The Affordable Care Act Is Constitutional

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As this commentary first appeared on www.annals.org, the Supreme Court was hearing arguments in one of the most important social policy cases of the past several decades: the constitutionality of the requirement that individuals obtain minimum health insurance coverage under the Patient Protection and Affordable Care Act (ACA). The "individual mandate" is the centerpiece of the ACA, and removing it will dramatically diminish the law's effectiveness. It is also clearly constitutional within the powers of the Constitution's Commerce Clause. We explain why in this essay, drawing on an amicus brief that we and others filed in the Supreme Court (1). This article reflects our joint view and not necessarily that of the other signatories to that brief.

THE IMPORTANCE OF THE INDIVIDUAL MANDATE

At the heart of the ACA is a "three-legged stool" designed to solve two of the most important failures in insurance markets in the United States today: Not everyone can afford insurance, and insurers can discriminate against the sick by excluding preexisting conditions, denying or dropping coverage, and basing insurance prices on health. The first leg of the stool is insurance market reform—ending the ability of insurance companies to discriminate against the sick. No longer will people be one bad gene or one chronic condition away from being uninsured. The second is the individual mandate, which requires individuals to purchase coverage as long as it is affordable (defined as costing less than 8% of income). The mandate is fundamental; without it, sick people will disproportionately buy insurance, many healthy people will not, and prices to the sick will increase accordingly. The third leg of the stool is extensive subsidies that will make health insurance affordable for those who cannot afford it. Thus, everyone will be able to access the insurance system.

This model is based on a very successful reform that took place in Massachusetts. Five years into its execution, the landmark Massachusetts health reform has covered about two thirds of the formerly uninsured and reduced premiums for individual purchasers by about 50% relative to national trends—with strong public support (2). There is no reason to believe that the ACA will be any different. Indeed, the nonpartisan Congressional Budget Office projects that the ACA will cover about 32 million uninsured Americans and significantly lower premiums for individual buyers (3).

If Massachusetts is a success, insurance reform without subsidies and mandates is a failure. In the 5 states that tried comprehensive insurance market reform without an individual mandate, healthy people chose not to buy insurance, sick people did, and thus prices rose (4). Only by guaranteeing broad participation in insurance markets can we end the cycle of unsecure coverage and high costs. That is why estimates of reform without a mandate suggest that such a policy would be much less effective in achieving coverage—but not much less expensive (5, 6).

WHY THE MANDATE IS CONSTITUTIONAL

Although we are not constitutional scholars, it is clear to us that the mandate is consistent with Article I, Section 8, which states that Congress has the right to regulate interstate commerce. That the health insurance mandate will affect interstate commerce in a meaningful way is beyond dispute.

Individuals cannot avoid medical care with certainty or be sure that they can pay for the costs of care if they become uninsured. In 2007, a total of 57% of uninsured persons used medical services that year (7)—very few individuals go 10 or even 5 years without accessing medical care (8). Because medical care is so expensive, most individuals who receive care require funds beyond their own resources. In 2007, the average person used $6305 in personal health care services, and the top 1% of medical spenders used an average of $85 000 (9). Very few people would be able to afford this care out-of-pocket.

Moreover, the United States has a long-standing and virtually universal practice of ensuring that all Americans have access to at least some minimal level of medical treatment when needed, without regard to ability to pay. This consensus is enshrined in legislation (EMTALA) as well as in the custom and practice of health care providers (10). But this practice, while noble, necessarily imposes costs on others; providers pass along these costs by charging more to those with insurance.

As a result, the individual mandate affects interstate commerce in several ways. First, it reduces uncompensated care costs, which amounted to roughly $43 billion in 2008 and are rising rapidly. Second, it reduces health insurance premiums by reducing the ability of healthy people to purchase insurance only when they get sick. Third, it makes possible reforms that will repair the insurance market, providing an outlet for people who are restricted in their job decisions out of fear of losing their current coverage. In short, few areas affect interstate commerce more than health care.

Some have argued that the mandate does not fall under the Commerce Clause because it regulates economic "inactivity" rather than activity. But this claim is simply

This article was published at www.annals.org on 27 March 2012.

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wrong—the decision to forgo purchasing health insurance is not a passive act taken without thought, but rather a considered decision driven by economic factors. For example: Individuals are more likely to remain uninsured when there are more sources of "uncompensated care" available, such as public hospitals or hospitals that have high uncompensated care provision. There is no doubt that most people think about their insurance actions and what they are able to afford (11).

Other critics have worried about the "slippery slope": If Congress can mandate that people purchase health insurance, can it also mandate that people eat broccoli, or drive American cars? But a moment's thought shows that these analogies are specious. The reason to regulate health insurance is because people will use medical care regardless of whether they are insured, and insurance is the only mechanism by which they will be able afford health care. This is not true of food, transportation, or almost any other goods or services in the economy. The individual mandate does not specify the type of medical care that people have to receive, it simply requires them to pay a reasonable amount for the care that they will ultimately use anyway.

In that sense, the individual mandate is about as conservative an idea as there is. Indeed, no less a conservative than former Massachusetts Governor Mitt Romney noted when signing the Massachusetts equivalent of the individual mandate: "Some of my libertarian friends balk at what looks like an individual mandate. But remember, someone has to pay for the health care that must, by law, be provided: Either the individual pays or the taxpayers pay. A free ride on the government is not libertarian" (12).

On this point, we agree with the governor. The individual mandate is a part of fixing the insurance markets so everyone can get care when they need it, at a price they can afford. That is the obligation we owe to ourselves, and it is entirely appropriate for Congress to have enacted that obligation into legislation.

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Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M12-0725.

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References

1. Brief of Amici Curiae Economic Scholars in Support of Petitioners Urging Reversal on the Minimum Coverage Issue, No. 11-398. Accessed at www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs/11-398_petitioner_amcu_econscholar.authcheckdam.pdf on 21 March 2012.

2. **Gruber J.** The Impacts of the Affordable Care Act: How Reasonable Are the Projections? NBER Working Paper 17168. 2011. Accessed at www.nber.org/papers/w17168 on 21 March 2012.

3. Letter to House Speaker Nancy Pelosi. Washington, DC: Congressional Budget Office; 2010.

4. **Gruber J, Rosenbaum S.** Buying health care, the individual mandate, and the Constitution. N Engl J Med. 2010;363:401-3. [PMID:20573918]

5. **Gruber J.** Health Care Reform Without the Individual Mandate. Washington, DC: Center for American Progress; 2011. Accessed at www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf on 21 March 21, 2012.

6. Effects of Eliminating the Individual Mandate to Obtain Health Insurance. Washington, DC: Congressional Budget Office; 2010. Accessed at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/eliminate_individual_mandate_06_16.pdf.

7. Medical Expenditure Panel Survey: Summary Data Tables, Table 1. Rockville, MD: Agency for Healthcare Research and Quality; 2011. Accessed at www.meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp? on 21 March 2012.

8. **Gruber J, Marder WD, Miller K.** Avoiding the medical care system? Not likely. Ann Arbor, MI: Thomson Reuters; 2011. Accessed at http://thomsonreuters.com/content/healthcare/pdf/articles/avoiding_medical_care_system on 21 March 2011.

9. Trends in Health Care Costs and Spending. Washington, DC: Kaiser Family Foundation; 2009. Accessed at www.kff.org/insurance/upload/7692.pdf on 21 March 2012.

10. **Walzer M.** Spheres of Justice: A Defense of Pluralism and Equality. Chapter 3. New York: Basic Books; 1983.

11. **Rask KN, Rask KJ.** Public insurance substituting for private insurance: new evidence regarding public hospitals, uncompensated care funds, and Medicaid. J Health Econ. 2000;13:1-31. [PMID:10947569]

12. **Romney M.** Health care for everyone? We found a way. Wall Street Journal. 11 April 2006; A16. Accessed at http://online.wsj.com/article/SB114472206077422547.html.

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