to spend out-of-pocket money on healthcare, but patients making that choice are not "self-insured." They have third-party insurance available for any healthcare they need.

insufficient savings. That is, Congress found that individuals who attempt to self-insure save too little to cover their medical expenses, and the legislature concluded that incentivizing individuals to shift to the market for fully-insured care would successfully eliminate the unstable market for self-insured care.

In short, in addition to the goals that the Eleventh Circuit and the parties identify of curing inefficiencies in the insurance market, one of Congress's goals with the individual mandate was to eliminate the alternative but less efficient market for self-insured healthcare. The mandate accomplishes that goal by creating an incentive for individuals to shift from the self-insured market to the fully-insured market, on the theory that rational consumers would rather spend their money on insurance coverage than on the equivalently costly "shared responsibility payment" that leaves them self-insured. See 26 U.S.C.A. § 5000A(b).

B. Eliminating the National Market for Self-Insured Care is a Legitimate Exercise of Congress's Article I Power to Regulate Interstate Commerce.

When characterized as an attempt to stimulate the insurance market, the individual mandate raises potentially difficult questions about the limits of Congress's powers, including the now-infamous question of whether Congress may require individuals to buy broccoli in order to stimulate the vegetable market.

But Congress's goal of eliminating the market in self-insured care presents a much easier question with virtually no "slippery slope" implications. Congress has well-established authority to ban an interstate commercial market – as well as clear concomitant authority to accomplish such bans by penalizing purely intrastate behavior.[7] See U.S. Const. art. I, § 8, cl. 3; *Gonzales* v. *Raich*, 545 U.S. 1 (2005) (marijuana); *Garcia* v. *San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985) (low-wage workers); *United States* v. *Rutherford*, 442 U.S. 544 (1979) (unapproved pharmaceuticals); *Perez* v. *United States*, 402 U.S. 146 (1971) (extortionate credit transactions); *Wickard* v. *Filburn*, 317 U.S. 111 (1942) (excess wheat); *United States* v. *Darby*, 312 U.S. 100, 113 (1941) (low-wage employees). Indeed, this Court has explicitly held that Congress's commerce authority "extends not only to those regulations which aid, foster and protect the commerce, but embraces those which prohibit it." *Darby*, 312 U.S. at 113.

Under this Court's precedents, then, Congress's authority to eliminate markets has no constitutional limits beyond those in the Bill of Rights (which protects discrete markets, such as speech-related

[7] Notwithstanding its holding below, the Eleventh Circuit has explicitly acknowledged this authority. *See United States* v. *Maxwell*, 446 F.3d 1210, 1215 (11th Cir. 2006) ("Thus, where Congress has attempted to regulate (*or eliminate*) an interstate market, *Raich* grants Congress substantial leeway to regulate purely intrastate activity (whether economic or not). . . .") (emphasis added).

markets). But a limitless constitutional power to prohibit commerce has never been thought particularly troubling because there are such strong political checks against excessive bans. Imagine, for example, that Congress passed a purchase mandate for broccoli in an effort to ban the markets for all other foods, attempting to channel consumption to the legislatively-dictated healthiest nutrition source. Or imagine that Congress passed a purchase mandate for American-made cars in an attempt to ban the markets for foreign automobiles. See *Florida ex rel. Bondi* v. *U.S. Dept. of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1289 (N.D. Fla. 2011) (analogizing the insurance mandate to a broccoli mandate and a GM car mandate), aff'd in part, rev'd in part *sub nom. Florida*, 648 F.3d 1235. Any admission on Congress's part that it sought to eliminate the markets for donuts or BMWs would cause tremendous political backlash, far more so than a stated goal of stimulating the markets for broccoli and Chevrolets. Importantly, this is not to say that political constraints are sufficient to enforce constitutional limits nor that constitutional limits are defined by political constraints. *Cf. United States* v. *Morrison*, 529 U.S. 598, 616 (2000) (noting that "the limitation of congressional authority is not solely a matter of legislative grace"). It is rather to say that this Court's long tradition of finding no constitutional limit on Congress's power to prohibit interstate commerce should not be worrying. Congress has clear and unbounded authority to eliminate any interstate commercial market, at least so long as

that market lacks substantive protection under the Bill of Rights.

Given this clear authority, the first question for the individual mandate ought to be whether the market for self-insured healthcare is, in fact, an interstate market over which the federal government has jurisdiction. Because the inputs and outputs into self-insured healthcare travel across state lines, because Congress has a long history of regulating the market for self-insured care, and because federalism doctrine and theory support federal jurisdiction in this context, the answer is clearly yes.

First, the inputs and outputs of the market for self-insured care travel interstate. Inputs, including prescription drugs, medical devices, and medical services, are all provided through interstate commerce. A doctor in Massachusetts may prescribe pills made in Illinois, use a syringe manufactured in New York, or take a continuing medical education course in Maryland. Decisions by a doctor in one state will therefore affect the availability and prices of those inputs in another. The outputs from the market for self-insured care are patients. These patients also regularly travel across state lines. Indeed, patients frequently travel interstate for the purpose of obtaining care, but even outside of a purely medical context, self-insured individuals regularly travel interstate, carrying with them some risk that they will experience a medical emergency requiring immediate care. Furthermore, individuals born in one state might not stay there forever, and a patient's long-term health status that

arose in one state will travel to future states, impacting the future states' healthcare infrastructures. Assuming, then, that self-insured care is less efficient than fully-insured care – assuming Congress is right that self-insured patients negatively impact input prices and output qualities – those effects will not be state-specific. Massachusetts's success in reducing its own market for self-insured care will not proportionally reduce the negative effects Massachusetts experiences from self-insurance because some of those negative effects will continue to seep in from other states' self-insured markets. The individual mandate thus clearly targets an *interstate* commercial market, not just intrastate decisions.

Second, Congress has a long history of regulatory involvement in the healthcare market, which includes a long history of prohibiting commerce in medical commodities. See, *e.g.*, Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105–277, § 902, 112 Stat. 2681 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.); Health Insurance Portability and Accountability Act, Pub. L. No. 104–191, 101 Stat. 1936, 1936 (1996) (codified as amended in 42 U.S.C.); Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93–406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.); Old-Age, Survivors, and Disability Insurance Act of 1965, Pub. L. No. 89–97, 79 Stat. 286 (codified as amended in 42 U.S.C.) (establishing Medicare); Federal Food, Drug, and Cosmetic Act of 1938 (FDCA), Pub. L. No. 75–717, 52 Stat. 1040

(codified as amended in 21 U.S.C.). The Eleventh Circuit's apparent holding that Congress may not attempt to prohibit self-insured healthcare would, if adopted by this Court, require disruption of many deeply entrenched federal regulations.

Finally, federalism theory and doctrine support federal rather than state authority over a ban on self-insured care. Individual states face difficult challenges in regulating their own healthcare markets, including legal obstacles that this Court has specifically upheld, such as preemption under ERISA, see *Aetna Health, Inc.* v. *Davila*, 542 U.S. 200 (2004), and under the FDCA, see *Riegel* v. *Medtronic, Inc.*, 552 U.S. 312 (2008). Furthermore, the mobility of the citizenry and the reality of interstate competition create practical obstacles for state regulation. States that have implemented insurance regulations, for example, have found that insurers flee the state rather than adapting to regulation, making the regulations almost entirely ineffective. Conrad F. Meier, Council for Affordable Health Insurance, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States* (2005). Furthermore, states can free-ride on their neighbors' reforms. For example, now that Massachusetts has nearly eliminated its market for self-insured care, strengthening its own healthcare infrastructure, residents of New Hampshire can simply use the better Massachusetts healthcare environment rather than banning New Hampshire's self-insured market. See generally Abigail R. Moncrieff

& Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 Kan. J.L. & Pub. Pol'y 266 (2011).

The Eleventh Circuit correctly noted that healthcare and insurance regulation have historically fallen within the states' police power, *Florida*, 648 F.3d at 1305-06, but outright bans of commodities and enterprises – even those that relate to traditional police power regimes like health – have never been considered exclusive state realms. See generally Kevin Outterson, *Health Care, Technology and Federalism*, 103 W. Va. L. Rev. 503 (2001). The elimination of any nationwide market is necessarily a regulation of commerce *among the several states*, falling squarely within Congress's enumerated authority. U.S. Const. art. I, § 8, cl. 3. States have no claim to that power. See *United States* v. *Comstock*, 130 S.Ct. 1949, 1962 (2010). Because the market for self-insured healthcare is an interstate commercial market, elimination of that market is unquestionably a permissible end under Congress's Article I powers. The individual mandate therefore should be upheld so long as the provision is a rational means of accomplishing that end.

C. The Individual Mandate is a Rational, Permissible, and Reasonably Adapted Means of Eliminating the Self-Insured Healthcare Market.

The Necessary and Proper Clause, art. I, § 8, cl. 18, grants Congress "broad power to enact laws that are convenient, or useful or conducive" to the beneficial exercise of an enumerated power. *Comstock*, *supra*, at 1956 (internal quotation marks omitted). In describing the scope of this authority, Justice Marshall famously stated: "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." *McCulloch* v. *Maryland*, 4 Wheat. 316, 421 (1819). The Court thus looks for means-ends rationality in conducting a Necessary and Proper analysis. *Sabri* v. *United States*, 541 U.S. 600, 605 (2004) (citing generally *McCulloch*). The "relevant question is simply whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *Gonzales*, 545 U.S. at 37 (Scalia, J., concurring) (citing *Darby*, 312 U.S. at 121). The question here is whether the individual mandate is "reasonably adapted" to Congress's goal of eliminating the market for self-insured healthcare. There is no doubt that it is.

The individual mandate will make the market for self-insured care significantly less attractive, channeling consumers to the obvious substitute market for

fully-insured care. The mandate requires all able individuals to spend a fixed amount of money each year on supporting the healthcare infrastructure, either by purchasing a private insurance contract or by making an equal or lesser "shared responsibility payment" to the national treasury. See 26 U.S.C.A. § 5000A(b); § 5000A(c)(1) (capping the penalty at the cost of bronze-level insurance). Given the choice between giving money to a third-party insurer for the benefits of coverage and giving the same money to the government for no direct benefit at all, the vast majority of consumers will likely prefer to acquire insurance. As more consumers make the rational choice to purchase insurance, the market for self-insured healthcare will disappear. In short, because fully-insured healthcare is nearly a perfect substitute for self-insured healthcare (with limited exceptions for medically necessary care that the third-party insurer does not cover and for small copayments or deductibles that the patient must cover), a patient who has bought third-party insurance has definitionally left the market for self-insured care. The individual mandate is thus an elegant means of eliminating the inefficient self-insured market.

Of course, there are other approaches that Congress could take to eliminating the self-insured market. These approaches would be clearly constitutional, but they would be equally infringing of liberty, equally implicative of a federal police power, see *Florida*, 648 F.3d at 1309, and more problematic for various policy reasons. Because of these unfavorable

policy implications, the individual mandate is more "reasonably adapted" to Congress's goal than its alternatives.

One alternative to the individual mandate would be to repeal the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. Enacted in 1986, EMTALA requires hospitals that accept Medicare reimbursement and that operate trauma centers to provide care to anyone who requires emergency medical attention, regardless of his ability to pay. *Id.* Repealing EMTALA would allow hospitals to refuse emergency care to the self-insured, even when the self-insured truly require emergent interventions. Individuals would then have a strong incentive to move from the self-insured market to the fully-insured market in order to guarantee that they would receive treatment when needed. The problem, of course, is that repealing EMTALA would allow hospitals to screen for insurance before providing emergency care, potentially delaying lifesaving treatments even for the fully-insured. Furthermore, insured individuals who forgot their insurance cards or whose wallets could not be found after an accident might be rejected for treatment. This is clearly undesirable policy.

Another possible and clearly constitutional means of eliminating a market for self-insured care would be to punish the consumption of such care. That is, Congress could require the self-insured to pay an additional fee to the government – a penalty for self-insurance – whenever they consume

healthcare without third-party insurance. This method of banning self-insurance, however, would be extremely impractical; individuals who can't afford to pay for care in the first place and who are filing for bankruptcy because of their medical bills would not be able to pay the penalty. See 42 U.S.C.A. § 18091(a)(2)(G). The punishment would therefore be ineffective absent a return to debtors' prisons – which would be far more infringing of liberty than the individual mandate. Furthermore, a consumption penalty would be no less implicative of liberty interests or of a federal police power than the individual mandate. Because all individuals will one day need healthcare, the consumption penalty would be equally unavoidable. In the end, a punishment that triggers upon consumption of self-insured care would be less rational than the individual mandate, and it would be equally anti-libertarian. See also Br. of Pet. at 43-44 (supporting the idea that Congress need not target only those patients who consume uncompensated care).

One final constitutional alternative to the individual mandate would be to provide mandatory public insurance, like "Medicare For All," which would serve an identical function to the individual mandate by compulsorily shifting individuals into a substitute for self-insured healthcare. See United States National Health Care Act, H.R. 676, 111th Cong. (2009). Medicare is constitutional, see *Helvering* v. *Davis*, 301 U.S. 619 (1937) (upholding the Social Security Act on logic that supports the constitutionality of Medicare), and

expanding the program would not raise any additional constitutional concerns, see Adam Liptak, *Some Common Ground for Legal Adversaries on Health Care*, N.Y. Times, Sept. 29, 2011, at A16 (noting that both sides of the fight over the ACA agree that Medicare For All would be constitutional). A single-payer program, though, would be more infringing of liberty and more implicative of a federal police power than the individual mandate. The mandate allows Americans to choose among many insurance options, and the ACA allows states to retain primacy over health insurance licensure, insurance exchange design, and enforcement of ACA regulations. Traditional Medicare, by contrast, creates a single insurance pool in which all elderly Americans must participate and over which states have virtually no influence. Medicare might well be better than private insurance – which might be why one protester infamously commanded Representative Robert Inglis to "keep your government hands off my Medicare," see Phillip Rucker, *Sen. DeMint of S.C. is Voice of Opposition to Health-Care Reform*, Wash. Post, July 28, 2009, at A4 – but the program is certainly more centralized and less libertarian than the individual mandate.

II. THE MARKET FOR SELF-INSURED CARE IS, IN FACT, LESS EFFICIENT THAN THE MARKET FOR FULLY-INSURED CARE.

Congress's attempt to eliminate the market for self-insured healthcare is rational given the proven economic inefficiencies in the market for self-insured

care, such as optimism bias and hyperbolic discounting, which lead patients to under-consume preventive care, over-consume catastrophic care, and under-save for future care. The market for fully-insured care corrects these inefficiencies through carefully designed cost-sharing structures, and insurance definitionally guarantees that patients are saving sufficiently for future costs. Insurance also adds its own efficiencies to the healthcare market by negotiating volume discounts, providing quality assurances, and engaging in medical management. Congress had these benefits in mind when it chose to shift patients from self-insurance to full-insurance. Of course, many voters – and perhaps many judges and justices – might have chosen a different approach to curing these problems, but the standard for constitutionality is only whether Congress had a rational basis for making the choice it did. Given the economies of healthcare and insurance, Congress's decision is clearly rational.

A. The Market for Self-Insured Healthcare Transactions is Inefficient.

Due to two proven cognitive failures, individuals systematically underestimate their need to save for future medical care. First, individuals underestimate their personal risks for bad health outcomes, and second, individuals undervalue long-term costs relative to short-term costs. As a result, patients forgo the immediate costs associated with living a healthy lifestyle and receiving preventive care while simultaneously saving too little to pay for future care. These

habits lead individuals to consume inefficient medical services such as emergent care and to over-consume catastrophic care relative to their ability to pay.

1. Individuals underestimate their personal risks for bad health outcomes.

One of the reasons that Congress wants to eliminate self-insurance is that individuals who self-insure systematically under-invest in healthcare savings due to a cognitive failure known as "optimism bias." Optimism bias describes a patient's proven tendency to be unrealistic about her vulnerability to bad health. 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). It is an unfortunate statistical truth that not every individual in a given group can have below average risk for health complications. Patients, however, systematically underestimate their relative susceptibility to such complications, in part because they lack complete information about population characteristics and in part because they cognitively overemphasize their positive risk factors while underemphasizing their negative risk factors. Weinstein, *Reducing Unrealistic Optimism*, *supra*, at 12. Because of the inherent egocentrism involved in self-assessments of risk, a patient can lose sight of the fact that a majority of people share her positive risk

factors, overrating the effect those factors might have on her health outcomes. *Id.* at 18.

Importantly, optimism bias is not a matter of ignorance. Studies consistently show that even when risk information is effectively delivered to a patient that has greater than average risk factors for particular health problems, she does not change her behavior. See, *e.g.,* Weinstein & Klein, *supra* (describing multiple studies where education was ineffective in reducing individuals' tendency to overrate their susceptibility to illness). This systematic failure to take account of personal risk factors causes all patients to under-invest in protections against poor health outcomes, such as by making healthy choices and seeking preventive care. It also leads to underestimation of future health costs, leaving the patient unprepared to pay for the full costs of the healthcare she ultimately needs. Optimism bias is a well-established market failure that causes significant inefficiencies in the market for self-insured healthcare. Whether or not the individual mandate is constitutional as an attempt to combat adverse selection, it ought to be upheld as a rational attempt to steer individuals away from their tendency to under-invest in healthcare savings.

2. Individuals undervalue long-term costs relative to short-term costs.

Another cause of individual under-investment in healthcare savings – and another market failure that

justifies Congress's attempt to eliminate the market for self-insured care – is a cognitive bias known as hyperbolic discounting. In theory, a patient should refrain from engaging in an activity today if the long-term costs, in today's dollars, will outweigh the immediate benefits. In practice, however, patients frequently undervalue the present value of their actions because they underestimate the magnitude of the ultimate harm, a cognitive failure known as hyperbolic discounting.[8] See, *e.g.*, Peter Fishburn & Ariel Rubenstein, *Time Preference*, 12 Int'l Econ. Rev. 39 (1982); Uri Benzion, Amnon Rapoport & Joseph Yagil, *Discount Rates Inferred From Decisions: An Experimental Study*, 35 Management Science 270 (1989).

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[8] While in theory a patient will discount at a constant rate over time, in practice individual preferences are inconsistent. *See* Gretchen Chapmen & Arthur Elstein, *Valuing the Future: Temporal Discounting of Health and Money*, 15 Med. Decision Making 373, 373 (1995). "[T]he relative marginal price of waiting for rewards" declines as the time necessary to wait increases. Richard Thaler, *Some Empirical Evidence on Dynamic Inconsistency*, 8 Econ. Letters 201, 205 (1981). To take a monetary example, while today one may prefer $100 three weeks from now to $50 a week from now, when the time comes to receive the $50 next week, she might reverse her preference, taking the $50 rather than waiting the marginal two weeks. Chapman & Elstein, *supra*, at 374. The rate at which she values the money has thus increased as the time horizon has decreased. *Id.* Since the resulting discount factor is described by a hyperbolic rather than constant or exponential function, the phenomenon is known as "hyperbolic discounting." Thaler, *supra*, at 374-75.

For example, a patient might resolve to start a new diet tomorrow, but when faced with the prospect of actually beginning the next day, his preference will switch for the short-term reward of eating a donut. The farther in the future a cost or reward is, the more likely he will be to discount the value at a lower rate. The end result is that the patient discounts the future benefits of maintaining a healthy lifestyle more than he should because the benefits are hidden while the costs are immediate. This leads the patient to make time-inconsistent choices about whether to maintain a healthy lifestyle, whether to receive preventive care, and whether to save for future care. See generally Chapman & Elstein, *supra* note 6. On the other hand, when the patient gets sick, the benefits of care are immediate and the long-term costs of healthcare inflation from over-consumption are less apparent, leading him to consume more healthcare than he potentially needs or can afford.

Like optimism bias, this market failure has been proven in patient behavior in numerous settings, and it provides a sufficient justification for Congress's decision to steer individuals away from self-insurance.

3. Optimism bias and hyperbolic discounting lead to over-consumption of healthcare relative to what an individual can afford and over-consumption of inefficient emergency care.

As a result of optimism bias and hyperbolic discounting, an uninsured patient under-consumes preventive care and fails to save enough to pay for future healthcare costs. See, for example, Families USA, *Getting Less Care: The Uninsured With Chronic Health Conditions*, Families USA 2 (2001) (showing that uninsured individuals with chronic conditions receive less preventive care than those with insurance). These trends have a compounding effect because the patient's under-consumption of preventive care leads to worse catastrophic events. For example, a patient that did not seek preventive care is unlikely to detect emerging health conditions such as heart failure and diabetes early enough to avoid them. The patient will also over-consume care when faced with a catastrophic event because she cannot see the long-term costs of these expenditures relative to the short term cost of forgoing care. At the same time, when a catastrophic event occurs, the patient who has saved too little to pay for her future healthcare costs will be unable to afford medically necessary care such as bypass surgery and diabetic management. A recent report from the Department of Health and Human Services shows that the median savings for self-insured families is only $20. Office of the Assistant Sec'y for Planning and Evaluation, Office of Health

Policy, Dep't of Health & Human Servs., The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills (2011). Over 58 percent of hospital stays result in bills of more than $10,000, so the median self-insured patient will not be able to pay for the services she receives at all. *Id.* Furthermore, as Congress found in its legislative findings, these problems lead to billions of dollars per year in uncompensated care, 42 U.S.C.A. § 18091(a)(2)(F), and they also contribute to more than half of all personal bankruptcies filed each year, 42 U.S.C.A. § 18091(a)(2)(G).

Another systematic inefficiency arises from these market failures: The self-insured patient's reliance on emergency departments and trauma centers – two of the least efficient settings for healthcare delivery. By failing to receive preventive care, a patient is more likely to suffer a catastrophic event that requires emergent care. Failure to save for catastrophic events drives patients to emergency rooms rather than cheaper urgent care centers because emergency rooms are required as a condition of Medicare participation to provide medically necessary treatment regardless of a patient's ability to pay. See 42 U.S.C. § 1395dd. The increased cost of treatment in an emergency room relative to an urgent care center adds even more to the over-consumption effects that arise from self-insurance, contributing significantly to the alarming rate of inflation in the healthcare sector. See generally Daniel Simonet, *Cost Reduction Strategies for Emergency Services: Insurance Role, Practice*

Changes and Patients Accountability, 17 Health Care Analysis 1 (2009).

Over-consumption of healthcare by a self-insured patient may manifest in other ways as well. For example, self-insured patients likely contribute to greater costs in Medicare consumption and Social Security disability payments. Wilhelmine Miller, Elizabeth Richardson Vigdor & Willard G. Manning, *Covering the Uninsured: What Is It Worth?*, Health Affairs W4-157 (Web Supp.) (2004). Because a patient abstains from receiving preventive care, she is more likely to need costly catastrophic care later in life, after she has joined Medicare. While these costs are difficult to quantify, the stress on the system is a direct result of inefficiencies in the market for self-insured healthcare.

In short, the many failures in the market for self-insured care combine to create a pathologically inefficient market that Congress may rationally seek to eliminate under its authority to regulate interstate commerce. The Eleventh Circuit and the parties have failed to consider Congress's authority to eliminate an inefficient marketplace, but that authority provides a sufficient basis to uphold the individual mandate. Because it is difficult to target the market for self-insured care directly, Congress enacted the individual mandate as a rational strategy to shift patients from that market to a near-perfect substitute market: the market for insured care.

B. Insurance Cures Many of the Self-Insured Market's Inefficiencies and Creates Additional Efficiencies, Making it an Attractive Substitute for Self-Insurance.

Many of the inefficiencies in the self-insured market are corrected when a patient becomes part of an insurance pool. The health insurance market fixes optimism bias and hyperbolic discounting problems present in the self-insured market by creating incentives for patients to obtain preventive care and to avoid emergency room care. Furthermore, the insurance market provides a commitment mechanism to help patients pay for future healthcare costs and creates additional efficiencies by leveraging market power. Congress's decision to channel patients from the market for self-insured care to the market for fully-insured care is therefore an eminently rational – indeed, quite an elegant – approach to the project of eliminating the market for self-insured healthcare. Insurance fixes all of the relevant problems.

1. The insured market fixes the optimism bias problems present in the self-insured market.

The insured market fixes optimism bias and hyperbolic discounting problems by providing incentives for a patient to seek preventive care and by requiring mandatory savings and risk coverage.

One of the primary ways that health insurance has historically corrected for the patient's inconsistent time preferences is by making preventive care as cheap as possible, setting low or zero copays. See, *e.g.*, BlueCross BlueShield of Illinois, *Health Insurance Plan Comparison Guide* (2011). This strategy reduces the patient's immediate cost of receiving preventive care, nudging the patient towards screening that can prevent larger medical problems in the future. For example, a patient is more likely to receive breast exams, cervical screenings, and influenza shots when the marginal costs are relatively low. Robert L. Kane, Paul E. Johnson, Robert J. Town & Mary Butler, *A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior,* 27 Am. J. Preventive Med. 327, 327 (2004). Furthermore, when faced with the choice of a small copayment for a primary care visit or full cost for a specialist visit, the patient will be much more likely to choose the cheaper primary care physician. All of this logic underlies the ACA regulatory scheme, motivating Congress to prohibit copayments entirely for at least some preventive care. See ACA § 1501, 42 U.S.C.A. § 300gg-13 (prohibiting cost-sharing for preventive services that the Preventive Services Task Force, see *id.* at 42 U.S.C.A. § 299b-4, finds to be successful in preventing health problems); *id.* at 42 U.S.C.A. § 13951(a)(1) (same for Medicare).

The insurance market further corrects for cognitive failures by creating a payment structure that requires mandatory saving and risk coverage. The required monthly payments for health insurance act as a commitment mechanism, requiring a patient to commit money to her healthcare costs ahead of time and ensuring that she will have enough available for care when it becomes necessary. David Laibson, *Golden Eggs and Hyperbolic Discounting*, 112 Q.J. Econ. 443, 443-45 (1997). As discussed at length above, without such a structured payment plan, a patient will not save enough for her future costs. The insurance market, thus, provides clear corrections to the market failures for self-insured care, making Congress's choice of an incentive to insure an elegant means of eliminating the market for self-insured transactions.

2. Insurance reduces over-use of emergency room facilities by charging high copays if the patient is not admitted to the hospital.

Just as insurance companies create incentives for primary and preventive care through copay design, so too do they correct for overuse of emergency departments by imposing higher copayments for emergency room visits that prove to be non-emergent. For example, many insurance contracts charge a $50 copay for an emergency room visit that does not result in the

patient's admission to the hospital but waive the copay if the patient is admitted. See, *e.g.*, BlueCross BlueShield, *Blue Care Elect Preferred (PPO) Summary of Benefits: 2011-2012 Massachusetts State Universities Student Blue Plan* (2011). If the patient's condition was truly emergent, then she has no copay, but if she was relying on the emergency room as a substitute for more efficient outpatient settings (like primary care offices or urgent care centers), she pays a hefty penalty. These financial incentives have been shown to reduce the number of emergency visits, correcting the uninsured market's inefficiency. See generally Daniel Simonet, *supra* (showing a 40 percent reduction in emergency room consultations from similar efforts).

Channeling a patient away from emergency rooms is beneficial not only to relieve over-burdened emergency rooms but also to allow patients to receive more efficient care. By seeing primary care physicians instead of emergency departments, the patient becomes part of a health management program that provides disease management for chronic diseases and consistent oversight moving forward. Insurance thus provides a structured bundle of incentives to help individuals overcome their cognitive failures and resulting over-consumption. Congress's preference for the insured market is therefore quite rational.

3. Beyond correcting for inefficiencies experienced in the self-insured market, the insured market has additional efficiency advantages.

Although insurance provides clear corrections to the particular failures in the self-insured market, those discrete corrections are not the only advantages of insurance. The insurance market adds at least three additional efficiencies that make it even better as a substitute for self-insured care. Unlike the self-insured market, the insured market is able to provide (1) negotiated volume discounts, (2) quality screening and assurance, and (3) medical management services such as medical necessity review.

First, the insurance market has been able to use patient volume as a bargaining chip in commercial market negotiations for discounts on physician payments, pharmaceutical prices, and hospital services. By contracting with pharmaceutical companies and health providers, insurance companies can agree to channel patients towards certain network providers or can threaten to exclude a provider from coverage under the insurance plan in an effort to receive price discounts. See Vivian Y. Wu, *Managed Care's Price Bargaining with Hospitals*, 28 J. Health Econ. 350 (2009). In other words, the insurance pool gives insurers collective bargaining power that can discipline healthcare inflation for insured patients.

A patient seeking care in the self-insured market, on the other hand, has no leverage to threaten or

incentivize providers to change their pricing structure. For example, a Department of Health and Human Services Report to the President from 2000 found that cash payers paid on average 14.6 percent more for the 200 most commonly prescribed drugs than did patients in the insured market. Dept. of Health & Human Servs., Report to the President: Prescription Drug Coverage, Spending and Prices 96 (2000). The insurance market thus creates a clear efficiency in controlling costs relative to the self-insured market.

Second, insurers provide quality screening and assurance that self-insured patients are incapable of providing for themselves. Congress was clearly cognizant of this problem as the ACA includes a number of provisions designed to increase transparency in the healthcare market, allowing patients better access to information. See generally ACA Title VI (codified as amended in scattered sections of 42 U.S.C.A.). But these provisions alone are insufficient to correct for the fundamental problem a patient faces in attempting to aggregate and analyze information. Most of the time, a patient is unequipped to draw appropriate conclusions about the quality of the care she is receiving. She often lacks both understanding of and access to the kinds of information necessary to make an intelligent and appropriate decision about her care. See generally Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941 (1963). Health literacy, the "degree to which people have the capacity to obtain, process, and

understand basic health information and services needed to make appropriate health decisions," is a difficult hurdle to overcome, and poor health literacy can result in a "worse health status, and a higher rate of hospitalization" for the patient. Ruth M. Parker, Scott C. Ratzan & Nicole Lurie, *Health Literacy: A Policy Challenge for Advancing High-Quality Health Care*, 22 Health Aff. 147, 147 (2003). Furthermore, even highly literate patients have a hard time drawing reliable conclusions about the quality of care they have received because causation is difficult to establish for many medical interventions. A patient who leaves the doctor feeling worse than she did before the encounter might have received poor quality care, or she might simply have been beyond help. Even patients with the highest possible health literacy – such as doctors themselves, when treated – often have a hard time differentiating between those scenarios based on an individual encounter. Only through population data can health analysts draw somewhat reliable conclusions about the quality of doctors and hospitals.

Of course, health insurers have ready-made access to such data based on the experiences of their insured. Health insurers thus provide a solution to the health literacy barrier by leveraging their access to collective data and their expertise in analyzing healthcare outcomes to provide quality screening. By comparing data on doctor quality alongside information about the risk factors of individual patients, insurers provide a more efficient mechanism for

assuring quality from health care providers, and they can channel their insured patients away from low-quality providers by refusing to cover visits to low-quality doctors and hospitals. See generally Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. Rev. 2323 (2010).

Moreover, the same bargaining power that allows insurers to receive discounted rates on services will provide an incentive for physicians to keep their quality standards high. Along with patient channeling, insurers may provide pay-for-performance incentives to physicians who demonstrate elevated performance relative to their peers. John W. Rowe, *Pay-for-Performance and Accountability: Related Themes in Improving Health Care*, 145 Annals Internal Med. 695, 697 (2006). This is also a point that Congress clearly had in mind; the ACA contemplates increased use of performance measures, enabling insurers to make better use of their bargaining power moving forward. See, *e.g.*, ACA §§ 10326-27, 10329, 10331-32 (codified as amended in scattered sections of 42 U.S.C.A.) (improving the physician quality reporting system and facilitating public reporting of physician performance results); see also Anne B. Claiborne, Julia R. Hesse & Daniel T. Roble, *Legal Impediments to Implementing Value Based Purchasing Healthcare*, 35 Am. J.L. & Med. 442 (2009) (describing the legal barriers to implementing effective pay for performance evaluation prior to the ACA).

Third, many private insurers (though not all) provide medical management functions by engaging in medical necessity review and by serving as gatekeepers for access to specialists, both of which can create efficiencies relative to the self-insured market. Medical necessity review creates those efficiencies by preventing a patient from over-consuming care relative to need. As described above, a self-insured patient often over-consumes health care services, both relative to what she can pay for and relative to what she needs to maintain her health. Furthermore, a patient's physician sometimes drives costs by suggesting more care than the patient needs, in order to capture greater profits. Because of the information asymmetries between doctor and patient, patients can fall prey to physician-induced demand that drives healthcare inflation. Private insurers are better than individual patients at reducing these over-consumption problems for three reasons. First, insurers' ability to aggregate data means they are in the best position to assess the effectiveness of treatments, leading to the elimination of treatments that are unnecessary or dangerous to the patient. Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637, 1667 (1992). Second, insurers are able to provide oversight of physicians whose "financial incentives are . . . a significant determinant of treatment behavior," using their bargaining power and their collective data to combat physician-induced demand. *Id.* at 1667. Finally, the insurer's relationship to the patient places the insurer in a good position to make efficient decisions

regarding healthcare costs since insurers "operate in a marketplace that penalizes them for failing to balance the customers' desire for cost containment with the desire for access to necessary medical services." *Id.* at 1665. Although medical necessity review does not do a perfect job of combating physician-induced demand and although insurance can have a countervailing moral hazard effect that causes patients to demand more care than they would if paying out-of-pocket, insurers are certainly in a better position than self-insured patients to make smart decisions about the safety and necessity of a requested medical intervention. Besides, Congress's decision to shift patients from a market in which they over-consume catastrophic and emergency care to a market in which moral hazard might cause them to over-consume preventive and specialty care is a *rational* choice, particularly given the potentiality for medical necessity review to curb moral hazard effects. And rationality is all that is required for constitutionality.

Gatekeepers are less popular and less common than medical necessity review in the private insurance market (and nonexistent in traditional Medicare), but they are similarly capable of creating efficiencies that are quite difficult for self-insured patients to capture. By channeling patients through primary care physicians before they see specialists, gatekeepers allow primary care physicians to manage patient flow, determine whether patients require non-routine care, and avoid patient referral to a specialist for costly and redundant tests. Simonet, *supra* at 7-8.

Gatekeepers, thus, allow some patients who would otherwise be inclined to see a specialist to have their problem resolved first through the cheaper channel of primary care. Overall, encouraging patients to seek primary care instead of specialty care is demonstrably cost effective. For example, it costs less for a primary care physician to treat a common illness than it would for a specialist to treat the same illness, even though the patient's outcome will be the same. Barbara Starfield, Leiyu Shi & James Macinko, *Contribution of Primary Care to Health Systems and Health*, 83 Millbank Q. 457, 473 (2005) (showing this effect for pneumonia). Insurers can effectively channel patients to primary care instead of specialists by carefully designing the patient's financial obligation for each kind of visit through cost sharing and also by refusing to reimburse at all for a specialty visit absent a referral from a primary care doctor. Again, these gatekeepers are not as common among private insurers as medical necessity review, and traditional Medicare does not require primary care visits at all before reimbursing for specialty care. This added feature of insurance is merely available for patients who freely choose cheaper insurance, like Health Maintenance Organizations (HMOs), on the private market. Regardless, gatekeeping is an efficiency feature that is quite difficult for self-insured patients to capture, and it bolsters the rationality of Congress's decision to shift patients into the insurance market.

In sum, the insured market not only corrects for the inefficiencies experienced by the self-insured

market, but also it provides additional efficiencies that help drive down costs for patients while providing them with more effective care.

Congress's chosen approach to eliminating the market for self-insured healthcare transactions is not just rational; it is quite elegant. The broader healthcare marketplace operates best when most patients purchase care through insurance contracts, which use cost-sharing designs and oversight mechanisms to correct individual patients' cognitive failures and information asymmetries. By creating a legal incentive for patients to choose third-party insurance over self-insurance, Congress will not only steer patients out of the inefficient market for self-insured care but also steer patients into the significantly more efficient market for fully-insured care. The end is legitimate; the means are rational; and the provision is constitutional.

CONCLUSION

For the foregoing reasons, we urge this Court to reverse the Eleventh Circuit and direct entry of

judgment for the petitioners on the constitutional validity of the minimum coverage provision.

Respectfully submitted,

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January 13, 2012