Does the Individual Mandate Coerce?

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The Patient Protection and Affordable Care Act includes an individual mandate which penalizes individuals who do not purchase health insurance. Critics of the individual mandate, including a majority of justices on the Supreme Court, contend that Congress cannot use its Commerce Clause power to coerce individuals to buy a product. Supporters concede that the mandate coerces but argue that it is otherwise permissible under the Commerce Clause. This Essay questions whether the individual mandate coerces. It uses a simple economic model to show that, under certain conditions, the individual mandate induces insurers to sell health insurance at a price each individual would voluntarily pay. In fact, the model shows that individuals would purchase the insurance even if they had no awareness of the individual mandate.

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I. INTRODUCTION

The Patient Protection and Affordable Care Act (the "ACA")\(^1\) contains provisions which penalize certain individuals who fail to purchase health insurance. Critics of the individual mandate, including a majority of justices on the Supreme Court, contend that Congress cannot use its Commerce Clause power to coerce individuals to buy a product. Supporters concede that the mandate coerces but argue that it is otherwise permissible under the Commerce Clause. This Essay questions whether the individual mandate coerces. It uses a simple economic model to show that, under certain conditions, the individual mandate induces insurers to sell health insurance at a price each individual would voluntarily pay. In fact, the model shows that individuals would purchase the insurance even if they had no awareness of the individual mandate.

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care insurance. These provisions are commonly known as the individual mandate.

Since the passage of the Act, there has been an extensive debate over whether Congress can enact the individual mandate under the Commerce Clause, which gives Congress "the Power . . . [t]o regulate Commerce . . . among the several States." The debate has resulted in litigation in a number of state and federal courts. Critics of the individual mandate contend that Congress cannot use its power under the Commerce Clause to coerce individuals to purchase a product.

Supporters of the individual mandate concede that the mandate coerces, but argue that it is a permissible exercise of Congress's Commerce Clause power because of the unique features of the health care market. They point out that a mandate is necessary given (1) the inevitability of health care purchases over the course of an individual's

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2 These provisions are entitled the "[r]equirement to maintain minimum essential coverage" and are codified as part of the Internal Revenue Code. 26 U.S.C. §§ 5000A et seq.

3 U.S. CONST. art. I, § 8, cl. 3.

4 Florida v. Dep't of Health & Hum. Servs., 648 F.3d 1235, 1331 (11th Cir. 2011) ("What Congress cannot do under the Commerce Clause is mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die."); Virginia ex rel. Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 788 (E.D. Va. 2010) ("At its core, this dispute is not simply about regulating the business of insurance - or, crafting a system of universal health insurance coverage - it is about an individual's right to choose to participate."); Randy E. Barnett, Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional, 5 N.Y.U. J.L. & LIBERTY 581, 684 (2010) (arguing that "commandeering" citizens to purchase health insurance is unconstitutional, noting that the individual mandate "crosses an important line between limited and unlimited government power"); Ezra Klein, Obamacare's Most Influential Legal Critic on Tuesday's Oral Arguments, WASH. POST: WONKBLOG, Mar. 27, 2012, 4:52PM, http://www.washingtonpost.com/blogs/ezra-klein/post/obamarcare-most-inuential-legal-critic-on-tuesdays-oral-arguments/2011/08/25/gIQAq2NpeS_blog.html (last visited Apr. 20, 2012) (interview with Randy Barnett, with Barnett noting that "[w]hat the government is claiming here is this power . . . to make people do business with private companies when Congress thinks it's convenient").

lifetime, (2) the uncertainty of when an individual would need to make those purchases, and (3) the refusal by society to deny care to individuals who cannot afford to pay for it. Consequently, supporters contend that the mandate forces younger and healthier individuals to purchase health insurance, which, when combined with the "community rating" and "guaranteed issue" provisions of the ACA, lowers the cost of health insurance for everyone. Supporters also point out that the mandate coerces individuals to prepay for their own health care to eliminate free-riding.

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6 Thomas More L. Ctr. v. Obama, 651 F.3d 529, 556-557 (6th Cir. 2011) (Sutton, J., concurring); Economic Scholars' Brief at 6-13 (same); Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941, 948-54 (1963) (same). The refusal to deny care is reflected in federal and state laws that mandate treatment in certain cases without regard to the patient's ability to pay. E.g., 42 U.S.C. § 1395dd (mandating treatment of emergency patients without regard to their ability to pay); Fla. Stat. Ann. § 395.1041(3)(k)(1) (mandating provision of emergency care if requested).

7 42 U.S.C. § 300gg-4(b) (prohibiting an insurer from "require[ing] any individual . . . to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual" based on certain health-status factors).

8 42 U.S.C. §§ 300gg-1, 300gg-3, & 300gg4(a) (providing that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in that State that applies for such coverage").

9 Specifically, (1) forcing younger and healthier individuals to purchase health insurance (the individual mandate), (2) prohibiting price discrimination among customers (the community rating provisions); and (3) prohibiting health insurers from refusing to insure an individual (the guaranteed issue provisions) all result in younger and healthier individuals subsidizing the health expenditures of others. See Thomas More, 651 F.3d at 535 (upholding the mandate, noting that "Congress found that [b]y significantly reducing the number of uninsured, the [minimum coverage] requirement, together with the other provisions of this Act, will lower health insurance premiums," quoting 42 U.S.C. § 18091(a)(2)(F)); Economic Scholars' Brief at 10 (noting that health insurance "is a mechanism for spreading the costs of that medical care across people"); Jack Balkin, Commerce, 109 MICH. L. REV. 1, 46 (2010) ("To . . . lower insurance costs, health reform must bring younger and healthier persons into the risk pool.").

10 See Thomas More, 651 F.3d at 535 (upholding mandate, noting that "Congress found that without the minimum coverage provision, other provisions in the Act, in particular the guaranteed issue and community rating requirements, would increase the incentives for individuals to 'wait to purchase health insurance until they needed care,'" quoting 42 U.S.C. § 18091(a)(2)(I)); id. at 557 (Sutton, J., concurring) ("The basic policy idea, for better or worse (and courts must assume better), is to compel individuals with the requisite income to pay now rather than later for health care."); Seven-Sky v. Holder, 661 F.3d 1, 18 (D.C. Cir. 2011) (upholding mandate, noting that "Congress, which would, in our minds, clearly have the power to impose insurance purchase decisions on persons who appeared at a hospital for medical services, as rather useless as that would be, is merely imposing the mandate in reasonable anticipation of virtually inevitable
The debate and subsequent litigation culminated in *National Federation of Independent Business v. Sebelius*, which the Supreme Court decided at the end of last term.\(^\text{11}\) There, the Court upheld the mandate as a valid exercise of Congress's tax power.\(^\text{12}\) However, the Court was divided over whether Congress could enact the mandate under the Commerce Clause. A majority of justices agreed with critics that the Commerce Clause does not permit Congress to "compel[] individuals to become active in commerce by purchasing a product."\(^\text{13}\) They point out that if the individual mandate is upheld under the Commerce Clause, then "Congress could address the diet problem by ordering everyone to buy vegetables."\(^\text{14}\) The remaining justices conceded that the individual mandate coerces. However, parroting the supporters, they concluded that the individual mandate is valid under the Commerce Clause given the unique features of the health insurance market.\(^\text{15}\)

In this Essay we question the consensus that the individual mandate coerces. Using a simple economic model, we show that, under certain conditions, the individual mandate may not coerce individuals to purchase anything. The individual mandate solves a problem of equilibrium selection. Under the conditions we identify, insurers have the choice to sell health insurance at a high price that only less healthy individuals would be willing to pay, or at a low price that everyone would pay, earning the highest feasible profit in either case. We show that the individual mandate induces insurers to choose the welfare-maximizing market equilibrium in which everyone purchases. The individual mandate therefore assists the provision of affordable insurance, but can do so without coercing individuals to purchase insurance against their will. Accordingly, we show that the premise underlying the debate over the future transactions in interstate commerce"); Economic Scholars' Brief at 10 (noting that health insurance "mitigate[s] the risk of facing overwhelming costs at a particular time by substituting a lower, regular premium cost over a longer period").


\(^\text{12}\) Id. at 44; see also U.S. CONST. art. I, § 8, cl. 1 ("Congress shall have the Power To lay and collect Taxes . . . and provide for the common Defence and general Welfare of the United States."). We do not address the issue, but others have. E.g., Robert D. Cooter & Neil Siegel, A Theory of the Tax Power for a Court that Limits the Commerce Power, 98 VA. L. REV. (forthcoming 2012).

\(^\text{13}\) NFIB at 20.

\(^\text{14}\) Id. at 23; see also id. at 12-13 (Scalia, J., dissenting) ("But the mere fact that we all consume food and are, thus, sooner or later, participants in the 'market' for food, does not empower the Government to say when and what we will buy.").

\(^\text{15}\) Id. at 18-23 (Ginsburg, J., dissenting).
constitutionality of the individual mandate under the Commerce Clause should not be taken for granted.

II. THE MODEL

We provide a simple economic model to illustrate our argument. A large population of individuals exists. Each individual is at risk for an adverse event, which can be interpreted as an illness or injury requiring medical care. Different types of individuals face different levels of risk: high-risk individuals are more likely to experience this event than low-risk individuals. Let \( a_h \) represent the probability that a high-risk individual experiences the adverse event, and \( a_l \) represent the probability that a low-risk individual experiences the event; by definition, \( a_h > a_l \). In addition, let \( g \) represent the share of low-risk individuals in the population; the probability that an individual drawn from the population is low-risk is therefore equal to \( g \). Individuals do not know whether they will have an accident or illness at the time they decide to buy insurance, but they do know their level of risk.\(^{16}\) No outsider, in particular an insurance company, can directly observe an individual's type.

If they choose to do so, individuals can purchase insurance. To keep the analysis as straight-forward as possible, we assume that only a single insurance plan is offered.\(^{17}\) In exchange for a premium \( p \), the insurer promises to cover all losses caused by the adverse event, which we normalize to one. Normalizing the payoff of the status quo (no adverse event, no insurance) to zero, an insured individual expects a payoff of \(-p\) whether or not the event occurs, while an uninsured individual receives a payoff of zero if no event takes place and negative one if the individual is required to pay for medical care in case of illness or accident.

\(^{16}\) We assume that individuals cannot affect the level of risk they face by changing their behavior. We therefore do not incorporate moral hazard, a potentially important issue in insurance markets (but not in the argument against the mandate), into the analysis. We note that the evidence of moral hazard may be overstated due to income effects. See Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. Econ. Lit. 571, 581 (2008) (citing literature). Moreover, there are legal mechanisms to reduce or eliminate moral hazard, such as deductibles and co-payments. See STEVEN SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* 194-99 (1987).

\(^{17}\) For simplicity, we assume that an insurer is unable to offer different plans in order to screen the customer's information. We note that the ACA contains "community rating" provisions which prohibit insurers from engaging in price discrimination on the basis of a consumer's health status. 42 U.S.C. § 300gg-4(b).
If an individual has probability $a_i$ of having an adverse event and does not purchase insurance, he or she expects payoff $-a_i$. By buying insurance, the individual guarantees a payoff of $-p$. Therefore, the individual will choose to purchase insurance if the price of insurance is less than the probability of accident or illness, $a_i \geq p$. This simple idea points out a fundamental aspect of the insurance market: high-risk individuals have the greatest incentive to purchase insurance. If low-risk individuals are willing to purchase insurance at a certain price, high-risk individuals are also willing.

The insurance industry is characterized by a single incumbent firm and a potential entrant. In order to enter the market, the entrant must pay a fixed fee $\beta$, which covers infrastructure, staff, licenses, and other costs associated with market entry. If the entrant chooses to enter the market at a point in time, the entrant may have an advantage: by undercutting the incumbent’s price to consumers slightly and offering slightly more to doctors and medical providers, the entrant could successfully poach both the incumbent’s customers and medical providers at terms nearly identical to those offered by the incumbent. The entrant could therefore earn nearly the same expected profit as the incumbent, while effectively forcing the incumbent out of the industry. Thus, the presence of the entrant limits the incumbent's ability to earn profit. If the incumbent's expected profit exceeds the entry fee $\beta$, the incumbent should anticipate being undercut by the entrant, leaving the incumbent with zero profit. Thus, the incumbent’s expected profit cannot exceed $\beta$, the entry fee.

Because the incumbent insurance firm is a large buyer of medical services, it is able to negotiate favorable rates for these services with hospitals and doctors, allowing it to pay a lower price for medical care.

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18 Our model does not make any assumptions about each individual's risk preferences. Thus, the model can accommodate both risk-averse and risk-seeking individuals as long as their risk preferences are homogenous.

19 We note that these differing preferences, along with the insurer's inability to price discriminate, may result in adverse selection. See George A. Akerlof, The Market for "Lemons": Quality Uncertainty and the Market Mechanism, 84 Q. J. ECON. 488 (1970). We further note that, as an empirical matter, "there is surprisingly little work on the general question whether those who choose to be insured are adversely selected.” Gruber, supra note 16, at 577.

20 The same would be true if we considered competition over a longer time horizon. We focus on one-time competition for ease of exposition.
than is available to individual consumers. While an individual with no insurance pays a price of one for treatment in case of illness or injury, the insurance company pays only $c < 1$ for its customer's treatment.

In the equilibrium of this market, the entrant chooses the price of insurance to maximize its expected profit, accounting for the limitations placed upon it by the potential entrant; meanwhile, individual consumers choose whether or not to purchase insurance at the prevailing price. Of course, the incumbent's expectation about its profit depends on its beliefs about the type of individuals buying insurance. In turn, individual purchase decisions depend on prices. In equilibrium, sophisticated firms understand consumer incentives to purchase insurance, and expect those individuals to purchase insurance for whom doing so is optimal.

To briefly summarize, we consider a market equilibrium in which three conditions are satisfied:

- **Consumer Rationality**: Consumers purchase insurance if the benefit of doing so exceeds the price; that is, if the price of insurance is less than the probability of the adverse event.

- **Profit Maximization**: The insurance provider chooses its price to maximize expected profit, anticipating rational purchase decisions by consumers. The maximum profit that the incumbent can expect to earn is equal to $\beta$, the entry fee.

- **Small Entry Barriers**: The fixed fee for entry, $\beta$ is positive, but not too large. Specifically, $0 < \beta < (1 - g)(1 - c)\alpha_H$.

### A. Equilibrium

Because the insurance provider cannot observe an individual's risk level, it cannot charge different prices for different levels of risk. In the simple insurance market that we consider, the firm charges a single price for coverage. Each type of individual is willing to purchase insurance if the price $p$ is less than his or her probability of experiencing the adverse event $\alpha_i$. Therefore, if low-risk individuals are willing to purchase insurance, then so are high-risk individuals. This implies that an insurance market can operate in only two possible equilibrium configurations

- **Separated**: High-risk individuals purchase insurance, but low risk individuals do not purchase insurance.
- **Pooled**: Both high- and low-risk individuals purchase insurance.

Before moving on to the analysis, it is helpful to introduce one simple piece of notation for purposes of exposition: let \( b = \frac{\beta}{a_H} \). The *small entry barriers* assumption then ensures that \( b < (1 - g)(1 - c) \).

1. **Separated Market**

In a separated market, only high-risk individuals purchase insurance. In this case, the insurer's expected profit is equal to \( \Pi = (1 - g)(p - ca_H) \). Profit maximization then implies that the insurer would like to set a price to achieve its maximum feasible profit \( \beta \). Assuming that only high-risk individuals buy insurance, the insurer can achieve its maximum profit \( \beta \) by selecting the price that solves the following equation:

\[
(1 - g)(p - ca_H) = \beta \leftrightarrow p^* = \frac{\beta}{1 - g} + ca_H
\]

Provided that only high-risk consumers are willing to purchase insurance at price \( p^* \), the consumer rationality condition is satisfied, and an equilibrium with a separated market exists. This is the case whenever the following inequality is satisfied:

\[
a_L < \frac{\beta}{1 - g} + c < a_H \leftrightarrow \frac{a_L}{a_H} < \frac{b}{1 - g} + c < 1
\]

The second part of this inequality, \( \frac{b}{1 - g} + c < 1 \) is satisfied whenever the *small entry barriers* assumption holds. Thus, an equilibrium with a separated insurance market holds whenever

\[
\frac{a_L}{a_H} < \frac{b}{1 - g} + c
\]

This result is intuitive. The ratio \( \frac{a_L}{a_H} \) measures the degree of risk-homogeneity between the groups. When this ratio is small, the low-risk group is significantly less likely to have an accident than the high risk group (and vice versa). We have found that when the risks faced by the two groups differ significantly, then an equilibrium exists in which only
the high-risk group buys insurance. The insurer achieves its maximum feasible profit by selling only to the high-risk group at relatively high prices. Low-risk individuals have a significantly lower probability of having an accident and are not willing to pay such a high price, leading to a separated market.

2. **Pooled Market**

In a pooled market, both types of individuals purchase insurance. In this case, the insurer's expected profit is equal to \( \Pi = p - c(ga_L + (1 - g)a_H) \). The insurer can achieve its maximum feasible profit \( \beta \) by selecting the price that solves the following equation

\[
p - c(ga_L + (1 - g)a_H) = \beta \iff p^* = c(ga_L + (1 - g)a_H) + \beta
\]

Provided that both types of consumers are willing to purchase insurance at price \( p^* \), the consumer rationality condition is satisfied, and a pooled equilibrium exists. If it is rational for low risk individuals to purchase, then it is also rational for high-risk individuals to purchase. A pooled equilibrium therefore exists if the following inequality is satisfied:

\[
c(ga_L + (1 - g)a_H) + \beta < a_L < \frac{c(1 - g) + b}{1 - cg} < \frac{a_L}{a_H}
\]

If this condition holds, the market can be pooled in equilibrium. Intuitively, because the two groups face similar (though not identical) levels of risk, both types of individuals are willing to pay similar prices for insurance. Here, the insurer achieves its maximum feasible profit \( \beta \) by setting a relatively low price that both types are willing to pay.

We summarize these results in the following figure. Note that, as represented in the figure below, \( \frac{c(1 - g) + b}{1 - cg} < \frac{b}{1 - g} + c \).

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\(^{21}\) \( c(g \frac{a_L}{a_H} (1 - g)a_H + \beta) < a_L \iff c(g \frac{a_L}{a_H} (1 - g)) + b < a_L \iff c(1 - g) + b < (1 - \frac{c}{cg})^\frac{a_H}{a_L} \) \( \iff \frac{c(1 - g) + b}{1 - cg} < \frac{a_L}{a_H} \)

\(^{22}\) To see this, observe that \( \frac{c(1 - g) + b}{1 - cg} - (\frac{b}{1 - g} + c) = -\frac{g(1 - c)(1 - g) + b}{(1 - g)(1 - cg)} < 0. \)
In this figure, the axis represents the degree of risk-homogeneity in the population as represented by the ratio $\frac{a_{l}}{a_{H}}$. The minimum value of this ratio is zero, and the maximum possible value is one. High values of this ratio correspond to a high degree of homogeneity between groups, as their chances of having an adverse event are similar. Low values of the ratio indicate that the probability of injury or illness in the two groups differs significantly. In this case, homogeneity is low. Consistent with the results presented above, when this ratio is less than $\frac{b}{1-g} + c$ an equilibrium exists in which the market is separated. Whenever this ratio is greater than $\frac{c(1-g) + b}{1-cg}$ an equilibrium exists in which the market is pooled. Thus we find three cases of interest:

1. **High homogeneity**: If $\frac{a_{l}}{a_{H}}$ is high, the equilibrium market is pooled.

2. **Low homogeneity**: If $\frac{a_{l}}{a_{H}}$ is low in equilibrium the market is separated.

3. **Medium homogeneity**: If $\frac{a_{l}}{a_{H}}$ is intermediate, the equilibrium market can be either separated or pooled.

**B. The Individual Mandate**

Here we consider the effects of the individual mandate in each of the three cases described above. In the high homogeneity case, the market is
already pooled. Because both types buy insurance even without the mandate, introducing the mandate does not change the market outcome. If homogeneity is low, the only possible equilibrium outcome is a separated market. Here, imposing a mandate drives down the price of insurance, but does not drive it down enough that low-risk individuals are willing to purchase at the (new) lower price. Introducing a mandate in this case coerces low-risk individuals to purchase insurance against their will, benefitting high-risk individuals at their expense. Here, the argument against the mandate applies in a straightforward way.

Consider now the last case, in which homogeneity is in the middle range. Here, both types of equilibria are possible. Which market configuration arises is therefore determined by the behavior of the insurance provider: if it sets a relatively high price the market will be segmented, but a relatively low price leads to a pooled market. Because the insurer expects the same profit in both cases, it has no clear preference for either market configuration; thus either market structure could naturally arise.

However, if the market that arises is separated, then imposing a mandate will change the prevailing market structure. If both types of consumers are required to purchase insurance, the insurer will be willing to sell to both types of consumers at a lower price, and this price drop will be drastic enough that low risk individuals will choose to purchase at the new price. Here, the mandate does not force anyone to purchase insurance against his or her will. In this case, imposing the mandate causes the industry to switch from a separated equilibrium into a pooled equilibrium; the insurer maintains the highest feasible level of profit, and each type of consumer purchases insurance because it is optimal to do so at the prevailing price. The mandate "nudges" the market out of a configuration in which healthy individuals are excluded into a new configuration in which both types of individuals voluntarily participate.

III. Discussion

The model shows that, under certain conditions, the individual mandate does not coerce. To make this lack of coercion more apparent, consider an extreme example. Suppose that Congress can communicate the passage of the individual mandate to the insurer, but can keep the mandate secret from all consumers. Further suppose that the risk homogeneity of the consumers is sufficiently high that knowledge of the mandate induces the insurer to sell the insurance at a price that everyone is willing to pay. Because the model assumes that the consumers are rational,
the consumers will still purchase the health insurance *even though they have no awareness of the individual mandate.*

The extreme example demonstrates that, under the conditions we identify, the individual mandate does not have to play any role in the consumer's decisionmaking to cause each consumer to purchase health insurance. If anything, the individual mandate induces insurers to sell insurance at a price everyone would be willing to pay by nudging insurers to choose an equilibrium that results in universal coverage.

The model also shows that coercion is not necessary for the individual mandate to perform the cross-subsidy and prepayment functions identified by the mandate's supporters. Because the model assumes that the insurer can only offer insurance at a single price, the low-risk individual pays more than the actuarially fair premium while the high-risk individual pays less. As a result, the higher amount paid by the low-risk individual subsidizes the high-risk individual. Nevertheless, the model shows that it would still be rational for the low-risk individual to purchase insurance because the costs of health care per individual, \( c \), are lower for the insurer. Under the model, the insurer uses economies of scale to purchase health care more cheaply than the individuals, which, under the conditions we identify, can offset the cross-subsidy the low-risk individual pays to the high-risk individual. Similarly, the insurer's economies of scale make it rational for both individuals to prepay for their health care through insurance rather than purchase health care when the need arises.

Critics may argue, however, that the model does not take into account the realities of the health care market. We concede that the model does not capture the market's full complexity.\(^{23}\) In fact, this was a deliberate choice. We abstracted away from the many complex facets of the health care market to demonstrate that the individual mandate may not force individuals to buy insurance. In doing so, our model casts some doubt on the central premise of the debate over the mandate's constitutionality under the Commerce Clause. Consequently, it is the critics who take too simplistic a view of the health care market. They automatically assume that the individual mandate would coerce individuals to buy insurance against their will without investigating whether the unique features of the health care market would result in coercion.

Moreover, the claim that the individual mandate coerces is, at the very least, exaggerated given empirical evidence about the U.S. health care market. First, the model assumes that insurers can use economies of scale in purchasing health care, and thus can purchase health care more cheaply

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\(^{23}\) See Arrow, *supra* note 6 (discussing the unique features of the health care market).
than individuals. There is some evidence to support this assumption. Anecdotally, insurers, hospitals, and other health care providers generally use group purchasing organizations ("GPOs") to purchase health care supplies and devices, presumably to take advantage of economies of scale. Moreover, arguments in favor of single-payer health care presume cost efficiencies that are consistent with the economies of scale we assume in the model.

Second, the model shows that the risk-homogeneity among individuals must be sufficiently high to avoid coercion. This may, in fact, be the case. Under the ACA, the two groups with the highest risk of health care expenditures – the elderly and the poor – are excluded from the mandate and are provided health insurance publicly through Medicare and Medicaid. The ACA, moreover, expands the individuals covered by Medicaid, even though, under the Supreme Court's ruling, states may be less likely to implement the expansion. In addition to the limited scope of the individual mandate, the ACA provides subsidies to individuals who may not purchase health insurance because, while it may be a rational to do so, they do not have the ability to pay for it.

Critics may further argue that, given the large population affected by the mandate, there may be individuals who are still coerced by it. Under the model, the types of individuals who would be coerced would be individuals who (1) have a very low risk of requiring health care and (2) can self-insure any health care purchases. There is some empirical evidence to suggest that there are not very many individuals who have these two characteristics. In fact, in her dissent, Justice Ginsburg pointed

\[\text{24} \text{ See U.S. Gen. Accounting Office, GAO-03-998T, Group Purchasing Organizations: Use of Contracting Processes and Strategies to Award Contracts for Medical-Surgery Products 5 (2003); see also Group Purchasing Organizations: Fed. Trade Comm. and Dep't of Justice Joint Hearings on Health Care and Competition Law and Policy, at 6 (September 26, 2003) (statement of Robert Betz, Ph.D., President and CEO of Health Industry Purchasing Group Association (HIGPA)) (noting that "72 percent of all hospital purchases are made via a GPO-negotiated contract").} \]

\[\text{25} \text{ These arguments rely mostly on the reduction in administrative costs in a single-payer system and a single-payer's monopsony power to negotiate lower prices for health care. See Sherry Glied, Single Payer as a Financing Mechanism, 34 J. HEALTH POL. POL'Y & L. 593 (2009) (reviewing literature).} \]

\[\text{26} \text{ See 26 U.S.C. x 5000A(e)(1) (exempting individuals from the mandate "who cannot afford insurance"); id. x 5000A(f)(1)(A)(i) & (ii) (providing that individuals who are covered under Medicare and Medicaid satisfy the individual mandate requirement).} \]

\[\text{27} \text{ Cf. NFIB at 51 (reducing incentives for states to accept the expansion since the current incentives in the ACA amount to "a gun to the head").} \]

\[\text{28} \text{ 26 U.S.C. § 36B(a) (providing "premium assistance" for individuals subject to the mandate based on certain income criteria).} \]
to a study that showed that the number of uninsured individuals who "did not want or need coverage" was too small "to warrant its own category."\(^{29}\)

Moreover, the Supreme Court has stressed that "where a general regulatory statute bears a substantial relation to commerce, the de minimis character of individual instances arising under that statute is of no consequence."\(^{30}\)

Finally, critics may disagree with the definition of coercion used by the model. The model defines coercion as being forced to purchase a product when it would not be rational to do so based upon an individual's risk of requiring health care and the cost of that care. Critics may have in mind a more expansive definition of coercion in which individuals are coerced if they are forced to purchase health insurance even if it would be rational to do so under the model. For example, an individual may refuse to buy insurance out of spite or ideological commitments.

First, we assume that critics of the mandate do not contend that the Constitution protects the liberty to refuse to purchase insurance and rely on others to pay for health care when the need arises. There is a general consensus that everyone has a responsibility to pay for their own health care costs.\(^{31}\)

We further assume that critics do not argue that the law protects the freedom of individuals to refuse to purchase insurance based on misinformation or other rationality defects. Such paternalism may be frowned upon by some,\(^{32}\) but is generally not viewed as coercive under the law. For example, courts generally prevent consumers from waiving certain remedies when they purchase a product. As a result, manufacturers

\(^{29}\) NFIB at 9 (Ginsburg, J., dissenting) (citing Dep't of Health and Human Serves, National Center for Health Statistics, Summary Health Statistics for the U.S. Population: National Health Interview Survey – 2009, Ser. 10, No. 248, at 71 tbl. 25 (Dec. 2010)).

\(^{30}\) United States v. Lopez, 514 U.S. 549, 558 (1995); see also Gonzales v. Raich, 545 U.S. 1, 17 (2005) (noting that the Court has never required Congress "to legislate [under the Commerce Clause] with scientific exactitude."); Perez v. United States, 402 U.S. 146, (1971) (noting that, under the Commerce Clause, "when it is necessary in order to prevent an evil to make the law embrace more than the precise thing to be prevented it may do so") (citations omitted) cf. Florida v. Dep't of Health & Hum. Servs., 648 F.3d 1235, 1294 (11th Cir. 2011) (concluding that "Congress may, in some instances, regulate individuals who are consuming health care but not themselves causing the cost-shifting problem").


\(^{32}\) Id. at 383 (noting that John Stuart Mill "rejected paternalistic justifications for the exercise of coercive power, which seek to prevent individuals from harming themselves").
pass on their expected remedy costs to the consumers, in effect forcing consumers to purchase "mandatory insurance . . . for a single price" that is tied to the product. Such "mandatory insurance" tends to be coercive even under our own definition of coercion because the resultant purchases generally do not "mirror the results achieved in voluntary transactions." But such "mandatory insurance" is ubiquitous in many settings, and courts do not consider it coercive.

Second, we are skeptical that preferences based on spite or ideology would cause individuals to forgo health insurance that would be rational to purchase based on their health risks. In addition, the individual mandate would not apply to many of these individuals because the ACA excludes those who refuse to purchase insurance for religious reasons.

Third, and most importantly, we emphasize that the definition of coercion we use in the model is generally accepted in the law. In many contexts the law has recognized that an individual is not coerced to purchase a private good if they otherwise would be willing to pay the price for it. In antitrust cases, for example, courts have concluded that an antitrust violation does not force a purchaser to buy a good at an inflated price if the purchaser would be willing to pay that price in the absence of the violation. Similarly, a fraud does not coerce an individual to purchase

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33 Richard A. Epstein, Products Liability as an Insurance Market, 14 J. LEGAL STU. 645, 668 (1985) ("The current doctrines of products liability law can be understood as a form of mandatory insurance that is tied to the sale of an automobile [or other product]," where "a single price has to be charged").

34 Id. at 668-69.

35 Critics may argue that a state may coerce the purchase of mandatory insurance by limiting the waiver of remedies, but the federal government cannot do so under the Commerce Clause. However, under the Magnuson-Moss Act, the federal government prohibits a supplier from disclaiming any implied warranties to consumers under certain conditions, which effectively requires consumers to purchase mandatory insurance under those conditions. See 15 U.S.C. § 2308(a) (prohibiting disclaiming of implied warranties if the supplier provides a written warranty or the parties enter into a service contract within 90 days). Relatedly, the federal government imposes a limitation on the waiver of remedies in the maritime context, effectively forcing passengers to purchase mandatory insurance from the owner of the vessel. See 46 U.S.C. § 30509(a) (providing that the owner of a vessel "may not include in a regulation or contract a provision limiting . . . the liability of the owner, master, or agent for personal injury or death caused by the negligence or fault of the owner or the owner's employees or agents").

36 26 U.S.C. § 5000A(e)(1) (exempting from the mandate those who refuse to purchase insurance because of religious objections or participate in a "health care sharing ministry").

37 E.g., In re New Motor Vehicles Can. Export Antitrust Litig., 522 F.3d 6, 29 (1st Cir. 2008) (noting that an alleged antitrust violation may not have injured all plaintiffs since some "poor negotiators" may have been willing to pay the same price in the absence
a good if that person would have willingly purchased the good in the absence of the fraud.  

IV. CONCLUSION

Our goal in writing this Essay is not to prove conclusively that the individual mandate does not coerce. Whether the mandate does coerce is an empirical question that, according to the model, depends on a number of factors. Instead, our goal is to suggest that any argument about the coercive effect of the mandate is incomplete if it does not take these factors into account. Although the Supreme Court has already passed on the constitutionality of the individual mandate, hopefully we will not make similar assumptions so easily in the future. Because we all know what happens when we assume . . .

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38 E.g., McLaughlin v. Am. Tobacco Co., 522 F.3d 215, 223 (2d Cir. 2008) (noting that the alleged fraud may not have induced individuals to purchase cigarettes if they would have purchased the cigarettes anyway because they "preferred the taste."); see also Sergio J. Campos, Proof of Classwide Injury, 37 BROOKLYN J. INT'L L. 751 (2012) (discussing examples).