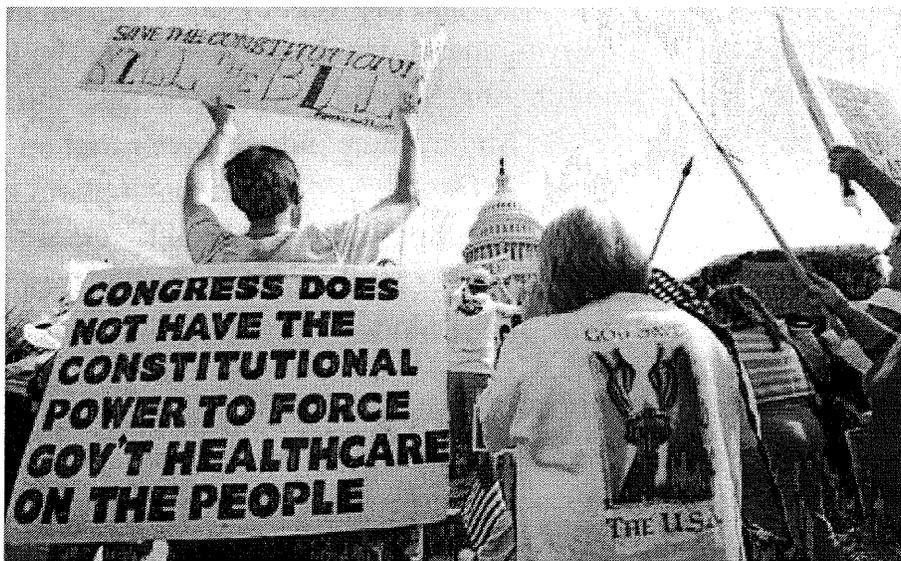


The New York Review of Books

Is Health Care Reform Unconstitutional?

FEBRUARY 24, 2011

David Cole



Nicholas Kamm/AFP/Getty Images

Tea Party supporters protesting against the health care bill, Washington, D.C., March 2010

1.

Can Republicans defeat Obama's health care bill by persuading the courts that mandatory health insurance is unconstitutional? On December 13, 2010, Henry Hudson, a federal judge in Virginia, declared unconstitutional the central provision of the health care reform law. Judge Hudson reasoned that the law's command that citizens purchase health care insurance extended beyond Congress's authority to legislate. It has long been established that Congress may regulate citizens' economic activities, such as entering into contracts, producing or purchasing goods and services, or shipping goods across state lines. But it is entirely unprecedented, Judge Hudson said, for Congress to regulate "inactivity"—a failure to buy insurance.

Obama dismissed the opinion as just "one ruling by one federal district court." But to others, it came as a shock. Dahlia Lithwick, Slate's legal affairs correspondent, said that before Judge Hudson's decision, most experts thought the legal challenges would

fail in the Supreme Court by a large margin, 8–1 or 7–2, but that after the ruling, the betting is that the Court will split 5–4, with Justice Anthony Kennedy likely casting the decisive vote. ¹

It is easy to see why commentators might expect the case to be closely divided. Health care reform has been nothing if not intensely partisan. The Patient Protection and Affordable Care Act was passed without a single Republican vote, and Republicans in the House have already voted to repeal it. The fight over its enactment helped promote the rise of the Tea Party and the Republican victories in the midterm elections. Most of the state attorneys-general who have challenged the law's constitutionality in court are Republicans. Several Democratic state attorneys-general have filed a brief supporting the law. So far, three judges have ruled on the merits of the challenges. Two, both appointed by Democratic presidents, upheld the act. Judge Hudson, the first to rule otherwise, is a Republican appointed by George W. Bush. Another Republican-appointed judge, Roger Vinson, has a similar case pending in Florida, and he is likely to side with Judge Hudson. ^{1a}

The roots of the ideological divide, moreover, run deep. The principal constitutional issue at stake—the extent of Congress's authority to pass laws governing Americans' lives—has separated conservatives and liberals since the beginning of the Republic. "States' rights" was the South's rallying cry in its effort to retain slavery before the Civil War, and to defend racial segregation from federal intervention thereafter. From the turn of the century through the early years of the New Deal, conservatives successfully invoked "states' rights" to interpret Congress's power over interstate commerce narrowly and thereby invalidate progressive federal laws designed to protect workers and consumers from big business. And the last two times that the Supreme Court struck down laws as reaching beyond Congress's Commerce Clause power, in 1995 and 2000, the Court split 5–4, with Chief Justice William Rehnquist writing the majority decision, over dissents by Justices Stephen Breyer, David Souter, John Paul Stevens, and Ruth Bader Ginsburg. ²

As Judge Hudson sees it, the health care reform law poses an unprecedented question: Can Congress, under its power to regulate "commerce among the states," regulate "inactivity" by compelling citizens who are not engaged in commerce to purchase insurance? If it is indeed a novel question, there may be plenty of room for political preconceptions to color legal analysis. And given the current makeup of the Supreme Court, that worries the law's supporters.

But the concerns are overstated. In fact, defenders of the law have both the better argument and the force of history on their side. Judge Hudson's decision reads as if it were written at the beginning of the twentieth rather than the twenty-first century. It rests on formalistic distinctions—between “activity” and “inactivity,” and between “taxing” and “regulating”—that recall jurisprudence the Supreme Court has long since abandoned, and abandoned for good reason. To uphold Judge Hudson's decision would require the rewriting of several major and well-established tenets of constitutional law. Even this Supreme Court, as conservative a court as we have had in living memory, is unlikely to do that.

The objections to health care reform are ultimately founded not on a genuine concern about preserving state prerogative, but on a libertarian opposition to compelling individuals to act for the collective good, no matter who imposes the obligation. The Constitution recognizes no such right, however, so the opponents have opportunistically invoked “states' rights.” But their arguments fail under either heading. With the help of the filibuster, the opponents of health care reform came close to defeating it politically. The legal case should not be a close call.

2.

The provision that Judge Hudson struck down requires all Americans, unless exempted on religious or other grounds, to purchase health care insurance. (Most Americans are already covered through their employment or Medicare or Medicaid, so for them this law would have no impact.) Those who do not obtain insurance must pay a penalty in the form of a special tax.

The individual mandate is aimed at so-called “free riders”—people who fail to get insurance, and then cannot pay the cost of their own health care when they need it. Under our current system, in which hospitals must treat people regardless of ability to pay or insurance coverage, hospitals are able to recover only about 10 percent of the cost of treating uninsured individuals. That cost is ultimately borne by the rest of us. The federal government picks up much of the tab, and hospitals and insurers pass on the rest to their paying customers in higher fees. The Congressional Budget Office estimated that in 2008 the uninsured shifted \$43 billion of health care costs to others.

Without the individual mandate, the health care law's more popular reforms—such as the bar on insurance companies denying coverage because of “preexisting conditions”—would actually make the insurance crisis worse. Knowing that insurers could not deny coverage or charge more for preexisting conditions, people could wait

to buy insurance until they were sick. But then more and more of the people insured would be the sickest, defeating the very purpose of insurance—to spread the risk by creating a pool of funds that can be drawn on for payments. Premiums would skyrocket, meaning that even fewer people could afford insurance, and that would in turn induce still more people to opt out. As Wake Forest University Professor Mark Hall testified in Congress, “a health insurance market could never survive or even form if people could buy their insurance on the way to the hospital.”

This is not just an academic prediction. When in 1994 Kentucky enacted similar reforms regarding preexisting conditions, but without an individual mandate, insurance costs rose so steeply that they became untenable, and insurers pulled out of the market altogether. Kentucky was forced to repeal the reform. Initiatives in New York and New Jersey faced similar problems. In Massachusetts, by contrast, where health insurance reform was coupled with an individual mandate, the system has worked; since 2006, insurance premiums there have fallen 40 percent, while the national average has increased 14 percent.

Judge Hudson acknowledged, as do the law’s challengers, that Congress has power to regulate any economic activity that, in the aggregate, affects interstate commerce—no matter how minimal the activity’s effects are standing alone. But the decision not to buy health insurance, Hudson reasoned, is not “activity” at all. It is “inactivity.” Rather than setting rules for those who choose to engage in interstate commerce, the individual mandate compels a citizen who has chosen *not* to engage in commerce to do so by purchasing a product he does not want. If Congress can regulate such “inactivity,” Hudson warned, there would be no limit to its powers, contravening the bedrock principle that the Constitution granted the federal government only limited powers.

Judge Hudson’s reasoning is not without precedent—but the precedents that his rationale reflects have all been overturned. In the early twentieth century, the Supreme Court ruled that the Commerce Clause authorized Congress to regulate only “interstate” business, not “local” business; only “commerce,” not production, manufacturing, farming, or mining. The Court also ruled that Congress could regulate only conduct that “directly” affects interstate commerce, not conduct that “indirectly” affects interstate commerce. Like Judge Hudson, the Supreme Court warned that unless it enforced these formal categorical constraints, there would be no limit to Congress’s power. Thus, for example, in 1936, the Court struck down a federal law that established minimum wages and maximum hours for coal miners, reasoning that

mining was local, not interstate; entailed production, not commerce; and had only “indirect” effects on interstate commerce.³ Using this approach, the Court invalidated many of the laws enacted during the early days of the New Deal.

Around 1937, however, the Court reversed course. It recognized what economists (and the Court’s dissenters) had long argued, and what the Depression had driven home—that in a modern-day, interdependent national economy, local production necessarily affects interstate commerce, and there is no meaningful distinction between “direct” and “indirect” effects. In the local, agrarian economy of the Constitution’s framers, it might have made sense to draw such distinctions, but in an industrialized (and now postindustrialized) America, the local and the national economies are inextricably interlinked.

As a result, Congress’s power to regulate “interstate commerce” became, in effect, the power to regulate “commerce” generally. The Court rejected as empty formalisms the distinctions it had previously drawn, between local and interstate, between production and commerce, and between “direct” and “indirect” effects. Since 1937, the Supreme Court has found only two laws to be beyond Congress’s Commerce Clause power. Both laws governed noneconomic activity—simple possession of a gun in a school zone and assaults against women, respectively—and were unconnected to any broader regulation of commerce.⁴ But the Court has repeatedly made clear that Congress can regulate any economic activity, and even noneconomic activity where doing so is “an essential part of a larger regulation of economic activity.”

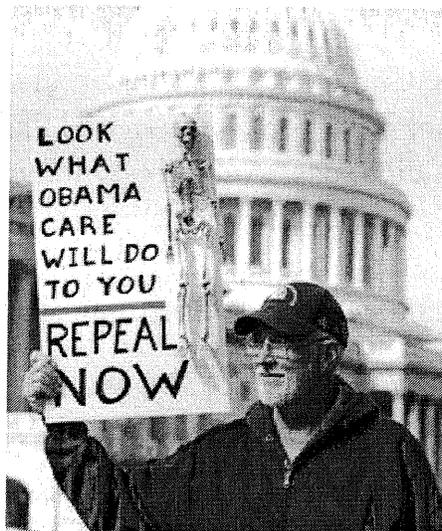
On this theory, the Supreme Court has upheld federal laws that restricted farmers’ ability to grow wheat for their own consumption and that made it a crime to grow marijuana for personal medicinal use, even though in both instances the people concerned sought to stay out of the market altogether.⁵ The Court reasoned that even such personal consumption affects interstate commerce in the aggregate by altering supply and demand, and that therefore leaving it unregulated would undercut Congress’s broader regulatory scheme.

Under these precedents, a citizen’s decision to forgo insurance, like the farmer’s decision to forgo the wheat market and grow wheat at home, easily falls within Congress’s Commerce Clause power. When aggregated, those decisions will shift billions of dollars of costs each year from the uninsured to taxpayers and the insured. As a practical matter, there is no opting out of the health care market, since everyone eventually needs medical treatment, and very few can afford to pay their way when

the time comes. (Those who refuse all medical treatment for religious scruples are an exception, but they are exempt from the mandate.) That one might affix the label “inactivity” to a decision to shift one’s own costs to others does not negate the fact that such economic decisions have substantial effects on the insurance market, and that their regulation is “an essential part of a larger regulation of economic activity.”

3.

Another part of the Constitution, the “Necessary and Proper Clause,” provides even more well-established support for Congress’s action. That catch-all provision authorizes Congress to enact laws that, while not expressly authorized by the Constitution’s specific enumerated powers, are “necessary and proper” to the exercise of those powers. In one of the Court’s most important decisions, *McCulloch v. Maryland*, written by Chief Justice John Marshall nearly two hundred years ago, the Court unanimously ruled that this provision must be given a broad reading, permitting any laws that are “convenient” or “rationally related” to the furtherance of an express power.⁶ In that case, the Court upheld Congress’s creation of a national bank, even though the authority to do so is nowhere expressly provided, because a national bank was rationally related to the exercise of Congress’s other powers, including the power to coin money and tax and spend. By the same token, because the individual mandate is rationally related to Congress’s conceded power to regulate health insurance, it is “necessary and proper.”



Saul Loeb/AFP/Getty Images

A protester at a Tea Party rally, Washington, D.C.,
November 2010

The wide reach of the Necessary and Proper Clause was reaffirmed just last year when, in a 7–2 decision joined by Chief Justice John Roberts and Justices Kennedy

and Samuel Alito, the Supreme Court upheld a federal law authorizing civil commitment of federal prisoners who are sexual predators, even though no provision expressly authorizes Congress to do so.⁷ The Court explained that as long as there is some initial link to an explicitly enumerated power in the Constitution, the Necessary and Proper Clause authorizes actions many steps removed from that power. Thus, the Court reasoned, Congress may pass criminal laws “rationally related” to any of its other enumerated powers. It may then build prisons to house those convicted, enact rules to govern prisoners, and provide civil commitment to protect the community from those leaving federal prison—even though the Constitution expressly authorizes none of these actions.

If the Necessary and Proper Clause supports such an extended string of implied powers, there can be little dispute that it authorizes the individual mandate. Congress undoubtedly has the authority to regulate health insurance under the Commerce Clause, so the individual mandate is “necessary and proper” as long as it is “rationally related” or “convenient” to that larger project. It clearly passes that test, as it is integral to avoiding a very large increase in health insurance premiums. Judge Hudson concluded, however, that because in his view the mandate was not permissible under the Commerce Clause, it could not be authorized by the Necessary and Proper Clause. That approach renders the latter clause meaningless, and directly contravenes *McCulloch v. Maryland*.

Finally, the individual mandate is also sustainable under Congress’s independent power to tax. President Obama insisted on a Sunday talk show that the mandate was not a tax, but the Court has long ruled that the validity of a law turns not on what label is attached to it, but on what it does. The individual mandate collects revenue from individuals as part of their income tax. It is expected to generate \$4 billion annually, which will help the federal government defray the health care costs the uninsured fail to pay.

Judge Hudson deemed the law to be a penalty, not a tax, citing a 1922 decision that invalidated a federal tax on child labor on this ground.⁸ But that case, which dates from the same pre–New Deal era when the Court was narrowly construing Congress’s Commerce Clause powers, rested on another formalist distinction, since rejected, between laws that collect revenues and laws that regulate behavior. As with the pre–New Deal Commerce Clause distinctions, the Court has since abandoned this distinction, recognizing that taxes inevitably have regulatory effects by increasing the cost of the activity that is taxed. Thus, according to modern constitutional

jurisprudence, a tax law is valid if it raises revenue and its regulations are reasonably related to the exercise of the taxing power.

Congress plainly can tax for the purpose of providing health insurance. It does so already, through Medicare and Medicaid. Had it simply expanded these programs to provide universal care, there would be no question that its actions would be permissible under the taxing power. Similarly, it indisputably could have granted tax credits to those who purchase health care, and withheld them from those who do not. Imposing the tax directly on free riders is no less an exercise of the taxing power.

Judge Hudson's concerns that upholding the law would lead to unlimited federal power are wildly exaggerated. A decision to sustain the individual mandate would not mean that Congress could require all Americans to exercise or eat only healthy food, as some have suggested. The individual mandate regulates an *economic* decision that is in turn an essential part of a comprehensive *economic* regulation of the interstate business of insurance. And health care is a unique commodity, in that virtually everyone will eventually need it; along with taxes and death, a trip to the doctor is one of life's inevitabilities. Thus, to say that Congress can require an individual to purchase insurance or pay a tax does not signal the end of all meaningful limits on federal power.

In short, Congress had ample authority to enact the individual mandate. Absent a return to a constitutional jurisprudence that has been rejected for more than seventy years, and, even more radically, an upending of Chief Justice Marshall's long-accepted view of the Necessary and Proper Clause, the individual mandate is plainly constitutional.

4.

Near the end of his decision, Judge Hudson writes: "At its core, this dispute is not simply about regulating the business of insurance—or crafting a scheme of universal health insurance coverage—it's about an individual's right to choose to participate." Virginia Attorney General Ken Cuccinelli, who brought the suit, echoed that point the day the decision came down, insisting that "this lawsuit is not about health care. It's about liberty." But that is exactly what the case is not about. A decision that Congress lacks the power to enact the individual mandate says nothing about individual rights or liberty. It speaks only to whether the power to require citizens to participate in health insurance, a power that states indisputably hold, also extends to the federal government. The framers sought to give Congress the power to address problems of

national or “interstate” scope, problems that could not adequately be left to the states. The national health insurance crisis is precisely such a problem. The legal question in the case is about which governmental entities have the power to regulate; not whether individuals have a liberty or right to refuse to purchase health care insurance altogether.

But Judge Hudson and Ken Cuccinelli’s misstatements are nonetheless telling. Opposition to health care reform is ultimately not rooted in a conception of state versus federal power. It’s founded instead on an individualistic, libertarian objection to a governmental program that imposes a collective solution to a social problem. While Judge Hudson’s reliance on a distinction between activity and inactivity makes little sense from the standpoint of federal versus state power, it intuitively appeals to the libertarian’s desire to be left alone. But nothing in the Constitution even remotely guarantees a right to be a free rider and to shift the costs of one’s health care to others. So rather than directly claim such a right, the law’s opponents resort to states’ rights.

In this respect, Judge Hudson and the Virginia attorney-general are situated squarely within a tradition—but it’s an ugly tradition. Proponents of slavery and segregation, and opponents of progressive labor and consumer laws, similarly invoked states’ rights not because they cared about the rights of states, but as an instrumental legal cover for what they really sought to defend—the rights to own slaves, to subordinate African-Americans, and to exploit workers and consumers.

Here, too, opponents of health care reform are not really seeking to vindicate the power of states to regulate health care. Rather, they are counting on the fact that if they succeed with this legal gambit, the powerful interests arrayed against health care reform—the insurance industry, doctors, and drug companies—will easily overwhelm any efforts at meaningful reform in most states. Unless the Supreme Court is willing to rewrite hundreds of years of jurisprudence, however, they will not succeed.

—January 27, 2011

1

It is not certain that Judge Hudson's decision will reach the Supreme Court. He found that Virginia had standing to sue because its legislature had enacted a law giving citizens the right not to buy health insurance, as part of a national campaign by health care reform opponents to create obstacles in the states. It is far from clear that a state

can manufacture a dispute by enacting such a law, so it is possible that the case could be thrown out on appeal for failing to present a concrete controversy. However, at some point the health care law will plainly be subject to a constitutional challenge, at a minimum by any individual who objects to being required to purchase health insurance or pay the tax. So whether in this case or some other, the courts will eventually have to address the law's constitutionality. □

1a

On January 31, 2011, after this article went to press in the print edition, Judge Vinson issued his decision. Like Judge Hudson, he ruled unconstitutional the provision requiring individuals to purchase health insurance, because it regulates "inactivity." He went further than Judge Hudson, however, by declaring the entire health care reform law unconstitutional, not just the provision requiring individuals to purchase health insurance, because he concluded Congress would not have enacted the rest of the statute without the "individual mandate" provision. His decision, like Judge Hudson's will certainly be appealed. □

2

United States v. Morrison , 529 U.S. 598 (2000); *United States v. Lopez* , 514 U.S. 549 (1995). □

3

Carter v. Carter Coal Co. , 298 U.S. 238 (1936). □

4

See cases cited in note 2. □

5

Gonzales v. Raich , 545 U.S. 1 (2005); *Wickard v. Filburn* , 317 U.S. 111 (1942). □

6

McCulloch v. Maryland , 17 U.S. (Wheat.) 316 (1819). □

7

United States v. Comstock , 130 S. Ct. 1949 (2010). □

8

Child Labor Tax Case , 259 U.S. 20 (1922). □

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POLITICO

Child-only health plans endangered

By: Sarah Kliff and J. Lester Feder
January 27, 2011 01:29 PM EST

Health insurers in 34 states have stopped selling child-only insurance policies as a result of the health reform law, and the market continues to destabilize.

According to a survey¹ of state insurance departments by Republican Senate committee staff and obtained by POLITICO, states that have seen carriers exit the market include those that have been a rdent supporters of the health reform law, like California and Oregon. Twenty states now have no insurers offering child-only policies.

Since September, the health reform law has barred insurers from withholding policies to children under 19 who have a pre-existing condition. Rather than take on the burdensome cost of writing policies for potentially-pricey medical conditions, many carriers decided to leave the market altogether.

The Department of Health and Human Services responded by changing the rule to allow states to institute an open enrollment period for child-only health insurance plans. The move was meant to stop subscribers from jumping on plans only when they were diagnosed with a medical condition.

But the regulation seems to have done little to stop carriers from leaving the market.

“We only know of one company [a local

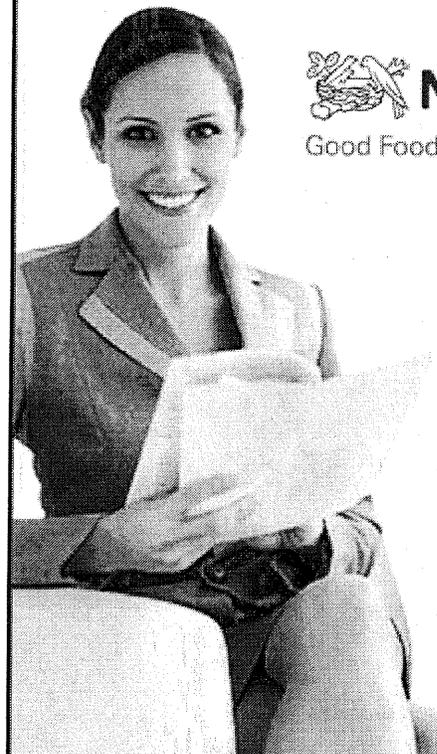
affiliate of Blue Cross Blue Shield] offering child-only health insurance,” Dan Honey, Deputy Commissioner for Life and Health in the Arkansas Department of Insurance, said Thursday. “The actual law federal law requires no underwriting for pre-existing conditions, which means guaranteed issue. Of course once HHS came out with that directive, that’s when a lot of companies

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started balking.”

One of the largest insurance markets in the country, Texas, has seen all their carriers drop child-only health insurance, as have other large states including Florida and Illinois.

Other states that no longer have carriers selling child-only plans include Alaska, Arizona, Connecticut, Delaware, Georgia, Minnesota, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, Tennessee, Utah, West Virginia and Wyoming, according to the investigation by GOP staff on the Senate Health, Labor and Pensions Committee.

Sen. Mike Enzi (R-Wyo.) pressed Health and Human Services Secretary Kathleen Sebelius on the issue at a Thursday morning hearing.

“It’s absolutely devastating,” Enzi said. “The outcome is predictable as a result of the drafting that would allow people to buy a policy on the way to the emergency room.”

When asked for what “specific steps” she would take to remedy the situation, Sebelius pushed back against the notion that the new regulation would lead to widespread disruption.

“While there was an initial flurry of announcements, [insurance companies] in many states are reconsidering,” Sebelius said. “I would suggest it was a pretty cynical notion that you would only insure... children without a health condition.”

To Sebelius’ point, multiple states tell POLITICO that the damage could have actually been a lot worse, had they not taken aggressive action to intervene. At least eight states have taken regulatory or legislative action to encourage health insurance carriers to continue to offer health insurance. California, Washington, Ohio, Indiana, New Hampshire, Kentucky,

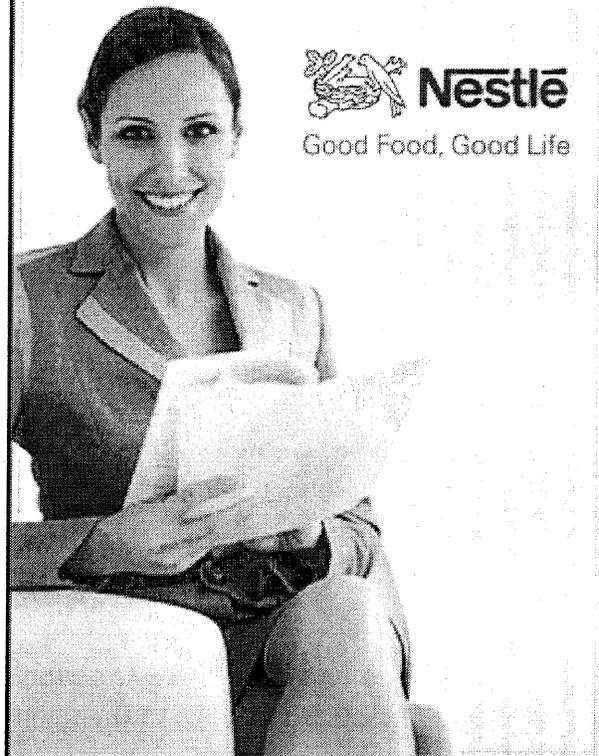
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Maryland and Colorado have all taken some form of action to encourage carriers to continue to offer child-only health insurance.

Washington state aggressively pushed back at insurers' plans to drop child-only health insurance, issuing a "cease and desist" order for insurers aiming to end their child-only health insurance policies. The state also issued an emergency rule, establishing an open enrollment period for child-only health plans, in order to "help prevent disruption in the individual health insurance marketplace by promoting a uniform approach to new, regulatory requirements," according to a copy of the regulation.

The move has stopped any Evergreen State carriers from leaving the child-only market.

Oregon, which has seven major insurers, has only seen two pull out of the child-only business: HealthNet of Oregon and Blue Cross Blue Shield Regence. With the new federal regulations looming the state instituted two open enrollment months, in February and August, when subscribers could enroll.

"We have options here," said Oregon Insurance Division spokeswoman Cheryl Martinis. "We have still been trying to get the word out and tell folks it's important not wait. We don't want to lose sight of the fact that people should be carrying insurance."

Oregon may pursue more aggressive action in the coming legislative session, pursuing

policy that would further encourage insurers to participate in the child only market.

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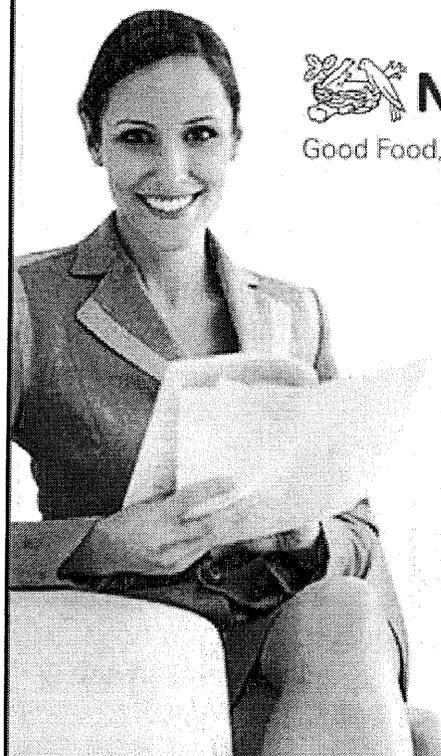
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Health Care Reform without the Individual Mandate

Replacing the Individual Mandate would Significantly Erode Coverage Gains and Raise Premiums for Health Care Consumers

Jonathan Gruber February 2011

Introduction

A central pillar of the recently enacted Patient Protection and Affordable Care Act is the individual mandate, the requirement that all individuals for whom insurance is affordable purchase such coverage or pay a tax penalty. Yet this is also one of its most controversial elements. In recent public opinion polls, the individual mandate is rated as one of the least popular elements of the new health law. And recent court decisions on the constitutionality of the individual mandate have reached mixed conclusions, with two courts upholding the mandate and two striking it down.

So what happens to health care reform if the mandate is repealed? And is there a reasonable alternative? This issue brief answers both of these questions. In particular, I consider the two most-discussed alternatives to the mandate and estimate their impact on insurance coverage, public sector costs, and insurance prices. I find that both alternatives significantly erode the gains in public health and insurance affordability made possible by the Affordable Care Act.

Reform with and without an individual mandate

We have a fairly good sense of how the world will look if health care reform includes the individual mandate. Both the Congressional Budget Office and independent modelers such as myself find that the majority of the uninsured would be covered.¹ CBO and I both estimate that Affordable Care Act will cover about 60 percent of those who would be uninsured absent the law. We both find that there would be a very modest reduction of employer-sponsored insurance, that premiums in the nongroup insurance market for the same quality product would fall, and that there would not be much effect on premiums in the employer-provided insurance market.

These estimates are consistent because we have a clear example to draw on in this case, the state of Massachusetts, which four years ago enacted a plan that is very similar to the new federal health reform law. In Massachusetts we have seen more than 60 percent of the uninsured gain coverage with little effect on employer-sponsored insurance premiums. We have seen a steeper drop in nongroup premiums that estimates suggest for the Affordable Care Act, however. According to insurance industry figures, nongroup premiums have fallen by 40 percent in Massachusetts while rising by 14 percent nationally.²

This much steeper drop in Massachusetts arises because the state has also given us a glimpse of what the world would look like if the mandate were stripped from the Affordable Care Act. In the mid-1990s, Massachusetts along with several other northeastern states passed insurance market reforms similar to those in the Affordable Care Act, eliminating or restricting the ability of insurance companies to discriminate against the ill either in prices or coverage exclusions. The result in each state was very high nongroup insurance prices as insurance companies worried that only the sick would enroll in insurance and priced their products accordingly.

We do not, however, have an example of a state that has included the other major element of the Affordable Care Act—extensive subsidies for low-income individuals to buy insurance. This will offset to some extent the “adverse selection” that drives up premiums in the nongroup market by bringing some healthier individuals into the market. The extent of such offset, however, is unclear. CBO estimates that removing the individual mandate from the new federal health law will cut the number of individuals newly insured in half (from 32 million to 16 million), while I estimate that it will cut the number of newly insured individuals by three quarters (from 32 million to 8 million). CBO estimates that the reduction in employer-sponsored insurance will double with no mandate; I estimate that it will triple. CBO estimates that premiums in the nongroup market will rise by 15 percent to 20 percent; I estimate they will rise by 27 percent. Finally, CBO estimates that removing the mandate would lower net government spending by \$47 billion in 2019, or roughly 25 percent of the costs of the policy. I estimate a cost reduction of 30 percent.³

So there is agreement between CBO and myself that a bill without the individual mandate will cover significantly fewer persons, with more erosion of employer insurance, and lead to significantly higher premiums. Moreover, we both agree that removing the mandate would significantly lower the “bang for the buck” of health policy, reducing coverage by 50 percent to 75 percent while only lowering costs by 25 percent to 30 percent. But there is more uncertainty and divergence in the estimates. And this is a key point to highlight about removing or replacing the individual mandate—it will raise our uncertainty about what health care reform can accomplish. One advantage of the individual mandate is that we have an example to build on; alternatives put us in a much less clear world.

Alternative: Auto-enrollment

If we were to replace the mandate, then there are two common alternatives that have been proposed. One is “auto-enrollment,” whereby individuals would be automatically enrolled in insurance as a default but could “opt out” if they decide they don’t want coverage. This has been called a “soft mandate” because it doesn’t force individuals to buy insurance, but it does force them to take affirmative action to avoid coverage. If some of the lack of enrollment in pensions (or health insurance) is due to “inattention,” then such a policy could greatly increase coverage.

This alternative is inspired by research by David Laibson and Brigitte Madrian at Harvard University along with various collaborators, which shows that such default changes in the context of so-called defined-contribution 401(k) pension plans can significantly increase participation in such plans, reducing the number of nonenrolled employees from 50 percent to 10 percent.⁴ Evidence from a broader universe of firms from money manager Fidelity Investments suggests that the effect is smaller, which could be due to a higher willingness to “opt out” at smaller firms. Fidelity finds that auto-enrollment raises participation from 53 percent to 81 percent.⁵ That is, of the 47 percent of employee that choose not to voluntarily enroll in 401(k) plans, 19 percent choose to opt out of auto-enrollment.

Applying this finding to the context of health insurance is difficult, but several considerations suggest that we would see a larger opt-out rate for health insurance than for 401(k) plans. First of all, employers actively encourage a broad cross-section of employees to participate in 401(k) plans because it is critical to meet nondiscrimination tests that allow them to tax defer the 401(k) contributions of higher-income employees. There is no such need for employers to encourage participation in health insurance plans, where nondiscrimination rules appear to be nonbinding. Indeed, employers should actively oppose auto-enrollment for health insurance: even if it encourages healthier employees to join, total employer spending rises.

Second, health insurance enrollment is a decision to which employees, particularly young employees, have already given much more consideration than to 401(k) enrollment. The largest auto-enrollment effects are found for young employees, for whom retirement is distant and so who probably weren’t considering 401(k) accounts before being auto-enrolled. These same young employees will have given much more consideration to the near-term decision about whether or not to insure.

Indeed, Fidelity data show that among 20- to 29-year-old employees, only 30 percent sign up for a 401(k) without auto-enrollment, yet only 23 percent opt out when auto-enrolled, a very large effect. Yet among workers 20 to 29 years old who are offered health insurance, 88 percent enroll today.⁶ Clearly, this is a decision that young workers are taking more seriously—and as a result the “inattention” that results in auto-enrollment

increases is likely to be a much smaller consideration. Furthermore, the dollars at stake here are potentially much larger, particularly for low-income workers, so once again they will be paying much more attention, and therefore will be much likelier to opt out.

Third, a recent study from the same team of Harvard authors shows that auto-enrollment may not work well when the default option is one that is very undesirable. They study a British firm that auto-enrolled employees into a very high contribution product (12 percent of pay), and one that was dominated because employer matching only began after 12 percent of pay. They found that only 25 percent of employees remained auto-enrolled in this option after one year.⁷

Fourth, as CBO points out in its 2008 discussion of key health issues, if you “overcontribute” to 401(k) pension plan accounts then you can get the money back with a small penalty.⁸ With health insurance, any premiums paid that you did not wish to pay are lost forever. This will further cause individuals to pay more attention to the opt-out decision and opt out more frequently if they don’t want the insurance.

Fifth, auto enrollment for health insurance raises an additional difficult issue: what to do about dependents. Pension enrollment is individual, but of the uninsured individuals offered insurance coverage today, 56 percent are dependents, not the employees themselves. Thus, auto-enrollment will not make much of a dent in the uninsured unless it extends to dependents. At the same time, 31 percent of workers who are offered employer-sponsored insurance also have a spouse that is offered insurance.⁹ This implies that inattention to auto-enrollment could lead to duplicative double coverage with inattentive individuals paying excessive bills that they may not notice until several months later.

Finally, only about one-third of the uninsured are actually *offered* employer-sponsored insurance in which they can be auto-enrolled.¹⁰ Individuals who auto-enroll outside of employer-sponsored insurance present an entirely new set of challenges. In principle, such individuals could be auto-enrolled based on past tax return information. But charging individuals premiums for insurance for which they did consciously enroll will raise a host of very difficult political and potentially constitutional issues.

Moreover, given lags in tax data, many individuals would be misclassified across subsidy levels, which would either lead to difficult issues of reconciliation or higher government spending.

As a result of these limitations, I estimate that auto-enrollment will be much less effective in the health insurance context. I find that if the Affordable Care Act were stripped of the individual mandate but instead accompanied solely by auto-enrollment of individuals who are offered insurance into single coverage, then only 1.1 million uninsured would gain coverage. Auto-enrollment that included dependents (with the associated double-coverage issues) would extend the gains to another 1.7 million uninsured. If the

government could successfully auto-enroll individuals into free public insurance, then that would be more effective, subject to individual concerns about having to pay for the free insurance if their income has gone up. I estimate that adding this feature would extend the gains to another 8.1 million uninsured. Finally, if the government could auto-enroll individuals in the exchanges, this would add another 3.7 million uninsured.¹¹

Thus, in the most generous case of full auto-enrollment (including those not offered employer-sponsored insurance), I estimate that:¹²

- Twenty-four million persons would gain insurance coverage, as opposed to the 32 million that would gain coverage with the mandate. Partly this is because the erosion of employer-sponsored insurance would double if there were no individual mandate in the new health reform law; that is, *twice as many individuals* would lose their employer coverage as would under the mandate.
- Since young healthy individuals would opt out of coverage, premiums in the nongroup market would rise by about 11 percent.
- Strikingly, though, I estimate that net *government costs would not fall at all*. This is because such a larger share of enrollment under this alternative comes through government-sponsored insurance. Under the Affordable Care Act with the individual mandate, about half of the net gain in coverage is in public insurance; under auto-enrollment 80 percent of the net gain in coverage comes through public insurance. That is, under this option, *8 in every 10 newly insured* are gaining coverage through government-provided insurance.

The bottom line is that losing coverage from employer sponsored insurance or the unsubsidized exchange, and making it up through fully publicly financed care, raises costs. So the government spends the same amount of money while covering two-thirds as many individuals and raising premiums in the nongroup market by more than 10 percent.

Alternative: Late enrollment penalties

An alternative to both auto-enrollment and the individual mandate is to allow voluntary opt-in to insurance under the Affordable Care Act, but then impose a penalty for late enrollment. Such an approach is followed by the Medicare Part D prescription drug plan, and enrollment in that plan was very rapid. In work with Gary Engelhardt of Syracuse University, we estimate that about half of the 28 percent of elders with no prescription drug coverage signed up for the program within one year of its introduction.¹³ Similarly, Medicare Part B, which covers outpatient costs for enrollees in Medicare, combines auto-enrollment with a late enrollment penalty (10 percent of premiums for each year of delay), and enrollment is virtually universal despite the fact that enrollees have to pay 25 percent of the premiums.

There are once again, however, a number of reasons to think that these findings overstate the impact that late enrollment penalties might have under the new health reform law without the individual mandate. Most importantly, we do not have a benchmark for what enrollment in these programs would be absent the late enrollment penalty. So while we know that enrollment under these late penalty regimes is high, we don't know what it would be if the program were strictly voluntary. Both Medicare Part D and Part B are heavily subsidized, with the government picking up approximately 75 percent of the insurance costs. For many individuals who would be targeted for late enrollment penalties outside of employer-sponsored insurance under the Affordable Care Act, subsidy rates will be much lower, if not zero.

Moreover, the seniors being assessed these penalties particularly value the insurance they are receiving and would likely enroll at high rates even absent penalties. This will not be true for many individuals of all ages (and their dependents) who don't voluntarily choose to enroll under the Affordable Care Act without the individual mandate. This conclusion will be further enforced by the social dynamic around universal enrollment in Medicare at age 65.

The impact of late enrollment penalties under the new health reform act would vary with the severity of the penalty, which could range from a small financial penalty to more severe penalties. Paul Starr of Princeton University suggests that if individuals do not sign up for insurance at the first opportunity under the new law, they would be barred from purchasing insurance in the new health insurance exchanges for a period of five years. This could leave individuals without access to nondiscriminatory insurance markets or insurance subsidies should they need them.

Of course, there is a tradeoff between the severity of the penalty and the realism of imposing it consistently. It seems highly unlikely that the federal government would be willing to tell a 30-year-old individual with cancer that they can't get insurance coverage because they didn't sign up when they were 27 years old—or that they have to pay some very large amount of money in the same situation.

Moreover, any solution such as Starr's places the very viability of reformed nongroup insurance markets at risk. It is the young and healthy who would take their chances with a late enrollment penalty rather than sign up for insurance that they don't fully value. As these young and healthy individuals leave the exchanges, they will raise prices for those left behind, causing even further exit—and potentially unraveling the entire market.

There is even more uncertainty, as a result, in estimating the impact of late enrollment penalties. My best estimate is under a late enrollment penalty regime:¹⁴

- Twelve million individuals will gain coverage, or only about *one-third* of those who we would expect to see enrolled under the individual mandate.

- Premiums in the exchange would rise about 20 percent relative to the mandate case as the healthy exit the exchanges.
- Government costs would fall by only about 25 percent, however, since subsidies would still be provided to the sicker enrollees who stay behind.
- Therefore, instituting late enrollment penalties reduces coverage by 65 percent for only a 25-percent reduction in government spending, while raising premiums by 20 percent for those who do want to buy non-group insurance.

Conclusion

Modeling the impact of fundamental health reform is a balancing act between leaning on what is known and modeling what we need to know. In the case of the new health reform law, that balancing act was greatly assisted by the experience of Massachusetts, which provides a great case study of the world with reformed insurance markets and an individual mandate. Once we move away from the individual mandate, our estimates become considerably more uncertain.

Nevertheless, several lessons are clear from the exercises described in this paper. First, no alternative to the individual mandate can cover more than two-thirds as many uninsured as the Affordable Care Act does as passed by Congress and enacted into law. Second, no alternative to the mandate saves much money—even removing the mandate altogether, which cuts the number of uninsured covered by 50 percent to 75 percent but only reduces government spending by 25 percent to 30 percent. Strikingly, broad and aggressive auto-enrollment, which I estimate to cover two-thirds as many uninsured as the mandate, costs just as much because the coverage comes almost exclusively through auto-enrollment into public insurance. Finally, any alternative imposes much higher costs on those buying insurance in the new health insurance exchanges as the healthiest opt out and the less healthy face increased premiums.

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Endnotes

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- 2 Jonathan Gruber, "Massachusetts Points the Way to Successful Health Care Reform," *Journal of Policy Analysis and Management* 30(1)(2011): 184-192.
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- 4 See, for example, John Beshears and others, "The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States," in Stephen Kay and Tapen Sinha, eds, *Lessons From Pension Reform in the Americas* (New York: Oxford University Press, 2008).
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- 6 Author's Calculations from the Current Population Survey.
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- 10 Author's Calculations from the Current Population Survey
- 11 Results from the Gruber Microsimulation Model.
- 12 All results from the Gruber Microsimulation Model.
- 13 Gary Engelhardt and Jonathan Gruber, "Medicare Part D and the Financial Protection of the Elderly," Working Paper 16155 (National Bureau of Economic Research, 2010).
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