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Before the

House Ways and Means Committee
Subcommittee on Health

Hearing on

The Constitutionality of the Individual Mandate in the Affordable Care Act

March 29, 2012

Chairman Herger, Ranking Member Stark, and distinguished Members of the Subcommittee, it is an honor to appear before you today to discuss the constitutional issues raised by the individual mandate in the Affordable Care Act (the "ACA").

I participated in preparing three amicus briefs for the Supreme Court on behalf of a large number of economists, including two Nobel laureates, former senior government officials, and professors from major research universities, supporting the challengers to the ACA and addressing the economic realities behind the law. We filed briefs on the individual mandate, the severability issue, and the Medicaid expansion. Our brief on the mandate offered a counterpoint to the economic justifications cited by the Solicitor General in support of his Commerce Clause arguments, and I want to share with the Subcommittee today the highlights of the points we set out for the Court in our brief on the mandate.

Introduction and Summary

In defending the constitutionality of the individual insurance mandate, the Solicitor General argues that the mandate is necessary to address the asserted effects on interstate commerce caused by the shifting of medical costs from the millions of Americans who voluntarily decide not to participate in the health insurance market—Americans who, by definition, tend to be younger, healthier, and less poor—onto those who do purchase insurance. As an estimate of this cost-shifting

problem, the Solicitor General cites a figure of $43 billion, which is identified as the total yearly amount of uncompensated medical costs attributable to all uninsured persons in the United States. *See* Solicitor General Opening Brief (Minimum Coverage Issue) ("SG Br.") at 2, 8, 19.

The "cost-shifting" justification for the individual mandate, however, does not withstand scrutiny. In reality, the individual mandate has almost nothing to do with cost-shifting in healthcare markets since the people primarily targeted by the mandate (those who can afford health insurance but who voluntarily choose not to purchase it because they reasonably expect the cost of insurance to outweigh their foreseeable medical costs) account for only a small fraction of the $43 billion of uncompensated costs identified by the Solicitor General. While the *amici* supporting the Government emphasize the approximately $6,300 in medical costs incurred by *the average* American per year, the Government provides no analysis of the costs actually paid by those subject to the mandate. In fact, the undisputed data show that the young, healthy, and uninsured, who are the real targets of the mandate, on average incur annual healthcare costs that are less than one-seventh of that figure.

Consistent with that reality, and as expressly stated in the ACA's findings, the mandate was actually enacted not to stop cost-shifting, but to compel millions of Americans to pay more for health insurance than they receive in benefits in order to subsidize both the voluntarily insured and the insurers, and thereby to mitigate the steep rise in insurance premiums that would otherwise be caused by the ACA itself. This true purpose is what the Solicitor General calls the mandate's "second" function—namely, maintaining "the viability of the Act's guaranteed-issue and community-rating provisions." SG Br. at 18.

The ACA prevents health insurers from making the basic actuarial decisions made in every other insurance market. Insurers may no longer withhold health insurance from those with preexisting conditions or price insurance premiums to match applicants' known actuarial risks. By requiring health insurers to cover the sick and to set premiums based on average costs, these federal requirements would dramatically increase healthcare premiums for all insured Americans, unless Congress at the same time forces the young and healthy with relatively little need for comprehensive health insurance to enter the market on terms that are economically disadvantageous. As the *Washington Post* frankly stated in its March 27, 2012 editorial supporting the mandate: "Insurance companies would be unable to offer affordable coverage to those with preexisting conditions, for example, unless they also

were guaranteed enrollment of the young and healthy customers who are less likely to consume healthcare services."

Whether or not the ACA's regulatory requirements are good policy, what is clear as a constitutional matter is that Congress is exercising federal power not to regulate "how health care consumption is financed," SG Br. at 17, but to compel the voluntarily uninsured to purchase insurance at disadvantageous prices, as a *quid pro quo* for health insurers and other existing market participants to compensate them for the deleterious effect of the ACA's costly regulations. The economic data prove that point, and they belie the Solicitor General's claim that the individual mandate is constitutional on the ground that it "regulates economic conduct with a substantial effect on interstate commerce." SG Br. at 18, 33.

An Economic Analysis of the Individual Mandate

A. Individuals Who Voluntarily Forgo the Purchase of Health Insurance Do Not Impose Significant Costs on the Healthcare System.

As a central argument in his defense of the individual mandate under the Commerce Clause and the Necessary and Proper Clause, the Solicitor General contends that the mandate is justified because "the uninsured as a class" impose $43 billion on the rest of the economy. SG Br. at 19. But this claim is unfounded. In fact, only a small fraction of the uninsured—and therefore only a fraction of the costs of uncompensated care—are the targets of the mandate.

The individual mandate targets people who could but who *choose* not to purchase health insurance and who will not otherwise be covered by Medicaid or Medicare. These people tend to be younger and healthier.[1] These Americans make the rational economic decision to pay for their relatively modest healthcare expenditures out of pocket, rather than purchasing insurance. Indeed, if they needed health insurance at all, they would require only the relatively inexpensive insurance that is limited to covering catastrophic care, a type of insurance now foreclosed by the ACA.[2]

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[1] *See* Jack Hadley et al., *Covering the Uninsured in 2008*, Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation 60 (Aug. 2008), *available at* http://kff.org/uninsured/upload/7809.pdf.

[2] Under the ACA, insurers may offer catastrophic coverage plans to those under 30 and other individuals who qualify for certain exemptions under the Act, but such "catastrophic" plans are very

The economic data do not support the conclusion that the younger and healthier Americans targeted by the mandate pass the cost of their medical care on to others in a manner that increases the costs of health insurance for the rest of us. In fact, those who voluntarily decide to forgo insurance coverage actually tend to *overcompensate* the market for their own care relative to other consumers of healthcare services, because they generally pay their medical bills and they are not able to obtain care at the discounted prices negotiated by insurance providers.[3] Accordingly, the individual mandate cannot be justified as a solution to the alleged cost-shifting problem.

The Solicitor General's $43 billion figure comes from analyses of healthcare costs contained in the Department of Health and Human Service's Medical Expenditures Panel Survey ("MEPS") dataset,[4] which is made up of data from "large-scale surveys of families and individuals, their medical providers, and employers," and is the most complete source of data on healthcare expenditures in the United States.[5] This figure is also cited in Congress's findings in the ACA itself.[6] To put this figure in perspective, it is worth pointing out that the total value of the healthcare market in 2008 was roughly *$2.4 trillion*.[7] As the Congressional Budget Office ("CBO") has stated, "the total amount of cost shifting in the current health care system appears to be modest relative to the overall cost of health insurance."[8] Thus, the $43 billion in total uncompensated care represents less than 1.8 percent of the overall market.

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different from the plans in the market today that are aimed only at large, truly unexpected expenses: They must still provide "essential health benefits" coverage, as defined under the Act, after a certain threshold has been met, and must also provide for "at least three primary care visits." 42 U.S.C. § 18022(e).

[3] Jonathan Gruber & David Rodriguez, *How Much Uncompensated Care Do Doctors Provide?*, 26 J. Health Econ. 1151, 1159-61 (Dec. 2007).

[4] *See* Families USA, *Hidden Health Tax: Americans Pay a Premium* 1, 2 (2009), http:// familiesusa2.org/assets/pdfs/ hidden-health-tax.pdf (other pages of this source cited by SG Br. at 7, 8).

[5] Medical Expenditure Panel Survey ("MEPS"), U.S. Dep't of Health & Human Servs., http:// www.meps.ahrq. gov/mepsweb (last visited Feb. 12, 2012).

[6] 42 U.S.C. § 18091(a)(2)(F).

[7] Centers for Medicare & Medicaid Services ("CMS"), National Health Expenditure Projections 2010-2020, at Table 1 (2011), *available at* https://www.cms.gov/NationalHealthExpendData/ downloads/proj2010.pdf.

[8] CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 13 (Nov. 30, 2009), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf (hereinafter *Premiums*).

Even that 1.8 percent, however, is quite misleading because it represents *the totality* of uncompensated care attributable to the uninsured in the healthcare system, not the costs specifically associated with those who are *voluntarily* uninsured and either not exempt from the mandate or not likely to become insured as a result of *other* provisions of the ACA. Indeed, the MEPS data reveal that the actual portion of uncompensated care attributable to those targeted by the individual mandate is much smaller, and in fact constitutes less than one-half of one percent of the overall market for health care.

This reality is demonstrated when we subtract from the $43 billion figure the uncompensated costs attributable to the various categories of individuals who are not targeted by the individual mandate, as follows:

- *Medicaid recipients*. An estimated $18.0 billion of the $43 billion reflects care rendered to cost-shifters who are now newly eligible for Medicaid based on the ACA's expansion of Medicaid to all individuals and households whose income is at or below 133 percent of the poverty line;[9]

- *Illegal immigrants*. Of the remaining $25 billion, roughly $1.3 billion is attributable to uncompensated care provided to illegal aliens, who are expressly excluded from the mandate;[10] and

- *Those with preexisting conditions*. From the remaining $23.7 billion, an additional $7.7 billion must be subtracted for uncompensated care rendered to non-Medicaid-eligible, non-illegal immigrant individuals who would purchase health insurance, but whose preexisting conditions prevented them from doing so; under the ACA, they will be guaranteed coverage and so will no longer be uninsured.[11]

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[9] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Most or all of those with income at or below 133 percent of the poverty line will also be exempt from the penalty that is tied to mandate, though not the mandate itself, under the exemption for those "who cannot afford coverage," 26 U.S.C. § 5000A(e)(1), and/or the exemption for those who do not file a tax return. *See* 26 U.S.C. § 5000A(e)(2).

[10] 26 U.S.C. § 5000A(d)(3) ("[i]ndividuals not lawfully present" not included in those subject to the mandate).

[11] 42 U.S.C. § 300gg-3. While it is possible that some with chronic conditions might fail to purchase insurance, it is reasonable to assume that given the guaranteed issue and community rating provisions, an overwhelming number of those individuals will make the economically rational

- *Those who will opt to pay the penalty rather than purchase insurance*. From the remaining $16 billion, another $3.2 billion should be subtracted to account for those younger, healthier Americans covered by the mandate who can afford to purchase insurance but are expected to opt to pay the tax penalty instead. The CBO projects that approximately four million Americans will opt to pay the penalty.[12] Based on CBO estimates that 90 percent of those who pay the penalty will have incomes over the poverty line and 75 percent will have incomes more than twice the poverty line, we can estimate that roughly 80 percent of those who pay the penalty are likely to fall within the group targeted by the mandate.[13]

Taking these adjustments into account, we see that the *maximum* share of uncompensated care attributable to the mandate's target class would be at most approximately $12.8 billion, a much smaller number than the $43 billion cited by the Solicitor General.[14] Indeed, the true number is almost certainly significantly lower, because even without the mandate, there are other healthcare coverage subsidies provided under the ACA that are intended to and can be expected to induce many of those who are currently uninsured to choose to become insured in the future.

Accordingly, the voluntarily uninsured, who choose to pay their own relatively modest healthcare costs out of pocket, plainly cannot be described as free-riders who impose significant uncompensated costs on others. The actual amount of cost-shifting fairly attributable to the class of uninsured who are targeted by the mandate is, in truth, only a small fraction of the $43 billion in total uncompensated

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choice to do so, since their healthcare costs would be expected to exceed the community-rated premiums.

[12] CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* (Apr. 22, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11355/Individual_Mandate_Penalties-04-22.pdf.

[13] *Id.* at 2.

[14] This analysis is consistent with a recent study of California's healthcare system, which concluded that "[c]ost shifting from the uninsured is minimal" and is far outweighed by cost shifting attributable to patients covered by government insurance programs. Daniel P. Kessler, *Cost Shifting in California Hospitals: What Is the Effect on Private Payers?*, California Foundation for Commerce and Education 1 (June 6, 2007), *available at* http://www.cornerstone.com/files/CaseStudy/9bc04cf2-dd57-4f1d-ab3c-e5e0d5e7c96e/Presentation/CaseStudyFile/4796ca54-3a8a-4676-a61c-4c4b9f5a5272/Kessler_CFCE_ Cost_Shift_Study%206-6-07.pdf.

costs cited by Congress, and only a drop in the bucket of national healthcare costs. For these reasons, the purported cost-shifting rationale offered by the Solicitor General cannot reasonably justify the legislative decision to enact the mandate.

Apart from invoking the $43 billion figure, the Solicitor General also contends that the voluntarily uninsured must receive uncompensated care because participation in the market is "essentially universal," SG Br. at 35, and frequently expensive, *see id.* at 8, 19. The economist *amici* supporting the Solicitor General claim that the "average person" in 2007 used $6,305 in "personal health care services," which is "over 10 percent of the median family's income." Econ. Br. at 8. The Solicitor General also emphasizes how such costs render the payment of medical bills without insurance so difficult that the mandate can be seen as a necessary means to protect consumers. *See* SG Br. at 8, 12.

But statistics designed to show that the "average" person consumes a substantial amount of health care reveal little or nothing about the healthcare costs of those people specifically targeted by the mandate. The Solicitor General and his *amici* confuse a particular subset of healthcare consumers—the young, healthy, and voluntarily uninsured—with the overall market.

The mandate is not targeted at the "average" American in the healthcare market. It is meant to address adverse selection, and it is directed at younger, healthier individuals who, in the absence of such a mandate, would make an economically rational choice to forgo health insurance. *See* SG Br. at 29 n.6; 42 U.S.C. § 18091(a)(2)(I) ("[I]f there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.").

As might be expected, the targeted subset consumes only a fraction of the national average in healthcare services per year. In fact, in 2010, the young, healthy, and voluntarily uninsured consumed, on average, only $854 in healthcare services, approximately 14 percent of the claimed "average" healthcare expenditure. That figure, moreover, constitutes less than 1.1 percent of an average family's yearly income based on the most recent available data, a far cry from the 10 percent costs of the "average" American cited by the Solicitor General's *amici*. *See* Econ. Br. at 8.[15]

[15] In 2007, the average household earned roughly $84,000. *See* Brian K. Bucks et al., *Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Fin-*

Thus, with regard to the specific class of persons targeted by the mandate, the Solicitor General's argument that these Americans' health care is too expensive to afford is simply not borne out by the data.

The Solicitor General's *amici* rely on the same flawed reasoning in arguing that because federal law requires emergency stabilization care, the voluntarily uninsured are an inherent cause of uncompensated care. *See* Econ. Br. at 13. Once again, the data show that the young and healthy who are the targets of the mandate consume *only $56* per year on average in *total* emergency-room care, which includes both the mandated emergency stabilization care (which may still be billed to, and paid by, patients) and the more routine care provided in emergency rooms. The data thus provide no evidence that the voluntarily uninsured are, as a class, receiving significant amounts of uncompensated care such that one could rationally justify the individual mandate as a solution to this purported cost-shifting problem.

The Solicitor General's economist *amici* argue that even if the average costs to the young, healthy, and uninsured are small, the expenses for such persons who do incur costs may be higher. *See* Econ. Br. at 9 (citing, for instance, $7,933 as the average in-hospital cost for a normal live birth and tens of thousands of dollars as the cost of treating ailments like colorectal cancer, pancreatic cancer, and heart attacks). Those numbers are surely larger than the average per capita cost. But the Solicitor General's *amici* provide no information about how many uninsured people actually *experience* such health events, or how many fail to pay those costs. Moreover, such an argument points toward requiring insurance for catastrophic costs, not for routine healthcare expenditures.[16]

B. The True Purpose of the Individual Mandate is To Subsidize the Higher Costs of Insurance Created by the ACA Itself.

The conclusion that the individual mandate will have little impact on reducing the costs of uncompensated care goes a long way toward exposing the real purpose of the mandate, which is to force millions of individuals into the health insurance market in order to subsidize the higher regulatory costs that the ACA itself

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ances, Federal Reserve Bulletin, Feb. 2009, A5, *available at* http://www.federalreserve.gov/pubs/ bulletin/2009/pdf/scf09.pdf.

[16] Even if the average healthcare costs of the uninsured population that is healthy, over 133 percent of the poverty line, and not an undocumented alien were considered (*i.e.*, not limited to the young), that sum would be $1,652, barely one-quarter of the $6,305 figure cited by the Government and its *amici*.

will impose on private insurers. *See* 42 U.S.C. §§ 18091(a)(2)(C), 18091(a)(2)(I) (explaining that the mandate forces "healthy individuals" into the market as "new consumers" to reduce premiums). The Solicitor General forthrightly acknowledges that the individual mandate "is key to the viability of the Act's guaranteed-issue and community-rating provisions." SG Br. at 18.[17]

In the name of expanding coverage, Congress prohibited insurers from making the basic pricing decisions that they otherwise would make as rational economic actors. The ACA requires insurers to provide health coverage to those with preexisting conditions. *See* 42 U.S.C. §§ 300gg-1(a), 300gg-3(a). More significantly, insurers may not price health insurance based on the actuarial risks posed by a class of applicants, but must employ "community-rated" premiums—*i.e.*, premiums based on the average costs of the insurance pool. *See id.* § 300gg.

The ACA's prohibition on traditional means of pricing the insurance pool disrupts the market function of rating insurance premiums based on the probabilities of unexpected medical conditions. By doing so, the ACA effectively converts private health insurance into a government-mandated entitlement, which insurers must provide regardless of individual characteristics. By forcing health insurers to cover those with expensive medical conditions and to set premiums based on average costs, the ACA would cause health insurance premiums for everyone to rise dramatically. The CBO has estimated that before other offsetting reductions, including those due to the cross-subsidies provided by the individual mandate, the ACA's insurance reforms would cause costs for health insurance in the individual market to rise 27 to 30 percent over current levels in 2016.[18]

Congress thus imposed the individual mandate to subsidize private health insurers and lower the premiums for other insureds by compelling individuals, no matter how young and healthy, to pay for health insurance they do not want at premium levels that significantly exceed the value of the healthcare benefits they are likely to receive under the insurance. By forcing these individuals to engage in economically disadvantageous transactions, Congress sought to compensate for the

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[17] That the ACA was never grounded in an attempt to curb cost-shifting is likewise strikingly clear in Congress's half-hearted commitment to compel compliance. The penalty tied to the mandate is modest enough that many "free riders" would rationally choose to pay it rather than purchase insurance, and the ACA liberally excuses individuals from the penalty. *See* 26 U.S.C. § 5000A.

[18] CBO, *Premiums* at 6.

regulatory costs imposed on insurers and to mitigate somewhat the sharp rise in health insurance premiums otherwise caused by the ACA.

The CBO estimates that the individual mandate will have the effect of reducing premiums for those currently insured by a total amount between $28 and $39 billion in 2016 alone.[19] In other words, those targeted by the mandate will be forced to purchase health insurance at elevated premiums for the sole purpose of subsidizing the premiums of those who voluntarily enter the private health insurance market. Such a subsidy obviously has no correlation to any putative cost-shifting and everything to do with making more palatable the rise in health insurance costs that will result from the dramatic new regulatory requirements imposed by the ACA.

Thus, those subject to the mandate have not contributed materially to the cost-shifting problem identified by the Solicitor General. Instead, in using the individual mandate as a subsidy, Congress hoped to compensate for the market-distorting effects of its own policy choices. Whatever one might say about such a course as a policy matter, the constitutional implications of permitting such bootstrapping as a valid regulation of interstate commerce are sweeping and unprecedented.

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Thank you, Mr. Chairman. That concludes my testimony, and I would be happy to answer the Committee's questions.

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[19] CBO, *Premiums* at 5, 6; CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/ doc11379/Eliminate_ Individual_Mandate_06_16.pdf.