When the Tenth Justice Doesn’t Bark: The Unspoken Freedom of Health Holding in NFIB v. Sebelius

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When the Tenth Justice Doesn’t Bark:
The Unspoken Freedom of Health Holding in *NFIB v. Sebelius*

Abigail R. Moncrieff*
Abstract

There was an argument that Solicitor General Donald B. Verrilli could have made—but didn’t—in defending Obamacare’s individual mandate against constitutional attack. That argument would have highlighted the role of comprehensive health insurance in steering individuals’ health care savings and consumption decisions. Because consumer-directed health care, which reaches its apex when individuals self insure, suffers from several known market failures and because comprehensive health insurance policies play an unusually aggressive regulatory role in attempting to correct those failures, the individual mandate could be seen as an attempt to eliminate inefficiencies in the health care market that arise from individual decisions to self-insure. This argument would done a better job than the Solicitor General’s of aligning the individual mandate with existing Commerce Clause and Necessary and Proper Clause precedent, and it would have done a better job of addressing the conservative justices’ primary concerns with upholding the mandate.

This Article hypothesizes that the Solicitor General made a strategic political choice to avoid this vision of the individual mandate because it would have provoked the strong political constraint against health care rationing—the freedom of health. It then considers the implications of that hypothesis for ongoing academic puzzles regarding the role of popular constitutionalism in Supreme Court decision-making and the role of the Solicitor General as an agent of either the Court or the President. The Article concludes that this story highlights a previously unexplored path for popular constitutionalism to impact Supreme Court holdings and that it highlights a particular circumstance in which the Solicitor General was emphatically an agent of the President, not the Court.
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Introduction

As the Obamacare litigation progressed, two important puzzles at the intersection of political science and constitutional law became highly relevant to the case. One is whether and how popular constitutionalism affects Supreme Court decision-making. The other is whether the Solicitor General of the United

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States, sometimes deemed the “Tenth Justice,”\(^3\) is primarily an agent of the Court or the President.\(^4\) This Article presents a hypothesis about both based on a failure of Solicitor General Donald B. Verrilli to make one particular argument—an argument that would have been compelling\(^5\)—in defense of Obamacare’s\(^6\) individual mandate.\(^7\) Importantly, the Article cannot and does not make an empirical assertion about the reason for Verrilli’s choice. Instead, I present a mere theory, arguing that the decision not to raise the particular defense at issue may have been purely political. If that theory is right (and it is certainly plausible), then popular constitutionalism had a tremendous impact on the Supreme Court’s decision, and it did so through a mechanism that the political science and constitutional law literatures have not explored: the Solicitor General’s conscious choice, as an agent of the President, to forgo a legally compelling but politically dangerous defense of a federal statute.

There were, in fact, two arguments that Verrilli notably failed to make in *NFIB v. Sebelius*.\(^8\) One, which has received a fair bit of commentary in the press and the literature, is that Congress has constitutional authority to require individual purchases of any good or service commercially available in multiple states. Rather than arguing, as he did, that Congress may mandate health insurance purchases but not broccoli purchases because health insurance is different from broccoli,\(^9\) Verrilli could have argued that Congress may mandate purchases of anything under the sun, including broccoli,\(^10\) cars,\(^11\) burial insurance,\(^12\) and cell phones\(^13\) as well as health insurance.

The other forgone argument, which the press and the literature have largely ignored, cuts in the opposite direction, bolstering the sense that health insurance is unique and that Obamacare’s mandate is unlike any other mandate that Congress might dream up. That argument would have highlighted health insurers’ unusual manipulations of health care savings and consumption

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\(^4\) Sara cites

\(^5\) See Abigail R. Moncrieff, Obamacare’s (3) Day(s) in Court, 141 CHEST 1389 (2012).

\(^6\) See Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified primarily in various sections of 42 U.S.C.) [hereinafter “ACA”]. The moniker “Obamacare” is one that has been associated with the law’s opponents, but I like the name better than “PPACA” or “ACA” and will therefore use it despite my support for the statute.

\(^7\) See id. § 1501, codified at 26 U.S.C.A. § 5000A.

\(^8\) 132 S.Ct. 2566.


\(^10\) Cf. Transcript at 13, 17–18, 75–76.


\(^12\) Cf. id. at 7–9, 15–16, 72.

\(^13\) Cf. id. at 5–7, 15–16.
incentives. Unlike ordinary indemnity insurance, health insurance requires its beneficiaries to cover routine care, requires them to save while young for care they will consume when old, charges different out-of-pocket amounts depending on where the beneficiary consumes care and what kinds of care she consumes, and reviews the beneficiary’s consumption choices before deciding whether to indemnify the loss. Because of these unusual mechanisms that health insurers use to steer savings and consumption, health insurance has a regulatory relationship to its subject market that is far more intensive than that of ordinary indemnity insurance. It is this uniquely aggressive regulatory relationship that Verilli failed to mention, even while arguing more generally that health care and health insurance are unique.

This Article focuses on the latter forgone argument for three reasons. First, there were strong indications, at least during oral arguments if not before, that a majority of the Supreme Court would reject a broad constitutional authority to mandate purchases. The decision to focus on health insurance exceptionalism rather than a broad mandate power might therefore have been legally as well as politically strategic. By contrast, the argument that health insurance is more intensively regulatory than standard indemnity insurance fit perfectly with the Obama Administration’s overall legal strategy of health insurance exceptionalism, and there was no reason to believe that the argument would have alienated any of the justices. The decision not to raise that argument was not plausibly part of a legal strategy; if it was strategic at all, it could only have been political. Second, Verrilli’s failure to highlight the unusual regulatory features of health insurance had a bigger impact on the justices’ analyses and the Court’s holding than his failure to argue for a broad authority to mandate purchases. As Chief Justice Roberts’s tax analysis makes clear, the Court majority did not buy the popular constitutional push for Lochner-like protections of individual purchasing decisions; the majority held that Congress is free to manipulate consumption choices as long as it uses taxes rather than penalties. By contrast, all of the justices’ analyses ignore the regulatory effects of health insurance, and it seems likely that briefing on those effects would have tempered the conservatives’ rhetoric, even if it would not have changed their conclusions. Third, the popular constitutional limit that the insurance-as-regulation argument evokes is an important one, but despite both its general importance and its central importance to one of the most widely-debated cases in recent history, it has gotten short shrift

14 See Moncrieff, supra note 5; Part I.A, infra.
15 It is not unique for insurance to have a regulatory role in the insured market, see Omri Ben-Shahar & Kyle D. Logue, Outsourcing Regulation: How Insurance Reduces Moral Hazard (unpublished manuscript), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2038105, but health insurance companies do more than other kinds of insurance. In other words, the difference is one of degree, not kind. See Part I.A., infra.
16 See Part I, infra.
17 Oral argument transcript
19 See NFIB, 123 S.Ct. at xx (holding that Congress may steer individuals’ purchasing decisions through tax incentives as long as the financial inducements qualify as taxes rather than penalties).
20 See Part II.B, infra.
in the popular and scholarly commentary. While many commentators have addressed the *Lochner*-like sensibility underlying the Administration’s hesitation to argue that all purchase mandates are permissible,\(^{21}\) very few\(^{22}\) have addressed the popular constitutional constraint underlying the Administration’s hesitation to highlight the regulatory features of health insurance.

What is that constraint? It is the overwhelming political opposition to health care rationing,\(^{23}\) which closely tracks a substantive due process norm: the freedom of health.\(^{24}\) In order to argue that a health insurance mandate is constitutional because of its intensive regulatory relationship to health care, President Obama’s legal team would have needed to emphasize the many ways in which health insurance companies essentially ration care. The argument would have been that health insurance, unlike standard indemnity insurance for things like home and auto repairs, actively steers its beneficiaries toward particular doctors and hospitals and even toward particular goods and services. In an infamous (though, in hindsight, ironic) example from Supreme Court history, the health insurance company Aetna refused to cover Vioxx for one of its beneficiaries, Juan Davila, requiring that he first try a cheaper alternative drug, naprosyn.\(^{25}\) Unfortunately, naprosyn caused permanent damage to Davila’s intestinal track\(^{26}\) (though perhaps to the exclusion of a Vioxx-induced heart attack\(^ {27}\)). Nevertheless, the usually salutary goal of Aetna’s coverage decision was to incentivize a more-efficient consumption choice, steering Davila toward a cheaper drug that was usually safe and effective for his condition. In a more mundane personal example, my insurance company recently refused to cover Zofran for my pregnancy nausea until I had first tried the cheaper drug Reglan. Only after my doctor ensured that Reglan was ineffective for me did my insurer agree to cover Zofran. (And, even then, the company put limits on the number of pills it would cover at a time and required physician preapproval for refills.)

This unusually comprehensive role that health insurers play in regulating consumption has three (interrelated) legal payoffs for the arguments in favor of the mandate under the Commerce Clause and Necessary and Proper Clause: It


23 Sesi cites

24 Moncrieff, Freedom of Health, supra note 22.


renders the individual mandate far more regulatory than it seems, demonstrating that the mandate is not only about stimulating or creating commerce in insurance but also about regulating existing commerce in health care; it thereby aligns the mandate more closely with existing constitutional doctrine; and it distinguishes health insurance from all other kinds of indemnity insurance and financing products, bolstering the government’s plea for health insurance exceptionalism and easing the conservative justices’ fears of a slippery slope. But the argument that health insurance is unusually regulatory also has the tremendous political downside of openly identifying health insurers—and, by extension, the individual mandate—as instruments of rationing.

In short, this Article hypothesizes that the popular constitutional freedom of health was an important constraint on the holding in NFIB v. Sebelius but that the constraint arose solely through political limitations on the Solicitor General’s argument. If that hypothesis is right, it highlights a particular mechanism for popular constitutionalism’s influence on Supreme Court decisions as well as highlighting a particular sense in which the “Tenth Justice” is emphatically an agent of the President rather than the Court. Sometimes “the curious incident” could be the Solicitor General’s failure to bark.28

The Article proceeds as follows. Part I lays out in greater detail the empirics and economics behind the health-insurance-as-regulation argument, explaining how and why health insurance is more intensively regulatory than other kinds of private insurance. Part II explains how this forgone narrative could have strengthened Solicitor General Verilli’s legal arguments under the Commerce Clause and Necessary and Proper Clause and even goes so far as to suggest that the forgone argument would have tempered (or might even have reversed) some of the conservative justices’ objections. Part III identifies the opposition to health care rationing as a strong political constraint, aligns that constraint with the quasi-doctrinal freedom of health, situates the constraint as a species of popular constitutionalism, and explores the implications of this story for the debates over the influence of popular constitutionalism and the role of the Solicitor General.

I. The Forgone Argument: Empirics and Economics

Health insurance is not ordinary insurance. To a greater extent than most kinds of private indemnity insurance (like car, home, life, and burial insurance), health insurance provides a robust incentive structure to steer beneficiaries’ behavior in the insured market. This incentive structure emerges from three unusual features of health insurance: (1) It requires its beneficiaries to set aside money for all kinds of care (including routine maintenance and wear-and-tear). (2) It requires its beneficiaries to save while young for the inordinate costs of care when old. And (3) it manipulates the perceived costs of various kinds of care.

28 Sir Arthur Conan Doyle, Silver Blaze, in The Memoirs of Sherlock Holmes (1892) (‘‘Is there any other point to which you would wish to draw my attention?’ ‘To the curious incident of the dog in the night-time.’ ‘The dog did nothing in the night-time.’ ‘That was the curious incident.’’
through differential cost-sharing and administrative obligations (especially copays, referrals, and medical necessity review).

Why is health insurance more intensively regulatory than other kinds of private insurance? For two reasons. First, health care is different (in degree, not kind) from other insured products. Medicine is still more art than science, and consumer-directed care, which reaches its apex when individuals self insure, suffers from known market failures that are much less impactful for car and home repairs and for deaths and burials. Private health insurers manipulate incentives for the same reason that government regulators do: to try to correct these known market failures. Second, both before and after Obamacare, there has been less public regulation of individual savings and consumption choices in health care than in car and home care, and there is less comprehensive social insurance available for health care than there is for deaths and burials. Private health insurers have therefore had bigger gaps to fill than private car, home, life, and burial insurers.

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

A. Market Failures

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

29 See Ben-Shahar & Logue, supra note 15. As Ben-Shahar and Logue acknowledge, the notion that insurance regulates in ways that are similar to government is far from novel. Legal and economics scholars have discussed the regulatory role and the regulatory potential of private insurance for decades. See, e.g., Kenneth S. Abraham, Distributing Risk: Insurance, Legal Theory, and Public Policy 57 (1986). There have also been recent calls for private health insurance to play an even greater regulatory role for health care and medical safety. See Ronen Avraham, Private Regulation, 34 Harv. J.L. & Pub. Pol’y 543 (2011).
1. Optimism Bias

Optimism bias is a well-known cognitive failure that causes individuals to underestimate their personal risks of harm relative to the average risk of the general population. This failure is sometimes deemed the Lake Wobegon effect, after Garrison Keillor’s Prairie Home Companion town “where all the women are strong, all the men are good-looking, and all the children are above average.” It is of course statistically impossible for more than 50% of a population to be above average, but when polling a group with optimism bias, it is not uncommon for more than 90% of the group’s individuals to claim above-average skills or below-average risks.

Furthermore, information does not combat optimism bias. Take, for example, a poll of obese teenagers. At the outset, the poll taker could give the subjects the statistical truth that the average obese individual is five times more likely to develop diabetes than the average normal-weight individual. The poll could then ask each member of the group whether he thought his own risk of developing diabetes was higher than, lower than, or the same as the statistical average. If the group suffered from optimism bias, more than 50% of them would report a lower-than-average individual risk of developing diabetes. That is, the problem for optimism bias is not that individuals are ignorant of average or statistical risks; it is that they systematically overemphasize their positive risk factors and underemphasize their negative risk factors when comparing themselves to other similarly-situated individuals. One teenager who walks to school every day but eats only fried foods will overemphasize her exercise and underemphasize her diet while another who takes the bus but eats a lot of steamed vegetables will do the opposite.

2. Hyperbolic Discounting

The second market failure is hyperbolic discounting. It is rational for individuals to apply a “discount rate” to future rewards, such that one might be willing to invest, say, $100 today to earn a reward of $150 a year from now. This kind of discounting is rational because of the time value of money, which might cause $100 today to be worth more than $150 a year from today. For example, instead of investing $100 in the $150 reward, the individual could invest the $100

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in an interest-earning account that would grow by more than $50 in the intervening year, or she could buy goods and services today that would provide her with more than $150-worth of utility by the expiration of the year. Furthermore, there is a risk that the individual will increase her income in the intervening year so that her marginal utility of dollars decreases and the extra $50 is meaningless to her a year from today, and there is a risk that, in the intervening year, the individual will suffer some negative event, like death or disfigurement, that would decrease or even negate the utility of the extra $50. In short, discounting of future rewards is a pervasive and rational human behavior.

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

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

3. Credence Goods

The final relevant market failure is the credence goods problem. A credence good is one that consumers have a hard time evaluating both before and after consumption such that experience provides little if any help in determining one’s willingness to pay for future consumption—even future consumption from the same provider. This problem arises from three features of credence goods, which cause problems whether they exist alone or in combination. First, credence goods do not reveal their full value upon consumption. A gastric bypass surgery, for example, usually has the observable benefit of making the patient skinnier, but it does not, without significant waiting time and further intervention like blood tests, reveal information about its success in decreasing the patient’s diabetes risk. Second, some credence goods are simply of uncertain value. Most dietary

supplements, for example, have never been tested for long-term efficacy, so their true value to the consumer is simply unknown. Third, credence goods are subject to tremendous information asymmetry between consumer and provider. For example, when a doctor tells her patient that his knee pain is due to a sprained medial collateral ligament (MCL) and that physical therapy is a better option than surgery, the patient rarely has enough independent information to verify or rebut the doctor’s assessment (even if he has seen his diagnostic test results).

Whether together or alone, these problems make it extremely difficult for an individual to determine his willingness to pay for any consumption at all, and they make it even harder for the individual to determine the right differential in willingness to pay for various substitute goods. Imagine, for example, that one of the obese teenagers is trying to decide between a diet pill and a gastric bypass surgery to cure his morbid obesity. To decide between the two options, he would want to know their relative prices as well as their relative efficacies at improving his appearance and health. If, for example, the pills cost $10,000 over a lifetime of use while the surgery cost $25,000 for the one-time intervention, he would need to know whether the surgery is sufficiently more efficacious than the pills to justify the $15,000 in additional cost. But both the pills and the surgery will have unknown efficacies before consumption and, in their abilities to improve long-term health, will have unknown efficacy after consumption as well. The potential consumer, thus, will be incapable of making an informed choice between the pills and the surgery. Neither the goods themselves nor the reports from friends who have consumed the goods will reveal full information about the goods’ values relative to one another. In such a case, the patient is very likely to consult a doctor for advice and to rely on the doctor’s presumably better-informed assessment, but the doctor’s incentives are not perfectly aligned with the patient’s; the doctor might strongly recommend surgery simply because she will get paid for performing a surgery but not for prescribing a drug.

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

B. Health Insurance as Regulation

There are three features of health insurance that make it more aggressively regulatory than ordinary indemnity insurance. All three of those features are attempts to correct the market failures described above. First, health insurance requires individuals to insure against all kinds of loss, not just catastrophic loss. Second, health insurance requires individuals to save when young for care they
will consume when old. Third, health insurance companies manipulate the relative cost of consumption for various kinds of health care by setting different payment and administrative obligations for different goods and services. This section will flesh out each of those unique features in turn. In the process, it will also explain why these private market adaptations have been more necessary for health insurance than for car, home, life, and burial insurance, demonstrating that the market failures are more impactful for health care and that public regulatory corrections are less pervasive in health care.

There is one general caveat that is worth identifying at the outset but that I will repeat when relevant as well: All three of these unusual features of health insurance are characteristic of comprehensive insurance products of the kind that will satisfy the individual mandate,37 but they are not characteristic of all health insurance products that existed in the pre-Obamacare world. For example, high deductible health plans do not engage in the same level of incentive-setting for their beneficiaries. Nevertheless, these insurance features are all regulatory strategies that the private market adopted voluntarily, before Obamacare passed; they were not governmentally dictated in the first instance.

1. Comprehensive Coverage

The first unusual feature of private health insurance is that it covers all kinds of health care consumption, not just catastrophic loss. Car insurance won’t cover an oil change or a tire rotation, but health insurance will cover a routine physical. If your doorknob falls off, you can’t file a claim with your homeowners insurance to replace it, but if you scrape your knee, your health insurance will cover a visit to the doctor to have the scrape cleaned and bandaged. This feature of private health insurance was nearly universal in the private market before Obamacare; even high deductible plans would count the costs of routine care against their annual caps for out-of-pocket health care spending.38

Why? Why does health insurance, unlike other kinds of insurance, cover non-catastrophic losses? The problem is that the relevant kinds of consumption—consumption of routine maintenance and wear-and-tear—constitute present investments in future rewards, and they are therefore subject to hyperbolic discounting. The point of an annual checkup is to ensure that the patient is living a healthy lifestyle today and to catch and prevent future medical problems before they arise. If individuals are not required to spend money on this kind of future-regarding care, they will consume systematically too little of it. Comprehensive health insurance corrects this under-consumption by forcing individuals to spend money on preventive care. They bundle preventive care coverage with catastrophic coverage, gathering the cost of preventive care in premiums rather than out-of-pocket payments at the time of visit, in order to lower the perceived marginal cost of investing in the future reward of good health. In other words, the marginal cost of an annual checkup with insurance coverage is only the time and

37 See 42 U.S.C. § 5000A (requiring individuals to carry “minimum essential coverage”); provision defining minimum essential coverage and requiring comprehensive private insurance.
38 Cite
opportunity cost of going to the doctor; the financial cost is already paid.\footnote{Before Obamacare, many insurance policies charged a small copay, usually $15 or $20, for office visits like checkups. Under Obamacare, insurance may not charge a copay for any preventive care visits. Cite.} This decrease in the perceived cost of today’s investment in future health counteracts the systematic undervaluation of preventive care that results from hyperbolic discounting.

Of course, hyperbolic discounting similarly affects consumption of oil changes and tire rotations for a car and consumption of pest control and weather proofing in a home; those kinds of preventive care are also present investments in future value. So what’s different about health care? Two things. First, the relevant timescale is much longer for human health than it is for cars or homes. The average length of ownership for the human body is 78.5 years in the United States\footnote{See Centers for Disease Control and Prevention, FastStats: Life Expectancy, http://www.cdc.gov/nchs/fastats/lifexpec.htm.}, you’re stuck with your body for life. By contrast, the average length of ownership for both cars and homes is about 5 years,\footnote{See Jason P. Schachter & Jeffrey J. Kuenzi, Seasonality of Moves and the Duration and Tenure of Residence: 1996, U.S. Census Bureau (December 2002), online at http://www.census.gov/population/www/documentation/twps0069/twps0069.html; Kelley Blue Book, Average Length of U.S. Vehicle Ownership Hit an All-Time High (Feb. 23, 2012), online at http://www.kbb.com/car-news/all-the-latest/average-length-of-us-vehicle-ownership-hit-an-all-time-high/.} and the Internal Revenue Service estimates the total useful life\footnote{These figures are relevant only to cars and homes that are used for business purposes, and they include high-use vehicles like rental cars and taxis and high-occupancy rental properties like apartment buildings. The figures are therefore lower than they would be if they included owner-used cars and owner-occupied homes. See Internal Revenue Service, Publication 946, How to Depreciate Property (2011), online at http://www.irs.gov/pub/irs-pdf/p946.pdf.} of cars at 5 years\footnote{Id. at 104.} and the total useful life of residential properties at 27.5–40 years.\footnote{Id. at 40 (giving residential rental properties a 27.5-year useful life under one system of depreciation); id. at 41 (giving the same kind of property a 40-year useful life under a different system of depreciation).} One might think that these differentials would make individuals more precautionary, not less, in taking care of their bodies since they’re stuck with their bodies for longer (and cannot trade their current bodies for better ones when their current bodies degrade). But because of hyperbolic discounting, the longer timescale between present investment and future reward causes a bigger gap between optimal and actual present valuation. A young adult doesn’t expect to accrue the full benefit of exercise for fifty-some years, but a car owner will accrue the full benefit of regular oil changes within five years. The irrationalizing effect of hyperbolic discounting is therefore more impactful for exercise than it is for oil changes. Relative to the optimum, a twenty-year-old will undervalue exercise more than she undervalues oil changes.

Second, government has been far less interventionist for consumption of health care than it has been for consumption of car and home repairs. There is no legal requirement, at any point in the human life cycle, that one consume preventive health care (or any other kind of health care). There are, however,
requirements in every state that cars undergo and pass annual inspections,\(^{45}\) that houses undergo and pass inspections whenever offered for sale,\(^{46}\) and that all cars and homes meet a warranty of merchantability when traded.\(^{47}\) All of those laws effectively require car and home owners to consume preventive care—to keep their cars and homes sturdy enough to pass inspections and to be resold. Because of those laws, private insurance policies for cars and homes have not needed to create strong incentives for consumption of preventive care; government has already done so.

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

2. Community Rating

The second relevant feature of health insurance is that it requires individuals to save when young for health care that they will consume when old. Unlike other kinds of indemnity insurance, many health insurance policies do not set premiums according to individuals’ actuarial risk. Instead, they engage in community rating across age groups, despite the groups’ differential health risks. This feature of health insurance was less common among pre-Obamacare health insurance policies than the comprehensive coverage described in the prior subsection, but community rating was not Congress’s innovation in 2010. Many private health insurance policies, especially large-group plans provided through employers, engaged in age-based community rating long before Obamacare. (Indeed, the employer-provided plans that were most likely to have adopted this strategy pre-Obamacare are among the least regulated kinds of health insurance both before and after Obamacare.\(^{48}\))

The benefit of this feature of health insurance is that it combats both hyperbolic discounting and optimism bias. The point about hyperbolic discounting is identical to the discussion above about comprehensive coverage except that it relates to pure financial investments in future health rather than health care investments in future health. Just as they will consume too little preventive care for the future reward of good health, individuals will put aside too little money for the future reward of high-quality care. Community rating combats that problem by forcibly smoothing an individual’s monthly investments across his life, ensuring that the currently young pay too much for health insurance (relative to what they take out) so that they will be able to pay too little for health

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45 Cites
46 Cites
47 Cites
insurance when old. From a systemic perspective, insurance requires the currently young to invest today in their future health care needs.49

The problem that arises from optimism bias has different origins but similar effects. Optimism bias simply causes individuals to assume that they will not need much health care in the future—that their risk of incurring high medical bills in later life is lower than average. This problem does not depend on any distortions in the valuation of present or future health; it is simply a universal sense that the future will be healthy and cheap. Of course, that sense is emphatically misguided. All individuals—not just currently high-risk individuals—are very likely to need more and more-expensive health care when old. Americans spend only 1/3 of their lifetime health care costs in their first 50 years of life; the remaining 2/3 accrue in middle and older age, in the last 20-30 years of life.50 Put another way, the average 30-year-old spends seven times less per year on health care than the average 65-year-old,51 and he spends nearly twelve times less than the average person over age 85.52 Notably, the average 65-year-old does not earn anything close to seven times more than the average 30-year-old. Even taking pre-retirement figures (i.e. looking at 64-year-olds instead of 65-year-olds), the average American male earns only 1.50 times more than he did at age 30.53 (The average post-retirement male earns a mere 1.007 times more than he did at age 30, and even at the peak of an individual’s earning power, between ages 45-54, he earns only 1.53 times more than he did between ages 25-34.54) The rational 30-year-old therefore ought to save today for health care that he will need when old; starting around age 50, he will need far more and far more-expensive care than he will be able to afford.

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


51 These statistics may suffer a bit from the presence and operation of Medicare. It is possible that individuals could consume less medical care after age 65 than they currently do but that the generosity of Medicare creates a moral hazard that partially explains the statistical jump in spending at the Medicare age. Even looking at statistics from 40-year-olds, though, most of whom are not yet Medicare-eligible, it is clear that health care spending increases with age faster than income does. From age 20 to 40, health care spending increases 1.7 times and income increases only 1.3 times.

52 Alemayehu & Warner, supra note 50.


54 Id.
But all of the medical problems associated with old age are subject to optimism bias. Young people systematically underestimate their risks of one day needing cancer treatments, cardiovascular interventions, hip replacements—and everything else. When young, we all imagine that we will be the 80-year-old we see on the ski slopes, not the one we visit in the nursing home—even though we all know that there are far more 80-year-olds in nursing homes than on ski slopes. As a result, Americans who self insure save systematically too little for later-life health care consumption. Community rating across age groups is a way to combat that error—to ensure that younger people pay too much today so that they can pay too little tomorrow.

As with under-consumption of preventive care, the under-consumption of savings is more of a problem for health care than it is for car and home repairs or for deaths and burials, again for the two reasons outlined above: The cognitive failures themselves are more impactful for health care, and governmental intervention provides better corrections for the other markets’ failures.

First, both hyperbolic discounting and optimism bias are more impactful for health care than for car and home repairs (though they are about equally impactful between health care and deaths and burials). The hyperbolic discounting problem is a bigger issue for health for the reason given above: The relevant timescale is shorter for cars and homes than for human bodies. But optimism bias is also more impactful for health. Optimism bias impacts humans’ assessments of themselves and other humans. It might cause an individual to think that she is smarter, better-looking, and healthier than average, and it might cause her to think that her doctor, car mechanic, or home electrician is more skilled than average. But it does not make her think that her house’s plumbing is sturdier than average or that her car will hold up better than average in a crash. If making decisions about how much money to save for future home and car repairs, then, an individual will not underestimate the likelihood of home or car deteriorations the same way that she will underestimate her likelihood of sickness and death.

That said, optimism bias does cause individuals to overestimate their own driving skills—an assessment of the human driver rather than the vehicle—and the bias thus causes individuals to underestimate their risks of collision.\footnote{See David M. DeJoy, The Optimism Bias and Traffic Accident Risk Perception, 21 Accident Analysis & Prevention 333 (1989). To my knowledge, there has never been a similar finding of optimism bias in home repairs.} This failure might cause individuals to save too little for future car repairs in the same way that it causes individuals to save too little for future health care; they simply do not believe that they will need to consume much in the future. But that brings us to the second difference between health care and car repairs—the government’s greater intervention—which is also the relevant difference between health care and deaths and burials: Pre-Obamacare, government required more savings for cars, deaths, and burials than it did for health care.\footnote{There is no regulatory obligation to hold homeowners insurance, but most banks and lending institutions require mortgage holders to maintain such insurance until the loan is repaid.} All states require drivers to carry private car insurance so that they have money set aside to repair
collision damage. And for deaths and burials, the obligatory Social Security system of survivors’ benefits ensures that individuals save enough money to support their dependents—and to help their dependents pay for their burials—if they die younger than they were (optimistically) expecting. Admittedly, both before and after Obamacare, individuals are similarly required to contribute to Medicare and Medicaid throughout their working lives, and they are thus required to save money for nursing home care, hospitalization after age 65, and, to a lesser extent, routine care after age 65. But until Obamacare, government had not required individuals to carry insurance—or otherwise to save money when young—for the increased health care that they would need between ages 50 and 65. Private health insurance had to fill that gap, forcing young people to save for the 15-year period of high, pre-Medicare health care expenses by charging them too much today and allowing them to pay too little later.

3. Cost Manipulations

The final unusual feature of private health insurance is that it charges different out-of-pocket amounts and requires different administrative hurdles depending on where the beneficiary consumes care and what kinds of care he consumes. This differential cost-setting occurs through five related mechanisms, none of which is common among car, home, life, or burial insurance.

First, imagine a patient who scraps his knee over the weekend, when his usual doctor’s office is closed. If he goes to the emergency room rather than a 24-hour urgent care facility, most private health insurance companies will charge him significantly more than they would have for the urgent care center (unless he is admitted to the hospital, which he would not be for a scraped knee). In health insurance terms, the companies set different copays for different kinds of care.

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

Third, imagine that the patient instead scrapes his knee during regular business hours, but he goes straight to an orthopedist instead of visiting his primary care doctor, thinking that he might have done structural damage to the knee’s bone, tendons, or ligaments. Even if the orthopedist were a preferred or in-

57 Cite.
58 See generally Social Security Administration, Survivors Benefits: SSA Publication No. 05–10084, ICN 468540 (July 2012), online at http://www.ssa.gov/pubs/10084.html/.
59 Medicaid covers long-term care for many elderly patients. Cite.
60 Medicare Part A is obligatory for all Americans over age 65 and covers all hospitalization costs. Cite.
61 Medicare Parts B, C, and D are optional and require additional (but highly discounted) premiums. They provide coverage for outpatient (i.e. non-hospitalized) care and for prescription drugs. Cite.
network provider, the patient’s insurance might refuse to cover the visit altogether on the ground that the patient was required to see a primary care doctor before going to a specialist. In insurance terms, the company might require a referral for specialist visits.

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

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

Fifth, imagine that the patient tore his anterior cruciate ligament (ACL) rather than his MCL and that ACL tears almost always require surgery. Imagine further, though, that the patient was terrified of surgery and that his orthopedist had recently invented a nonsurgical, injection-based repair technique for torn ACLs, which last week received Food and Drug Administration (FDA) approval for marketing as a drug. Even if the doctor and patient both wanted to follow the nonsurgical route, the insurance company might refuse coverage on the ground that the technique was not sufficiently well-established as an effective alternative to surgery. In insurance terms, companies often deny coverage for new or experimental medical procedures.

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

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62 Approval requirement, statute or article
63 Cite (If possible, statutes that require repairs. I know MA has a legal requirement for repairs, but I don’t know whether it’s in a statute or a reg.)
repair strategies. They give the beneficiary a check, recommend a few repairmen, and allow the beneficiary, in consultation with his chosen repairman, to decide how he wants to go about fixing the damage with the insurance money he has. The car owner and the mechanic are free to use non-recommended, experimental repair techniques without risking a decrease in the insurance reimbursement.

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

With the other two cost-manipulation strategies—medical necessity review and evidence-based coverage decisions—health insurance companies directly combat the information asymmetry that is characteristic of credence goods. Take the example of medical necessity review outlined above: The orthopedist might have recommended surgery instead of physical therapy because she performs surgeries herself (and gets paid for doing so) but does not perform physical therapy. In short, her recommendation might be profit-motivated rather than medically motivated. But the patient wouldn’t know that. Most patients don’t know what the difference is between an ACL and an MCL, much less whether a ruptured MCL requires the same surgical intervention that a ruptured ACL requires. (It usually doesn’t.) Insurance companies, with their medical staffs and expert claims processors, know that MCLs usually repair themselves with physical therapy and that surgery would be an unnecessary expense for most

64 This is why credence goods are often characterized by price inflation. Consumers attempt to judge quality by price, and providers respond by raising their prices to signify quality.
66 She is also legally prohibited from taking a “kickback” for referring a patient to a particular physical therapist. See Anti-Kickback Statute, 42 U.S.C. § 1320a-7b.
patients with torn MCLs. By reviewing the individual patient’s claim and the doctor’s specific treatment recommendation, the insurance company can correct the element of the credence goods problem that arises from information asymmetry, preventing the doctor from abusing her superior information to extract greater profits.

Similarly, by denying coverage for new and experimental treatments, insurance companies combat the problem of actual uncertainty in the value of many medical interventions, which would otherwise allow doctors even greater leeway to abuse their superior information. Compare the examples above of the torn MCL and the torn ACL: There is a degree of actual uncertainty in both cases, but there is significantly more uncertainty for the nonsurgical repair of the ACL. In the MCL case, medical science knows from long experience that most ruptured MCLs respond to physical therapy, but it also knows that some do not; some patients with ruptured MCLs do not recover from exercise alone and ultimately need surgery after long efforts at physical therapy. Each patient therefore experiences some uncertainty as to his prognosis from physical therapy, but the insurance company advocates well for the patient in requiring that he try the much cheaper and usually effective course of physical therapy before deciding that his particular case needs the more painful, more expensive option of surgery. In the hypothetical ACL case, by contrast, medical science would know far less about the patient’s prognosis from the new, nonsurgical intervention simply because the science has had less opportunity to test the effectiveness of the new intervention. The uncertainty in that case would be not only particular to the individual patient but also general to the recommended treatment. That is, even if the nonsurgical injection technique had passed FDA clinical trials (which are far from perfect), the injection might be snake oil—or, like Vioxx, it might be hazardous. Until more information is available in the world, gathered from greater experience across more patients, a patient might rationally distrust a new medical procedure’s safety and effectiveness. But most patients would not know how new or untested a given procedure is, particularly if the procedure is approved for marketing. Informed consent rules require a doctor to notify her patients of established risks, but they do not require the doctor to notify her patients of general uncertainties. This higher-order information asymmetry about the state of medical science allows doctors greater leeway to push risky but profitable care on their patients. Insurance companies combat that possibility by refusing coverage altogether until a medical innovation has established itself through longer and wider experience.

All told, insurance companies go to great lengths to combat the credence goods problem in health care. But why are private car and homeowners insurance so much less aggressive in this regard? The relevant goods in those markets are also credence goods; the long-term value of regular oil changes is difficult to assess both before and after consumption, and mechanics, plumbers, electricians,

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67 See supra note 27.
68 Cite for informed consent.
69 On the difference between risk and uncertainty, see generally Frank H. Knight, Risk, Uncertainty, and Profit (1971) (distinguishing between risk and uncertainty).
carpenters, and architects all benefit from information asymmetries with their customers. What, then, explains health insurance’s greater regulatory aggression? In this case, the difference is not that government has been less interventionist for health care than for cars and homes. If anything, it has been more so. There are many state and federal laws that attempt to ensure the high quality of health care provided in the market (such as medical licensure and medical malpractice rules) and that attempt to prohibit unproven medical goods and services from being offered to unwitting patients (such as FDA approval requirements and informed consent laws). The difference, then, between the car and home markets and the health care market is only that the credence good problem’s impact is greater on health care than it is on car and home repairs.

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

Medicine is much finickier than that. Even in the MCL case, where there is a right answer for a majority of patients (that physical therapy will suffice), there are some patients who continue to complain of knee instability after months of physical therapy. So if my doctor tells me that I look like a patient who will ultimately need surgery and that I might as well get the surgery now rather than trying physical therapy first, I cannot simply consult others—or Google “MCL rupture”—to beat the information asymmetry. Other medical experts, including those posting on Googleable sources, will likely hedge on the necessity and value of surgery, telling me (honestly) that some patients do indeed fail to respond

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70 Cite
71 Cite
72 See supra note 62.
73 See supra note 68.
74 See
https://www.google.com/search?q=axle+deterioration+boot+replacement&rlz=1C1CHFX_enUS371US372&sourceid=chrome&ie=UTF-8#hl=en&safe=off&rlz=1C1CHFX_enUS371US372&client=psy-ab&q=axle+boot+replacement&oq=axle+boot+replacement&gs_l=serp.3..0i7j0i30l2.8503.9132.0.9310.2.2.0.0.0.0.98.190.2.2.0.les%3B..0.0...1c. Di5EIFlwVA&pbx=1&bav=on.2,or_r_gc.r_pw.r_cp.r_qf.&fp=9f3de7f9ee57ed80&biw=1600&bih=785.
to physical therapy. Whether or not I am likely to be one of those patients might
be an unanswerable question (unlike the question of whether my axle boot really
needs replacing), or it might be a question that only someone observing me
closely over a long timescale, like my own doctor, can answer. If so, then no
amount of external research will help.

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

C. Self-Insured, Uninsured, or Underinsured

In the debates over the individual mandate, the Obama Administration and
its allies tended to refer to those without comprehensive insurance as the “self-
insured” while the plaintiffs and their allies tended to refer to the same population
as the “uninsured.” The reason was purely rhetorical. Pro-mandate advocates
wanted to emphasize that those without comprehensive insurance were
nevertheless active in the health care and health insurance markets—that they
were making an active choice to “self insure”—while anti-mandate advocates
wanted to emphasize the inactivity of simply forgoing insurance—of being
merely “uninsured.” Throughout this article, I use the term “self-insured” rather
than “uninsured,” but the reason is not at all rhetorical. There are real definitional
differences in the terms “self-insured” and “uninsured,” and the arguments
throughout this article center on the self-insured, not the uninsured or
underinsured.

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

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

There is also a flip side to this point, which is that the problem with self-insurance arises from the absence of an insurance company’s manipulations, not from the mere fact of out-of-pocket spending. Individuals with comprehensive insurance policies remain free to spend extra-insurance money on health care that the policy refuses to cover. The MCL patient could get immediate surgery, notwithstanding his insurance company’s refusal to cover the procedure, if he was willing to pay for it on his own, without coverage. Juan Davila could have gotten Vioxx instead of trying naprosyn if he had paid for it without Aetna’s help.76 The usefulness of comprehensive insurance does not depend on forcing individuals to consume health care efficiently; it is the manipulation of costs and incentives that make individuals more likely to consume health care efficiently. Insurance companies send valuable signals to their beneficiaries about the costs and benefits of various consumption choices, and those signals suffice to make comprehensive insurance a better, more efficient option than self insurance. In the end, then, some colloquially “uninsured” health care transactions—some transactions paid for without indemnification—are tolerable in the market as long as they are not made in the absence of a comprehensive insurance company’s manipulations.

In short, the term “uninsured” does not accurately describe the problems associated with self-insurance. As will become clear in the remainder of this article, the relevant problem is not just that the self-insured consume care they cannot afford; it is also that they do a bad job of consuming care they can afford.

II. The Forgone Argument: Law

What does this vision of health insurance have to do with the constitutional challenge to the individual mandate? In short, this understanding could have changed the entire narrative under the Commerce Clause and Necessary and Proper Clause. Rather than arguing, as he did, that the mandate is a means of correcting adverse selection and cost-shifting in health insurance,77 Solicitor General Verrilli could have argued that the mandate is a means of eliminating inefficiencies that arise from self-insured health care transactions.78 That is, he could have argued that individuals who consume health care without insurance make systematically less-efficient choices than those who consume care with insurance, and he could have pointed out that one of Congress’s purposes in

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76 See Davila, 542 U.S. 200. See also text accompany note 25.
77 SG Brief and Ginsburg opinion.
78 See PPC Brief.
passing the mandate\textsuperscript{79} was to shift all individuals into the uniquely regulatory and more-efficient payment structure of insurance.

This narrative would have had three concrete advantages over the one that the Obama Administration presented. First, it would have demonstrated that the individual mandate is a regulation of the preexisting health care market, not just a stimulation of the health insurance market that became necessary because of Obamacare’s provisions related to preexisting conditions and community rating.\textsuperscript{80} Under this story, the point of the mandate is not to reimburse the health insurance companies for money that they will lose under Obamacare’s market reforms\textsuperscript{81}; it is to improve individuals’ health care consumption choices. Second, this story aligns the individual mandate with the prohibition of intrastate manufacturing of medicinal marijuana that the Court upheld in \textit{Gonzales v. Raich}\textsuperscript{82} rather than casting the mandate as a novel exercise of regulatory power to stimulate commerce. It establishes that one of Congress’s goals with the mandate was to eliminate a disfavored set of commercial transactions—in this case, self-insured health care transactions\textsuperscript{83}—and it casts the individual mandate as a rational means of accomplishing that uncontroversially legitimate goal. Third, because health insurance is more aggressively regulatory even than other kinds of indemnity insurance, this narrative could have eased many of the justices’ concerns about a slippery slope and a federal police power. If the mandate is a form of health care regulation, it is not a crass attempt to stimulate commerce by forcing people to buy things, and because health insurance is different from other kinds of indemnity insurance, Obamacare’s mandate would not set a clear precedent even for a burial insurance mandate,\textsuperscript{84} much less for a broccoli mandate.\textsuperscript{85}

This Part first elaborates the forgone narrative in doctrinal terms, explaining how the insurance-as-regulation argument would fit into existing Commerce Clause and Necessary and Proper Clause case law. Second, the Part elaborates the three advantages of this argument over the one that Verrilli presented, focusing particularly on this narrative’s ability to rebut the conservative justices’ concerns about the mandate.

A. The Doctrinal Narrative

It is well-established in constitutional law—and has been for decades\textsuperscript{86}—that the Commerce Clause allows Congress to regulate individual intrastate economic activities that have substantial effects on interstate commerce.\textsuperscript{87} There

\textsuperscript{79} Congress made this point explicitly in its findings. See 42 U.S.C.A. § 18091(a)(2)(E) (noting that “[t]he economy loses up to $207[ billion] a year because of the poorer health and shorter lifespan of the uninsured” and that near-universal coverage “will significantly reduce this economic cost”).

\textsuperscript{80} Cf. Roberts and dissenting opinion

\textsuperscript{81} NFIB Brief; dissenting opinion

\textsuperscript{82} 545 U.S. 1 (2005).

\textsuperscript{83} PPC Brief

\textsuperscript{84} Oral arguments, Roberts and dissent.

\textsuperscript{85} Broccoli cites

\textsuperscript{86} See Wickard

\textsuperscript{87} Wickard, Lopez, Morrison, Raich
is disagreement among the current justices as to whether the Commerce Clause authorizes that kind of intrastate regulation on its own or whether it does so only in conjunction with the Necessary and Proper Clause, but there is no doubt that Congress has the power, under many circumstances, to regulate intrastate economic conduct.

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

There is no doubt that the United States health care market includes significant commercial activity in self-insured health care. About forty million Americans lack health insurance coverage at any given moment, but those individuals do not abstain from consuming care. Importantly, the problem is not just that many Americans without health insurance consume interventionist medicine that they cannot afford—a point that Verrilli made at length. The problem has two additional dimensions, too. First, many self-insured Americans consume interventionist medicine that they can afford, but as discussed at length in the prior section, they do it badly. Second, on a nearly daily basis, everyone consumes “self-help” kinds of health care, and the self-insured do that badly, too. For someone with morbid obesity, for example, the decision to order a fish filet rather than a beef steak is an active health care choice, and for an otherwise-healthy person with a scraped knee, the decision to apply drug store hydrogen peroxide and a Band-Aid is likewise. Notably, I am not referring here to health care inactivity, such as the mere decision to forgo an annual checkup, nor am I referring to arguably noneconomic or noncommercial activities akin to home-growing marijuana for personal use, such as exercising during leisure time. I am referring to commercial transactions and economic activities related to quotidian health care: buying a bathroom scale rather than visiting a doctor’s scale to monitor weight loss, purchasing low fat foods or dietary cookbooks without consulting a nutritionist, buying a heart rate monitor rather than getting a checkup to determine cardiovascular fitness for a new exercise routine, treating low-grade

88 Compare Raich majority (Commerce Clause alone) with Raich Scalia concurrence (Commerce Clause in conjunction with Necessary and Proper Clause).
89 Eleventh Circuit opinion, briefs
90 Together with five excellent coauthors, including four students, I presented this argument in full in an NFIB amicus brief. See PPC Brief.
91 Cite.
92 Cf. Ginsburg opinion, SG brief
93 See Raich (O’Connor dissenting).
complaints with drug store visits rather than doctor visits. All such decisions might, if made badly, give rise to a need for more-serious (and more-expensive) medical intervention in the future, and all of them constitute active, commercial health care consumption today. In the end, the only way to avoid interacting with interventionist medicine is not only to be extremely lucky in avoiding sickness and accidents (as Verrilli pointed out), but also to be quite successful at self-help health care consumption throughout one’s youth, including both preventive care and low-grade curative care. (Even living in a bubble will eventually drive you to a psychiatrist.)

The problem is that both self-help health care and interactions with doctors are predictably less efficient among the self-insured. As discussed above, health insurance plays an unusual and important role in manipulating incentives for even quotidian health care consumption, and those without insurance lack the companies’ salutary manipulations. The inefficiency of self-insurance, then, is not only that many individuals who need medical intervention that they can’t afford will shift costs to others; it is also that the self-insured make overly optimistic, hyperbolically discounted, and informationally asymmetric choices about their daily health care needs. Even among the self-insured who can afford to pay for their medical visits and do not shift costs to others, decisions about what to consume and how much to consume will be predictably skewed. Those with comprehensive insurance do systematically better.

One purpose of the individual mandate was to eliminate these inefficiencies of self-insured health care transactions by channeling all Americans to the more-efficient substitute of comprehensively insured health care transactions. The mandate’s goal is to take a patient who might have treated his own scraped knee at home and to make him systematically more likely to seek a doctor’s help, just in case he actually did structural damage to the knee. Simultaneously, the goal is also to take a patient who might have gone straight to an orthopedist for a hurt knee and to make him systematically more likely to see a primary care doctor first to avoid the lower-value setting of specialty care for mere scrapes. Obamacare wants to prohibit self-insurance because self-insured health care is systematically less efficient than fully-insured health care.

This story is an easy fit for existing Commerce Clause doctrine. It is well-established that Congress’s power to regulate existing commerce includes a power to prohibit disfavored commerce. In *Raich*, for example, the difficult question was whether the power to eliminate the interstate market for recreational marijuana included a power to punish the purely intrastate growth and use of medicinal marijuana. No justice questioned whether Congress had power in the first place to punish—and thereby to try to eliminate—recreational marijuana

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94 Pun intended.
97 545 U.S. 1.
transactions. The dissenters merely questioned whether personal growth and use of medicinal marijuana had a big enough impact on the market for recreational marijuana to justify Congress’s intervention.

In this case, though, there is no doubt that the targeted intrastate behavior has a profound and immediate impact on the targeted interstate market. Individual decisions to self-insure (or, to use the NFIB dissenters’ terms, individual decisions to remain inactive in the health insurance market) are wholly responsible for the existence of self-insured health care transactions. If every individual in the United States obtained comprehensive health insurance of the kind that will satisfy the mandate, self-insured transactions, definitionally, would disappear. The mere possession of a comprehensive insurance policy addresses the inefficiencies that arise from self insurance. All of that is to say: Applying the Commerce Clause test announced in Lopez and Morrison in conjunction with the economic analysis in Part I, there is simply no doubt that individual decisions to self insure substantially affect interstate commerce in health care—and the individual mandate will likewise.

Under the Necessary and Proper Clause test, the question has an additional step, but the answer is equally clear. The Necessary and Proper Clause demands, first, that Congress pursue ends that are “legitimate” for the federal government to pursue under its enumerated powers and, second, that Congress choose rational, “reasonably adapted” means of attaining those ends. The two-part question for the individual mandate is, first, whether Congress’s goal of prohibiting self-insured health care transactions is a legitimate end and, second, whether the mandate’s financial incentive for individuals to obtain and maintain comprehensive insurance coverage is a rational means of accomplishing that end. Again, there is no doubt that Congress is allowed to pursue the goal of eliminating disfavored transactions in interstate commercial markets, so Congress’s goal with the individual mandate is undoubtedly legitimate. The only remaining question is whether the mandate itself is a rational and reasonably adapted means of accomplishing that goal. Given that mere possession of comprehensive health

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98 See Raich, 545 U.S. at 53 (O’Connor, J., dissenting) (noting, without questioning the broader constitutionality of the Controlled Substances Act (CSA), that “[t]here is simply no evidence that homegrown medicinal marijuana users constitute, in the aggregate, a sizable enough class to have a discernable [sic], let alone substantial, impact on the national illicit drug market—or otherwise to threaten the CSA regime”); id. at 59 (Thomas, J., dissenting) (“On this traditional understanding of ‘commerce,’ the Controlled Substances Act (CSA), . . . regulates a great deal of marijuana trafficking that is interstate and commercial in character.”).

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

100 See Raich, 545 U.S. at 37 (Scalia, J., concurring) (noting that the “relevant question [under the Necessary and Proper Clause] is simply whether the means chosen are ‘reasonably adapted’ to the attainment of a legitimate end under the commerce power”) (citing Darby, 312 U.S. at 121); Sabri v. United States, 541 U.S. 600, 605 (2004); McCulloch v. Maryland, 4 Wheat. 316, 421 (1819) (“Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.”).
insurance fixes many of the market failures impacting self-insured care, the incentive that the mandate sets for individuals to obtain and carry such insurance is an eminently rational and extraordinarily closely-adapted means of eliminating the relevant inefficiencies.

That said, comprehensive health insurance coverage of the kind that will satisfy the individual mandate also adds inefficiencies to health care markets. Most famously, insurance creates a moral hazard, which might cause individuals to engage in riskier behaviors, knowing that they can get the health care they need. For example, obese individuals might become less likely to combat their obesity if they know that they will have coverage for their later diabetes. Insurance also obscures pricing for health care, which might cause individuals to demand care that is not cost-justified without realizing how expensive the care is. Of course, insurance companies are aware of these problems, and some of the manipulations identified in Part I exist to combat them\textsuperscript{101}; medical necessity review, for example, does some work in correcting the problem of price obfuscation. But even if comprehensive insurance might create more inefficiencies than it corrects, that doesn’t actually matter to the constitutional analysis. It is not necessary to prove that the inefficiencies from self insurance are worse than the inefficiencies from comprehensive insurance. It is necessary only to show that self-insurance inefficiencies might be worse—that a rational basis exists for believing they are.\textsuperscript{102} Given the economic theory discussed in Part I, the existing data showing that the self-insured experience poorer health, shorter lifespan, and greater costs than the comprehensively insured,\textsuperscript{103} and the lack of long-term data on costs or savings associated with consumer-directed health plans,\textsuperscript{104} it was not irrational for Congress to believe that patients with comprehensive insurance will perform better than those without.

B. The Narrative’s Three Advantages

This narrative of the individual mandate’s constitutionality has three concrete advantages over the story that the Solicitor General told, all of which center on the narrative’s ability to rebut arguments against the mandate. First, this narrative responds to the conservative justices’ concern that Congress

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\textsuperscript{101} See Ben-Shahar & Logue, supra note 15.
\textsuperscript{102} See Raich, 545 U.S. at 22 (defining the standard of review as “rational basis”).
\textsuperscript{103} See 42 U.S.C.A. § 18091(a)(2)(E).
\textsuperscript{104} The trend of consumer-directed health plans, such as Health Savings Accounts and high deductible health plans, began in 2003. There was early evidence that those with consumer-directed plans spent less on health care than those with comprehensive insurance, but some or even most of those savings might have come from under-consumption of preventive care, which could result in increased spending later in life. See generally Amelia M. Haviland et al., Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save $57 Billion Annually, 31 Health Aff. 1009 (2012) (finding that patients with consumer-directed health plans spend less money but that a nontrivial amount of the savings arises from patients’ avoidance of recommended care like preventive care); Buntin et al., Consumer-Directed Health Care: Early Evidence About Cost and Quality, 25 Health Aff. w516 (2006) (finding that costs decreased among those with consumer-directed plans but that the data on quality of care and quality of consumption decisions were mixed).
bootstrapped a constitutional power to mandate purchases from its exercise of a constitutional power to regulate insurance. By focusing on the mandate’s responsiveness to preexisting problems in health care (rather than its responsiveness to arguably Obamacare-manufactured problems in health insurance), the vision of the mandate that I present here avoids this bootstrapping problem. Second, this narrative is somewhat responsive to the conservative justices’ concern that the mandate represents a novel exercise of regulatory power. By focusing on the mandate’s attempt to prohibit disfavored commercial transactions, this narrative aligns the provision not only with Raich but also with a long history of federal penal statutes that attempt to ban various practices and commodities as well as a long history of other kinds of purchase mandates. Third, this narrative does a better job than the Solicitor General’s of responding to the slippery slope. By focusing on the uniquely aggressive regulatory role of private health insurance companies, this narrative firmly distinguishes a health insurance mandate from a broccoli mandate. This section will elaborate each of those points in turn.

1. Bootstrapping

There was a sense among Obamacare’s opponents that Congress had bootstrapped a power to mandate purchases out of a power to regulate insurance—and that concern (if bootstrapping is concerning at all\textsuperscript{105}) made a lot of sense given Verrilli’s defense of the provision. The Solicitor General’s core argument was that Obamacare’s market reforms necessitated an insurance mandate in order to curb problems of adverse selection and cost shifting that were sure to arise in the post-Obamacare world. The argument was that Obamacare’s prohibition on preexisting condition exclusions and its requirement for community rating would cause rational consumers to wait until they were sick to buy insurance, and that phenomenon would cause insurance markets to fail. On this account, the individual mandate is a core part of a comprehensive regulatory scheme (a good doctrinal argument under the Necessary and Proper Clause), required to ensure that the statute’s market reforms will succeed as intended. But, of course, that argument casts the individual mandate as a fix to a problem of Congress’s own contemporaneous creation. If bootstrapping is problematic at all, then the mandate is certainly problematically bootstrapped on this account.

The vision of the mandate that I present here—an attempt to eliminate self-insured health care transactions—does not share this problem. Under this article’s narrative, the individual mandate is responsive to a series of pervasive inefficiencies in health care markets—inefficiencies that existed long before Obamacare was ever conceived. Indeed, as a fix to health care consumption errors, the mandate is responsive to market failures that would exist regardless of any prior governmental action. Hyperbolic discounting, optimism bias, and the credence goods problem would affect consumption choices in health care—and private insurance companies would be capable of regulating around those inefficiencies.

\textsuperscript{105} For an argument that it is not, see Stuart Minor Benjamin, Bootstrapping, 75 L. & Contemp. Problems 115 (2012).
failures—even if no government existed. On this account, then, the mandate avoids not only contemporaneous bootstrapping but any bootstrapping at all. In short, the constitutionality of the mandate on this account does not depend on the existence or effects of prior regulatory interventions. If it is constitutional as a regulation of commerce, it is constitutional as a rational attempt to fix pervasive inefficiencies in the interstate market for health care.

2. Novelty

The second advantage of this narrative is that it helps to undermine Obamacare opponents’ accusations of novelty. As with bootstrapping, it is not entirely clear that novelty should be a vice, but assuming it is, the Solicitor General’s argument failed to address the concern. If the individual mandate were merely an attempt to stimulate commerce in health insurance in order to avoid the problems of adverse selection and cost shifting, then the provision would undoubtedly represent a new exercise of federal regulatory power. All prior purchase mandates, including those for health insurance, have existed for other, narrower reasons. For example, the requirement that ship owners buy health insurance for their seamen and that seamen buy hospitalization benefits for themselves were discrete solutions to the discrete problem of higher-than-usual rates of contagious disease among sailors returning home. The founding-era requirement that all able-bodied men own and carry guns was a discrete solution to the discrete problem of our early nation’s reliance on militiamen, who needed to be armed. These prior purchase mandates were not broad-based attempts to stimulate markets by creating artificial demand—as the Obamacare mandate seemed to be under the Solicitor General’s defense. And the conservative justices’ concern seemed to be that Congress was exercising a newly expansive power to mandate purchases for the sole purpose of stimulating demand. If Verrilli had emphasized the mandate’s role in correcting health care market failures, he could have aligned Obamacare’s mandate much more closely with the prior mandates as well as aligning the mandate with countless other federal penal statutes that seek to prohibit disfavored commerce. Under the narrative that I present here, the individual mandate is a discrete correction to a discrete problem, much like the founding-era mandates, and it is a discrete correction to a problem that Congress undoubtedly has the power to solve, again like the founding-era mandates. Just as Congress has clear constitutional authority


107 Elhauge, If Health Insurance Mandates Are Unconstitutional, supra note 106; Elhauge, A Response to Critics, supra note 106.

108 Elhauge, If Health Insurance Mandates Are Unconstitutional, supra note 106; Elhauge, A Response to Critics, supra note 106.

109 Oral argument transcript, Roberts and dissent.
to enact maritime law and to regulate militias, so too does it have clear constitutional authority to prohibit disfavored commercial transactions in interstate markets. And just as Congress has been allowed to regulate seamen’s health and militias’ strength through purchase mandates, so too should it be allowed to prohibit self-insurance through a purchase mandate. In short, this narrative does not create a new federal power to mandate purchases for the sake of mandating purchases; it rests on the longstanding federal powers to prohibit commerce and to use purchase mandates to solve narrow problems of legitimate federal concern.

3. Slippery Slope

The final advantage of this narrative is that it eases opponents’ fears of a slippery slope.110 The concern that the conservative justices voiced most strongly in the oral arguments and in their opinions was that Obamacare’s individual mandate would set a precedent for other purchase mandates, and they focused particularly on hypothetical mandates for cars, broccoli, cell phones, and burial insurance. Again, under the Solicitor General’s narrative, this concern made sense. If the mandate is merely an attempt to correct adverse selection and cost shifting, then its justification rests solely on failures in the stimulated market—and the need to increase demand within that market. Under that justification, Congress could force people to buy American-made cars when foreign imports started to threaten the stability of American manufacturers, and it could force people to buy broccoli if green beans or donuts started to threaten the stability of broccoli farmers. Furthermore, Congress could pass purchase mandates for cell phones and burial insurance purely on the theory that those goods are under-demanded relative to optimum. Even if Congress could point to concrete costs that individuals without cars, broccoli, cell phones, or burial insurance were imposing on the economy, the justification for the relevant mandates would rest entirely on the failure of some individuals to consume a useful commodity. Although Verrilli attempted to articulate a limiting principle to rebut these points, his attempts centered only on the gravity of the problems and the magnitude of the costs associated with suboptimal demand in health insurance;111 he was unable to provide a theoretical (as opposed to empirical) distinction between the Obamacare mandate and the other hypothesized purchase mandates.

The narrative that I present here provides a theoretical distinction. Under this vision of the mandate, the provision’s goal is not to stimulate demand for the sake of stimulating demand nor is it to stimulate demand for the sake of preserving a market for the mandated commodity. Instead, the goal is to eliminate a disfavored commercial behavior by shifting consumers to a more-efficient substitute. That is, the mandate’s goal is to stop Americans from buying health care without insurance, and the requirement that all Americans carry insurance

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111 Oral argument, SG brief
accomplishes that goal in one step. On this justification, a broccoli mandate would be constitutional only if broccoli were a perfect substitute for some other food that Congress disfavored—only if mandating broccoli purchases would naturally shift all compliant consumers away from a disfavored commodity. But, of course, mandating broccoli purchases would not, on its own, stop Americans from eating donuts. It might cause a marginal decrease in demand for donuts, but the effect would be tiny (especially since broccoli and donuts are not direct substitutes, much less perfect substitutes, in most Americans’ diets). Similarly, a cell phone mandate would not, in one step, cause all compliant citizens to be more efficient in handling roadside accidents. They would need to use their cell phones correctly to solve the perceived problem. These points matter tremendously to the Commerce Clause test announced in *Morrison*, which requires the “substantial effect” on interstate commerce to occur through a short causal chain.113

That said, a mandate to purchase American-made cars might naturally shift compliant citizens away from the substitute good of a foreign import. But the justification that Obamacare opponents have imagined in hypothesizing a purchase mandate for cars has not been the elimination of commerce in foreign-made vehicles. It has been the stimulation of demand for American-made cars to save Chrysler and General Motors from bankruptcy. It has been imagined as an alternative to the 2009 bailouts of the failing auto industry.114 That point might seem like a distinction without a difference, but there are actually two big differences between elimination and stimulation that should matter to Commerce Clause analysis.

First, Congress does not have undisputed authority to use regulatory power to stimulate markets. It has undisputed authority to use the taxing power for that purpose (and has had such authority since long before *NFIB*, as the auto bailouts and farm subsidies and countless other subsidization regimes demonstrate and as the plaintiff-respondents gladly conceded throughout the debates115). But Congress has not had undisputed authority to use regulatory power for market stimulation. By contrast, as noted above, Congress has long had authority to eliminate commerce through regulatory power. The distinction between stimulation and elimination therefore matters tremendously to the raw doctrinal question (at least so long as precedent is valuable and novelty is suspicious).

Second, requiring Congress to demonstrate a rational basis for eliminating commerce places a much stronger political constraint on the mandate power than allowing it to demonstrate a rational basis for merely stimulating commerce. Imagine that Congress actually did try to mandate GM purchases, but instead of arguing that the mandate served the goal of saving Detroit, it argued that the mandate served the goal of eliminating the market for Toyotas. Toyota owners—and the Toyota corporation—would be outraged, much more so than they would be if Congress was merely trying to save GM. And that outrage would be well-

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112 Cf. oral argument Alito questions
113 See generally *Morrison*.
114 Cite for bailouts—statutory cite to budget item would be ideal.
115 Oral arguments and pop press cites. Heritage Foundation conceded Medicare for all would be constitutionally legitimate, e.g.
deserved. If Congress’s stated goal is to eliminate disfavored transactions in Toyotas and if the Court agrees that Congress has a rational basis for pursuing that goal, the next step after compelling GM purchases will be to fine or even imprison people for purchasing Toyotas. Americans who can afford to buy two cars might be okay with a requirement that one of those cars be a GM as long as the other can be a Toyota, but if they will be penalized just for buying a Toyota, they will be more concretely constrained. The elimination justification thus requires much more by way of political consensus; it requires consensus *against* the disfavored commerce rather than consensus in favor of the stimulated commerce. And many people who like Chevys don’t hate Toyotas.

The only hypothetical mandates that present the same theoretical justification as the Obamacare mandate are those for other kinds of insurance, but those mandates are empirically different. For the burial insurance mandate that Justice Alito mentioned at oral argument, for example, the identified problem was that individuals without such insurance must nevertheless be cremated or buried, and if they cannot afford cremation or burial out of Social Security survivors insurance or out of their own assets, then they must be cremated at taxpayer expense, shifting costs onto others. And, as mentioned above, those without burial insurance might save systematically too little for their burials. Aside from the failure to save, though, there are no market behaviors or active commercial transactions that are systematically less efficient among living individuals without burial insurance. In short, the problem that a burial insurance mandate would seek to address is much smaller and much less important than the problem that a health insurance mandate seeks to address.

Of course, that difference might not provide a doctrinal backstop for insurance mandates. If Congress were allowed to exercise its regulatory power to mandate health insurance, it probably could exercise the same power to mandate any similar kind of insurance, unless the Court were willing to draw a doctrinal distinction between payment structures that were aggressively regulatory and those that were merely regulatory. That is, the failure to save enough money for burials, though a minor problem, is one that Congress might rationally choose to address once it has the power to dictate more-efficient payment structures in failing markets. And if the Court wanted to invalidate a burial insurance mandate after upholding the Obamacare mandate, it would need to distinguish the two based on the depth of the market failures in deaths and burials and the aggressiveness of the corrections that private insurance provides. But this point does not undercut the idea that the slippery slope is less scary than the conservative justices made it out to be. Indeed, the point proves the Solicitor General’s assertion that his rule would allow purchase mandates only for payment structures—and narrows it even further to allow mandates only for payment structures that have regulatory characteristics. The Obamacare mandate certainly does not set a precedent for a credit card mandate or a cash mandate.

There was one other category of slippery slope concerns mentioned at oral argument, and it is the category that will become most relevant to Part III of this

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116 Cite.
117 Oral argument.
article. That was Justice Scalia’s concern that Congress could use the Obamacare precedent to pass a broccoli mandate or a gym membership mandate under a stated goal of improving health. These hypothetical mandates suffer from the same problem mentioned above—that the mandates’ impacts are far too tenuous to survive the Morrison test. Of course, a broccoli mandate might be an attempt to eliminate the disfavored commercial activity of buying unhealthy foods, and the gym membership mandate might be an attempt to eliminate the disfavored commercial activity of watching TV. But forcing people to buy broccoli doesn’t stop them from buying donuts, and forcing people to buy gym memberships doesn’t stop them from watching TV. Both mandates might have marginal impacts on the disfavored behaviors, but they will not definitionally eliminate the identified problems. The health insurance mandate, by contrast, definitionally eliminates the inefficiencies that arise from optimism bias, hyperbolic discounting, and the credence goods problem. Health insurance companies set the relevant incentives for their beneficiaries just by the very existence of the insurance contract.

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Because the narrative of insurance as regulation suffices to sustain the mandate under long-established Commerce Clause precedent and because the narrative avoids or at least tempers the conservative justices’ concerns about bootstrapping, novelty, and slippery slopes, the Solicitor General might have had much greater legal success by focusing on this argument than he had by focusing exclusively on the necessity of the mandate to combat adverse selection and cost shifting. Particularly Chief Justice Roberts and Justice Kennedy might have become more inclined to accept a regulatory mandate, and even Justice Scalia might have been moved by the analogy to Raich. And all of the conservative justices would have needed to figure out something that was wrong with the mandate other than its asserted problems of bootstrapping, novelty, and slippery slope setting.

III. The Tenth Justice and the Freedom of Health

If this vision of the mandate would have been so compelling, why did the Solicitor General fail to present it? Although I cannot say for sure, there is no doubt that the narrative of health insurance as a means of manipulating health care consumption would have been politically dangerous—perhaps extremely so. I therefore hypothesize that the Obama Administration made a strategic political decision to avoid this line of defense because it would have raised the popular constitutional constraint against health care rationing: the freedom of health. Given the intense backlash that arose from the phantom “death panels” during the Obamacare debate, the Administration might have been wise not to defend the

118 Oral argument.
119 See generally Morrison.
120 See Moncrieff, supra note 22; Jim Rutenberg & Jackie Calmes, Getting to the Source of the “Death Panel Rumor,” N.Y. Times, Aug. 14th, 2009, at A1 (detailing the political creation of
mandate as a private regulatory structure that essentially rations care—that actively manipulates the consumption choices of the insured.

If that hypothesis is right—and it is certainly plausible—then the story of \textit{NFIB v. Sebelius} highlights a particular mechanism for popular constitutionalism’s impact on the Supreme Court that the literature has not explored, as well as highlighting a context in which the Solicitor General is emphatically an agent of the President rather than the Court. The story here is a Solicitor General’s conscious decision, as an executive branch agent, to forgo a legally compelling but politically dangerous defense of a federal statute, based solely on popular opposition (rather than elite opposition) to the legal narrative. And the result in this case is an unspoken popular constitutional holding in the \textit{NFIB} opinions. Because of Verrilli’s decision not to raise the defense outlined in Part II, no justice was willing to uphold the mandate as an attempt to ration health care, even though health care rationing would clearly constitute a regulation of existing commercial activity in an interstate market and even though private insurance companies’ rationing behaviors do not violate any existing constitutional doctrine.\textsuperscript{121} That is, if my hypothesis is right, there was an unarticulated decision that health care rationing would be an unacceptable basis on which to uphold the individual mandate—an unspoken freedom of health constraint on permissible regulation—that arose solely from popular rather than doctrinal constitutionalism.

This Part first demonstrates the plausibility of the hypothesized story given the politics of rationing. It then situates the political story—and the freedom of health itself—as species of popular constitutionalism. Finally, this Part explores the implications of the hypothesis for existing theories in the political science and constitutional law literatures on the relevance of popular constitutionalism for the Court and the role of the Solicitor General as an agent of the President.

A. The R Word

If any politician wants to get ousted from Washington, one of his most sure-fire options, maybe second to sexual indiscretion, would be to openly recommend medical rationing. Just ask Donald Berwick.\textsuperscript{122} And if a politician

\textsuperscript{121} Although direct public rationing might violate a substantive due process norm preserving health care autonomy, see Moncrieff, supra note 22, private insurers’ coverage decisions do not raise constitutional concerns because they fail the state action doctrine. See American Mfrs. Mut. Ins. Co. v. Sullivan, 526 U.S. 40 (1999).

\textsuperscript{122} See The Berwick Evasion: Obama Dodges a Senate Debate on His Ideal Medicare Chief, Wall Street Journal (July 8, 2010) (noting that political opposition to Donald Berwick’s appointment as
wants to muster opposition to a health care proposal, her single best option would be to accuse the proposal of rationing. In short, the “R Word” is a death knell for political hopefuls of all varieties. Americans are fiercely opposed to any government regulation that would block their access to medical care, particularly if it would block access to care that their doctors recommend. Indeed, Americans are opposed to doctors or regulators even considering cost—especially social or distributional cost—when making medical decisions for individual patients. And this opposition is not unique to crackpot hyperbolists who see death panels in provisions for advanced directives. Polls on rationing show that about 80 percent of American voters oppose any role for cost-benefit considerations in determining their access to medical treatments.

Of course, it is one of the great ironies of modern politics that Americans hate the idea of rationing despite being fond of their current insurance. As Part I makes clear, private insurers engage in tremendous efforts at rationing—and have done so since long before Obamacare. Especially through the cost manipulations identified in Part I.B.3, modern private insurers actively attempt to steer patients away from high-cost, low-value health care, even if that care is

Administrator of the Centers for Medicare and Medicaid Services arose largely from his notorious statement that we must ration care and that “the decision is whether we will ration care with our eyes open”).

Sesi cites showing how many Americans believed Obamacare would ration, including the 40% stat on death panels.

Palin, supra note 120; see also Statement of Michelle Bachman, Cong. Rec. H8851 (July 27, 2009) (“The health bills coming out of Congress would put the decisions about your care in the hands of Presidential appointees. Government will decide, not the people, not their doctors, what our plan will cover, how much leeway our doctor will have, and what senior citizens will finally get under Medicare.”); Project for Excellence in Journalism, Six Things to Know About Health Care Coverage: A Study of the Media and the Health Care Debate (June 21, 2010), online at http://www.journalism.org/analysis_report/six_things_know_about_health_care_coverage.


See ABC News/Washington Post Poll, Oct. 2003 (finding that 79% of respondents oppose any government regulation by which “an increasing number of medical treatments that currently are covered by insurance will no longer be covered because they are too costly, not essential or have too little chance of success”).

See Bachman, supra note 124 (criticizing a suggestion from an Obama Administration advisor that doctors should “look beyond the needs of their patient and consider social justice, such as whether the money would be better spent on someone else”).

See PRWeb, National Poll Finds Seniors, Women and Americans from Across the Political Spectrum Reject FDA’s Consideration of Cost in Drug Approval Process (Sept. 15, 2010), online at http://www.prweb.com/releases/60Plus/FDArationingPoll/prweb4523024.htm (finding that 82% of respondents agree with the statement, “As a matter of principle, the government should not ration care or deny treatment options based on what it calls ‘cost-effectiveness.’ I don’t trust government to put a cost on human life.” and that 85% of respondents would be “angry” “if the government does in fact ration Medicare and Medicaid”).


See generally M. Gregg Bloche, The Hippocratic Myth: Why Doctors Are Under Pressure to Ration Care, Practice Politics, and Compromise Their Promise to Heal (2011) (reviewing the many ways that the private health care system in the United States rations care).
doctor recommended.\textsuperscript{131} Private insurers engage in the exact behaviors that voters claim to oppose, taking cost and benefit directly into consideration when deciding whether and by how much to indemnify a recommended course of treatment.

To make this point more concrete, consider again my personal experience with medication for pregnancy nausea.\textsuperscript{132} My insurer refused coverage for the more expensive pill, Zofran, until I had failed to get results from the cheaper alternative, Reglan. The insurance company thereby required me to prove a concrete need for the more-expensive drug. To analogize the case to stereotypical war-time rationing, I had to demonstrate a particularized need for additional rations of medical cost—akin to demonstrating a particularized need for additional rations of bread—before I could get permission from my insurance company to consume the additional cost of Zofran. Of course, despite frustration with the extra days of morning sickness that I suffered under this regime, I submitted to my insurers’ manipulations quite willingly and felt no temptation to change my insurance in response.

The political story, then, seems not to be that Americans truly hate rationing.\textsuperscript{133} It is either that they hate \textit{government} rationing or, more simply, that they hate to be \textit{aware} of rationing.\textsuperscript{134} In other words, the story is either that they will accept private rationing but not public rationing or that they will accept rationing as long as they don’t have to think about it. Either way, though, the Commerce Clause narrative outlined in Part II would provoke the relevant political ire.

Most obviously, the narrative of comprehensive insurance as a regulatory tool sheds light on the ways that insurers currently ration care. The forgone Commerce Clause argument would have made any listening audience uncomfortably aware of the fact that their health care is currently rationed—that they are, today, being actively encouraged to consume care that health insurers deem beneficial and actively discouraged from consuming care that insurers deem unjustified. Even if the relevant political constraint is just a distaste for awareness of rationing, then, the argument outlined here would have been politically risky.


\textsuperscript{132} See text accompanying notes 27-28.

\textsuperscript{133} That said, even private rationing can evoke intense backlash when it becomes particularly restrictive. The growth in managed care organizations (MCOs), especially health maintenance organizations (HMOs), in the early 1990s resulted in a tremendous backlash against restrictive coverage decisions. And one of the primary concerns in the managed care backlash was that MCOs would refuse to cover care that a patient truly needed. See Robert J. Blendon et al., Understanding the Managed Care Backlash, 17 Health Aff. 80 (1998). It was primarily this concern that drove the Patients’ Bill of Rights legislation in 2001, which would have exposed employer-sponsored HMOs to tort liability when their coverage denials caused injury to patients. See cite PBOR bill from 2001 Congress.

\textsuperscript{134} This distinction might explain the difference between ordinary reactions to insurance and the extraordinary reaction in the managed care backlash mentioned in note 133, supra. The managed care backlash arose in part because a few highly publicized problems arose, which raised an uncomfortable consciousness of rationing that was already occurring in the system.
Furthermore, from the perspective of an anti-rationing voter, the narrative presented here would sound like governmentally compelled rationing, not just privately agreed-to rationing. The legal story is not just that health insurers are good at steering health care consumption; it is that the insurers’ success at rationing care is a reason to let Congress force insurance contracts on all Americans. The story is that Congress should be allowed to ration care through the indirect mechanism of compelling all Americans into private rationing contracts. Even assuming that Americans are comfortable with rationing through a private contract that they voluntarily entered and that they can leave at any time, they probably would not be comfortable with rationing through a compulsory private contract that they cannot leave without suffering a regulatory penalty.

After the Obama Administration’s experiences with Palin’s death panels and Berwick’s appointment fiasco—and with high profile criticism of White House health policy advisor Ezekiel Emanuel as “Health Rationer-in-Chief”—it seems quite plausible that the Administration would have been wary of raising a legal argument that would sound pro-rationing. In an election year and in a case that an extraordinary number of ordinary voters were following closely, it would have been quite politically dangerous to defend the mandate as a means of improving efficiency in individuals’ health care consumption choices.

It also seems implausible that Solicitor General Verrilli would have neglected the insurance-as-regulator argument for any other reason. There was no indication from the Supreme Court that the current justices would be hostile to this line of defense. Indeed, the Court’s interpretations of the Employee Retirement Income Security Act of 1974 (ERISA)—both its remedial and preemption provisions—allow significant leeway to employer-sponsored health plans to ration care. In that line of cases, the Supreme Court justices have seemed perfectly comfortable with a regulatory regime that promotes, or at least allows, cost-motivated coverage decisions, even when those decisions harm patients. As an additional datum, in Raich, former Justice Sandra Day O’Connor was the only one who expressed discomfort with the idea of blocking individuals’ access to a medically useful drug. All of the justices who are still on the Court today ignored the medical implications of the marijuana ban.


136 See generally Davila, 542 U.S. at 222 (Ginsburg, J., concurring) (noting that the combination of the Court’s remedial and preemption holdings under ERISA allows employer-sponsored health plans to make bad coverage decisions with impunity).

137 The Court has also held directly that statutorily authorized utilization review by private workers’ compensation insurance companies does not constitute state action for purposes of 42 U.S.C. § 1983, indicating that rationing decisions made even under mandatory insurance regimes might not raise actual constitutional constraints. See American Mfrs. Mut. Ins. Co. v. Sullivan, 526 U.S. 40 (1999).

138 See Raich, 545 U.S. at 53 (O’Connor, J., dissenting).
The decision not to raise a rationing-based defense of the mandate, then, was not a legally strategic decision. If it was strategic at all, it must have been political.

Furthermore, it seems highly unlikely—if not downright impossible—that the Solicitor General’s decision was ignorant rather than strategic. The features of comprehensive health insurance that I highlight in Part I form the core of the Democratic Party’s opposition to consumer-directed health plans like Health Savings Accounts, and the argument that the individual mandate will improve the health care decisions and the health outcomes of the currently self-insured was one of the justifications that Congress explicitly enumerated for passing the mandate. I simply can’t imagine that President Obama’s legal and policy advisors were ignorant of the arguments outlined here. It seems much more likely that they made a conscious choice to avoid the narrative.

In the end, although I cannot verify that the decision to forgo the insurance-as-regulation narrative was a politically strategic decision, that explanation for the Solicitor General’s defense seems most likely. The forgone narrative would have been compelling under the Commerce Clause and Necessary and Proper Clause; it would have been responsive to some of the conservative justices’ most prominent concerns about the mandate; it would not have provoked any particular legal resistance from the current justices; and it is a line of defense that was almost certainly apparent to the Obama Administration’s health policy and legal experts. But it is a narrative that would have provoked intense political opposition. It would have entailed the Solicitor General of the United States, in the middle of an election year, raising a defense of a controversial statute that would resonate for many voters as an assurance that, in the absence of government death panels, Congress had decided to make them enter into private, contractual death panels instead.

B. Popular Constitutionalism

Despite extensive commentary on popular constitutionalism throughout the Obamacare debate, very few scholars have identified the anti-rationing constraint as a species of the same phenomenon. Admittedly, the commentary’s failure in that regard is understandable given that, unlike the Lochner-like constraint that most commentators have discussed, the rationing constraint has never received robust doctrinal recognition as a constitutional principle. The freedom of health has never carried the stature that the freedom of contract once did. Nevertheless, popular opposition to medical rationing aligns with a loose substantive due process norm that sometimes protects autonomy in medical

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139 Of course, the freedom of health challenge to the mandate was not before the Supreme Court. The Ninth Circuit rejected that challenge on remand, and the Supreme Court denied certiorari. Cites.
140 Cite to Democratic Party issue statement, floor statement from Democrat, etc.
142 See supra note 21.
143 See generally Moncrieff, supra note 22.
decision-making, and the anti-rationing sentiment is a powerful enough political constraint to rise to the level of constitutionalism despite its lack of true doctrinal stature. Furthermore, the rationing constraint seems, in this case, to have impacted Supreme Court decision-making despite a lack of sympathy for the popular sentiment among the justices themselves, making the constraint (in my view) an especially strong form of popular constitutionalism.

To make this point more concrete—to situate the relevant political constraint more fully as a species of popular constitutionalism—this section first gives a brief sketch of what popular constitutionalism entails and then discusses in turn the relevance of the substantive due process norm, the relevance of the strength and depth of the political constraint, and the relevance of the justices’ lack of sympathy for that constraint.

1. A Brief Sketch

The phenomenon of popular constitutionalism and its impact on Supreme Court doctrine is a disputed one, both in terms of whether it occurs and in terms of whether it matters. Those who believe that it is real and relevant tend to focus primarily on the ebbing and flowing of popular support for particular constitutional principles, aligning that ebb and flow with changes in Supreme Court precedent to demonstrate that popular opinion impacts the Court despite the justices’ insulation from transient political pressures. So, for example, the Court’s abandonment of Plessy v. Ferguson and adoption of Brown v. Board is an easy case of popular constitutionalism if the relevant phenomenon is the ability of powerful social movements to change constitutional meaning.

Those who are skeptical of this story focus on ordinary voters’ ignorance of constitutional doctrine as well as their ignorance of most cases that the Supreme Court decides. Skeptics also point out that changing social norms—given a long enough timescale—will impact not only popular opinion but also elite opinion, including the opinions of the justices themselves. On this view, the justices do not respond to the public; they are merely members of the public, who share the updated populist sensibilities of important constitutional issues.

Nevertheless, the puzzle for theories of popular constitutionalism is whether changing majoritarian preferences can impact judicial decision-making at all and, if so, how and why. Given that the justices have life tenure and

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144 Id.
145 Sara cites Friedman; other Sara cites.
146 163 U.S. 537 (1896).
148 Sara cites
151 See, e.g., id.
undiminished salary, it is not obvious that they should care at all about the preferences of the electorate.

This brief sketch raises three questions for the identification of the rationing constraint as a species of popular constitutionalism. First, should it matter that most Americans who oppose rationing are unaware that their preference has any doctrinal or constitutional import? Second, should it matter that opposition to rationing, rather than swaying the Court to adopt some particular holding like Brown, has served primarily to keep the question out of the Court’s hands? Third, should it matter that the justices and other political elites do not generally share the public’s fears of rationing? The following subsections address those questions in turn.

2. The Freedom of Health

Although most Americans who oppose rationing do not realize it, they are expressing a sentiment that has gotten some traction in Supreme Court doctrine. As I described at length in an article entitled The Freedom of Health, the Court has long recognized a soft substantive due process norm that protects individual autonomy in health care decision making. Indeed, in Washington v. Harper and Cruzan v. Missouri Dept. of Health, the Court explicitly acknowledged that individuals have a constitutional liberty interest in rejecting unwanted medical treatment, and in the reproductive rights cases, the Court has implicitly protected an individual liberty interest in obtaining certain kinds of medical care.

Of course, the political opposition to health care rationing is significantly broader than these soft protections, but the popular constraint tracks the underlying rationale of health care autonomy. Under the Court’s holdings, it might be unconstitutional for government regulators to forbid patients from buying health care with their own money—if, for example, a patient with a ruptured MCL wanted and could afford immediate surgery that his insurance refused to cover. But the current freedom of health would not stop public insurance programs like Medicare and Medicaid from denying insurance coverage for particular procedures or even to particular patients based on assessments of medical necessity, and the doctrine does not currently stop private insurers from doing the same. Furthermore, there is virtually no chance that even the most robust freedom of health would prevent insurers (whether public or private) from substituting their own judgment for the patient’s.

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153 Moncrieff, supra note 22.
157 Of course, coverage discrimination based on race or gender would raise Equal Protection constraints. Cite to EPC. If the freedom of health became more robust, one could imagine a regime in which discrimination based on health status or medical desert would be subject to strict scrutiny under Equal Protection. But the current doctrine doesn’t come close to that level of seriousness.
158 Private insurers cannot violate substantive due process, under the state action doctrine, unless they are so entangled with public regulation as to become quasi-public entities. See American Mfrs. Mut. Ins. Co., 526 U.S. 40.
from setting differential out-of-pocket and administrative burdens for different kinds of health care, as described in Part I.B.3.

In its most aggressive possible form, the freedom of health would require government to leave individuals free to reject care they did not want to consume and free to obtain care, with their own money, that they did want to consume. But the anti-rationing movement objects to much more. American who fear rationing do not just fear direct impositions on the freedom to reject or obtain care; they also fear indirect manipulations of their autonomy as patients, including things like coverage denials under Medicare that would leave them free to obtain the uncovered care at additional expense. Nevertheless, the general idea that patients and doctors should be free to set their own courses of medical treatment is the idea that underlies both the freedom of health and the opposition to medical rationing. The political constraint is simply stronger and broader than the doctrinal constraint.

That said, even with all of the hyperbolic political rhetoric that surrounds health care rationing and despite the anti-rationing argument’s alignment with a substantive due process norm, the vocal opponents of health care rationing do not usually invoke constitutional principle as a justification for their position. This point distinguishes the freedom of health arguments against the individual mandate from the *Lochner*-like arguments that many Obamacare opponents raised. Tea Party activists and sitting Republican congressmen invoked the notion that government should not be allowed to force people to buy things as a constitutional argument, not a mere political one, but they raised their objections to rationing in purely political terms.

The reason is probably that the Obamacare opponents were less aware of the freedom of health than they were of the freedom of contract. They surely did not think that the freedom of contract would be more likely to sway the modern Court, and conservatives’ general resistance to implied fundamental rights would apply equally to the freedoms of health and contract. In this case, then, it seems highly likely that the popular constitutional movement occurred without any awareness of its own constitutional relevance. It was, from the perspective of its leaders, merely a strong political argument, appealing to the fears of the average American voter. Its alignment with a weak substantive due process norm was irrelevant.

Admittedly, then, the freedom of health story in *NFIB* is not a genuine species of popular constitutionalism if it matters to popular constitutionalism that the leaders of a movement identify their argument as one of constitutional principle. I would argue, though, that this story demonstrates the irrelevance of self-consciousness to popular constitutional movements. If my hypothesis is right—if the Obama Administration forwent the rationing defense because of the

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159 Sesi cite
160 See Palin, Bachman, other Sesi cites
161 Barnett, supra note 21; other cites (litigation cites from the lower courts will suffice if we can’t find anything else from Tea Party speeches or writings)
162 See generally Jamal Greene, The Anticanon, 125 Harv. L. Rev. 379 (2011) (identifying *Lochner* as an anticanonical case that gets cited only for what it did wrong).
163 Cite
populist freedom of health constraint—then a widespread and strongly-felt popular opinion about the proper role of government and about Americans’ rights in medical decision-making had a direct and tangible impact on one of the Supreme Court’s most important constitutional decisions in recent history. The end result in this case was that the Supreme Court could not uphold the individual mandate as a permissible means of rationing health care. And it was Americans’ views of their own rights in relation to government—an emphatically constitutionalist notion—that stopped the most regulatory vision of the mandate from arising before the Court. That the mouthpieces of this political constraint did not envision their argument as one of constitutional principle does not make the effects of their actions any less constitutionally relevant.

3. The Court’s Role

In most examples of popular constitutionalism that the literature has identified, the Court has openly adopted a constitutional doctrine that garnered majoritarian popular support. In the change from Plessy to Brown, the Court explicitly abandoned “separate but equal”\(^{164}\); in Roe v. Wade,\(^{165}\) the Court fully embraced an abortion right; and at some point in the future, the Court will likely adopt a gay marriage right.\(^{166}\) By contrast, the Court has never actually held that direct regulatory rationing is unconstitutional, and it seems unlikely that the justices will ever have an opportunity to do so. The popular opposition to medical rationing is so strong and so resonant that the political branches simply cannot do anything that would offend the doctrinal freedom of health. Even non-rationing proposals that raise the specter of cost consideration in access to treatment—like the incentive for doctors to discuss end-of-life care with Medicare patients, which Governor Palin misidentified as a “death panel”\(^{167}\)—meet swift political defeats.

In some sense, then, the anti-rationing sentiment is a species of Ackerman’s “constitutional politics”\(^{168}\) more so than a species of popular constitutionalism. Moreover, the opposition to rationing is not a discrete “constitutional moment”\(^{169}\) that has given rise either to quasi-constitutional legislation like Medicare\(^{170}\) or to constitutional reinterpretation like Roe. It is a strong undercurrent of political feeling that transcends ordinary politics, controlling the forms that American health care regulation can take.

But, despite its relative lack of judicial imprimatur, this particular political constraint has all of the effects of an ordinary substantive constitutional right. Most importantly, it prevents the political branches from intruding too far on individuals’ health care autonomy. The popular freedom of health is quite

\(^{164}\) Compare Plessy, with Brown. Sara cites deeming this case popular constitutionalism.
\(^{165}\) 410 U.S. 113 (1973).
\(^{166}\) Sara cites predicting a gay marriage right based on popular constitutionalism.
\(^{167}\) Cites to the provision, its removal from the statute, and Palin’s commentary identifying the provision as a death panel (or just a news story telling the whole sordid tale).
\(^{168}\) See generally Bruce Ackerman, We the People: Foundations (1991).
\(^{169}\) See generally id.
\(^{170}\) See id. at xx (identifying the Medicare Act as a constitutional statute that arose from a constitutional moment during the Great Society).
effective—perhaps more so than doctrinal protections like the freedom of speech and the abortion right—at disarming governmental attempts to infringe the relevant liberty. Notwithstanding the absence of judicial review, no death panel will ever come into being in the United States. Given that the primary purpose and effect of substantive rights is to prevent regulatory infringements of protected liberties,\(^\text{171}\) there can be little doubt that the freedom of health is a successful constitutional right despite its relative lack of judicial protection.

Furthermore, the story that I present here (if it is empirically right) demonstrates that the freedom of health, despite being primarily political, can and does sneak into judicial opinions. Of course, the freedom of health did not successfully invalidate the individual mandate, but it did control the justifications that the government was willing to present in defending the provision. Much as the doctrinal freedom of speech prevents government from justifying regulatory regimes based on content discrimination,\(^\text{172}\) the political freedom of health prevented the government from justifying the individual mandate based on consumption efficiency.

The popular constitutional freedom of health is not a grand social movement that can be blamed or credited for a doctrinal evolution in American constitutional law. It is, however, a populist sentiment that has the fortitude of a constitutional principle, the effects of a substantive constitutional right, and the strength of a constitutional argument that can shape judicial opinions—albeit silently and politically rather than openly and doctrinally.

4. Elite Views

The final question is whether it should matter that neither the current justices nor the key players in the Obama Administration share the fear of medical rationing that underlies the popular constitutional freedom of health. On this question, I think the absence of rationing fears among the political elite bolsters rather than undermines the identification of the relevant constraint as a species of popular constitutionalism.

One of the means that the literature has identified for popular constitutionalism to impact judicial decisions is through the persuasion of political elites.\(^\text{173}\) If the Tea Party succeeds in electing a more libertarian president, for example, that president might appoint libertarian justices, who will then adopt libertarian constitutional doctrines. But as some skeptics of popular constitutionalism have pointed out, the possibility that democratic preferences will influence judicial appointments does not really undermine the description of the Court as a countermajoritarian institution.\(^\text{174}\) No one has ever doubted that the appointments process is a political one, but the possibilities for majoritarianism in


\(^{172}\) See generally Erwin Chemerinsky, Content Neutrality as a Central Problem of Freedom of Speech: Problems in the Supreme Court’s Application, 74 So. Cal. L. Rev. 49 (2000).

\(^{173}\) Sara cites (Young is good here)

the relatively rare occurrence of an appointment do not make the Court a majoritarian institution—or provide much if any incentive for sitting justices to respond to changing political preferences.\textsuperscript{175} As the skeptics point out, popular constitutionalism rarely if ever persuades a justice to adopt a constitutional rule that she does not believe is right, just because a majority of Americans currently want the Court to adopt the rule.

But that is exactly what happened in this case. Despite the lack of any strong feeling among the justices or the Obama Administration that medical rationing is an illegitimate regulatory pursuit, the strong anti-rationing sentiment among ordinary voters prevented the Court from upholding the individual mandate as a rationing tool.

The Supreme Court has considered a number of challenges to private insurance companies’ consumption manipulations, including tort and contract challenges\textsuperscript{176} as well as substantive due process challenges.\textsuperscript{177} Although those cases did not present clear opportunities for the Court to adopt a robust freedom of health,\textsuperscript{178} they did present opportunities for the justices to express any discomfort they might have felt with insurance companies’ manipulations of patients’ consumption incentives. Most of the justices seemed to experience no such discomfort.\textsuperscript{179} Furthermore, in a high profile case before the D.C. Circuit in 2007, a group of terminally ill plaintiffs argued that FDA restrictions on their access to potentially lifesaving drugs violated the freedom of health, and when the D.C. Circuit denied the challenge, the Supreme Court refused certiorari.\textsuperscript{180}

Moreover, President Obama and his health policy advisors seem no more concerned about these manipulations than the Supreme Court justices. Indeed, President Obama was so anxious to appoint Berwick as the head of CMS, despite many voters’ concerns that Berwick was pro-rationing, that the President exercised a recess appointment to avoid the political battle (temporarily).\textsuperscript{181} Of course, some political elites across the aisle, especially Governor Palin and Representative Michelle Bachman, have been extremely vocal in opposing health care rationing. But these Tea Party elite have not yet succeeded in influencing judicial appointments. The structural opportunities for political elites to import popular constitutionalism into the doctrine have not (yet) operated in the Tea Party’s favor. And the political elites with access to those structural inroads seem significantly less concerned than the populous about the manipulative, rationing impact of comprehensive health insurance.

\textsuperscript{175} Sara cites.
\textsuperscript{176} See Davila, 542 U.S. 200.
\textsuperscript{178} The ERISA cases suffer from the broad preemption provision in the federal statute, see Davila, 542 U.S. 200, and the substantive due process argument suffers from the barrier of the state action doctrine, see American Mfrs. Mut. Ins. Co., 526 U.S. 40.
\textsuperscript{179} Only Justice Ginsburg articulated a serious concern that ERISA preemption left insurance companies free to refuse coverage based on cost considerations. See Davila, 542 U.S. at 222 (Ginsburg, J., concurring).
\textsuperscript{181} See The Berwick Evasion, supra note 122.
The story of the popular freedom of health’s impact in *NFIB* is therefore significantly different from the story of the popular civil rights movement’s impact in *Brown*, which occurred largely through changes in the composition of the Court. And it is significantly different from the popular gay marriage movement’s impact in the legal challenges to the Defense of Marriage Act, a statute that the Obama Administration has refused to defend because the elites agree with the populist movement.\(^{182}\)

But these differences make the popular constitutionalism of the story *more* profound and interesting, not less. If the story that I present here is right, then it really is a story of majoritarian preference—not transient preference, but undoubtedly populist preference—impacting one of the Court’s most hotly debated constitutional decisions in a long time. Popular opposition to rationing forced the Solicitor General, presumably against his better judgment, to avoid an available defense of the individual mandate. As a direct result, the Supreme Court was not presented with a theory, in any of the litigants’ briefs, by which the mandate constituted a clear regulation of existing commercial activity rather than a stimulation of new commercial activity or a regulation of inactivity. Even if the justices had understood independently of the Solicitor General’s argument that one of the mandate’s purposes was to improve the efficiency of health care consumption (a point that they seemingly failed to grasp at all in the absence of briefing or argument\(^{184}\)), the Court probably would not have been comfortable upholding a statute on grounds that the litigants did not articulate.

In short, the populist muzzle on the Solicitor General profoundly impacted the future of health care law and the Commerce Clause.

C. Muzzles and Puzzles

The story of the unspoken freedom of health holding in *NFIB* highlights a particular answer to two important puzzles at the intersection of political science and constitutional law. The first is the subject of the prior subsection: whether and how democratic views of the constitution might impact Supreme Court decisions. The second is whether the Solicitor General is or ought to be primarily an agent of the Court or the President. Assuming that my hypothesis is right—that the Solicitor General really did avoid the insurance-as-regulation argument because of popular opposition to rationing—the *NFIB* story reveals a mechanism for popular constitutionalism’s impact that the literature has not explored, and it reveals a sense in which the Solicitor General is emphatically a political rather than a judicial actor. Both of these points are relatively straightforward, but I will elaborate each a little bit, primarily to demonstrate the potential for future exploration of this kind of popular muzzling.

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\(^{182}\) Statutory cite to DOMA and litigation cites.

\(^{183}\) News of Obama decision not to defend DOMA’s constitutionality.

\(^{184}\) Oral argument examples.
1. Muzzling Constitutionalism

In a recent article on popular constitutionalism in the Obamacare litigation, Erni Young discussed three mechanisms that the literature has identified by which political preference might influence constitutional doctrine.\textsuperscript{185} The first, discussed above, is the ability of popular preferences to impact judicial appointments. The second is the possibility that the justices will be directly responsive to popular preference. That possibility might seem remote or undesirable given the justices’ insulation from electoral pressures, but in extreme cases and given long enough timescales for popular views to entrench themselves, direct responsiveness might become somewhat likely. At a minimum, the justices might want to avoid institutional attacks like President Franklin Roosevelt’s court packing plan.\textsuperscript{186} The third mechanism that Professor Young identified is the possibility that popular movements will persuade a particularly powerful set of litigants: state governments. Young noted that one important and underappreciated aspect of the Obamacare litigation was the central role of state attorneys general in raising constitutional arguments that, a mere two years earlier, seemed implausible.

The muzzling impact of popular opinion that I discuss here is most similar to the third of Professor Young’s identified mechanisms insofar as it centers on a popular movement’s ability to influence a particularly powerful litigant: the Solicitor General. There is also a core difference, though, between muzzling constitutionalism and the state-initiated popular constitutionalism that Young discussed. In a muzzling story, the popular movement does not need to convince any litigant or any other political or legal elite to adopt the populists’ view of the constitution. In \textit{NFIB}, the popular movement successfully implemented a freedom of health constraint simply by making the Solicitor General scared of refuting the anti-rationing view. None of the litigants in \textit{NFIB} argued openly that rationing would be an impermissible exercise of governmental authority; they were simply scared of arguing that it would be.

This distinction makes the muzzling kind of popular constitutionalism much harder to ferret out and identify—but no less important. In most cases, it will not be obvious from the briefing or the holding whether there were important constitutional arguments that the litigants failed to present, but the failure to present important constitutional arguments can be crucially important to doctrinal outcomes. Even if my hypothesis about \textit{NFIB} and the freedom of health is wrong, there are undoubtedly other cases in which the Solicitor General and other politically accountable litigants (like state attorneys general) have shaped their constitutional arguments to comply with popular pressures, failing to raise constitutional arguments that the voting public would dislike. For scholars interested in the role of popular constitutionalism, this phenomenon seems like a fruitful line of inquiry, and it is one that the existing literature has not yet identified.

\textsuperscript{185} Young, supra note 2, at 185–99.
\textsuperscript{186} Cite the court packing statute.
2. The Tenth Justice

The other puzzle in the political science and constitutional law literatures is whether the Solicitor General is primarily an agent of the Court or the President—and why, in light of the answer, solicitors general tend to be disproportionately successful in influencing Supreme Court decision making. In a 1987 book entitled “The Tenth Justice,” Lincoln Caplan asserted that solicitors general are relatively independent actors within the executive branch and that they usually consider themselves to hold an obligation to the Court to elaborate constitutional arguments without partisan bias. He further argued that the increased politicization of the office under President Reagan had decreased the solicitor general’s influence with the Court. Many authors since have taken issue with Caplan’s views, arguing that the solicitor general’s office is and always has been a political office. Unsurprisingly, the truth seems to lie in the middle. According to a first-hand account from Drew Days, who served in the Department of Justice under three presidents, the solicitor general’s office seems to be one that receives a great deal of presidential latitude in ordinary cases but that the President will not hesitate to influence in high profile cases.

In the NFIB narrative, there are two interrelated points that are interestingly relevant to this debate. If my hypothesis is right about the reasons for Verrilli’s rejection of the insurance-as-regulation narrative, then, first, there is no doubt that popular political pressures—as distinct from a president’s own political views—can impact a solicitor general’s presentation to the Court, and second, these pure political pressures can even motivate the Solicitor General to withhold from the Court an important constitutional argument.

This story is not one of a president using litigation to promote his own political agenda, nor is it a story of a president following electoral incentives to choose between well-articulated sides in a constitutional contest, as through an amicus brief. The NFIB story is one of a president’s electoral incentives limiting the arguments that would be available to the Supreme Court in a constitutional case. In that sense, the story is emphatically one of a solicitor general’s agency to the President, not the Court. Verrilli was not serving as a mouthpiece for President Obama’s constitutional views; he was serving as a pure political strategist. And in order to play the role of President Obama’s political representative, Verrilli actively denied the justices access to a relevant constitutional argument.

Again, if that story is right, then it undermines any claim to judicial agency in the Solicitor General’s office in this case. Unless the Court’s interest is so entangled with popular constitutional views that the justices should not even be exposed to politically unpopular arguments, the Solicitor General did the Court a disservice in the NFIB case. And he did so purely as an agent of the President. Of

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187 Caplan, supra note 3.
188 Sara cites.
190 Sara cites on amicus briefs.
course, the relevance of this story to the broader literature on the role of the
solicitor general’s office is not entirely clear. It may have been an unusual case; it
may even have been a unique case. It is also a kind of politicization in the
solicitor general’s office that is very hard to detect—as should be clear from my
constant reminders that I can’t verify the truth of my story here. But the plausible
hypothesis about NFIB’s background raises the interesting possibility that the
solicitor general is, at least sometimes, far more beholden to the President than he
is to the Court.

Conclusion

There is no doubt that Solicitor General Verrilli failed to articulate a
defense of the individual mandate that was available, apparent, and compelling. I
cannot say for sure whether he forwent the argument for strategic political
reasons, but it certainly seems plausible that the rationing constraint would have
made the Obama Administration wary of highlighting health insurers’ many
manipulations of health care consumption incentives. If that story is right, then the
Supreme Court’s opinion in NFIB contains an unarticulated freedom of health
constraint, rejecting sub silentio the permissibility of health care rationing as a
regulatory project. This unspoken freedom of health holding highlights an
unexplored avenue for popular constitutionalism’s impact on Supreme Court
decisions as well as highlighting a case in which the Solicitor General served
 emphatically as an agent of the President, not the Court.