FREE RIDING ON BENEVOLENCE: COLLECTIVE ACTION FEDERALISM AND THE MINIMUM COVERAGE PROVISION

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I
INTRODUCTION

The Patient Protection and Affordable Care Act (ACA)[1] requires most lawful residents of the United States to maintain a certain level of health insurance coverage (the minimum coverage provision) or pay a certain amount of money each year (the shared responsibility payment).[2] These provisions go into effect on January 1, 2014. Present litigation over the ACA focuses primarily on the constitutionality of these provisions, which are popularly called the "individual mandate" by critics.[3] Those attacking the minimum coverage provision argue, among other things, that it is beyond the scope of Congress's power to regulate interstate commerce because it regulates inactivity (declining to obtain health insurance), as opposed to economic activity. To date, one federal court of appeals (out of three that have decided the merits of the question),[4] as well as three federal district courts (out of six that have decided

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1. Pub. L. No. 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 scattered sections of 42 U.S.C.).

2. The ACA labels this payment a "penalty." ACA, Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 (to be codified at 26 U.S.C. § 5000A).

3. For ease of exposition, this article will now use the term "minimum coverage provision" to refer collectively to the minimum coverage provision and the shared responsibility payment.

4. *Compare* Seven-Sky v. Holder, 661 F.3d 1 (D.C. Cir. 2011) (upholding minimum coverage provision as within the scope of Congress's enumerated powers), *and* Thomas More Law Ctr. v. Obama, 651 F.3d 529 (6th Cir. 2011) (same), *with* Florida *ex rel.* Att'y Gen. v. U.S. Dep't Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011) (invalidating minimum coverage provision as beyond the scope of Congress's enumerated powers).

the merits of the question),[5] have invalidated the minimum coverage provision in part on the ground that it regulates inactivity.[6]

The subject matter regulated by the minimum coverage provision can be characterized as health *insurance* markets. This characterization makes the provision appear to regulate inactivity (not obtaining health insurance). The provision requires individuals either to enter into an insurance contract or to pay money to the federal government each year if they do not. Critics of the provision prefer this characterization.

Alternatively, the subject matter regulated by the minimum coverage provision can be characterized as the interstate health*care* market. Almost all Americans participate in this market in some fashion, and everyone has access to it regardless of ability to pay in the event of an emergency.[7] Each year, uninsured Americans in this market obtain more than $50 billion worth of medical services for which other individuals and institutions must pay.[8] This characterization makes the minimum coverage provision appear to regulate the activities of delivering and receiving healthcare. Defenders of the provision prefer this characterization.[9]

This distinction between inactivity and activity, however, has nothing to do with the limits of congressional power granted in the clauses of Article I, Section 8 of the U.S. Constitution. Instead, as Robert Cooter and I have articulated, the presence or absence of multi-state collective action problems is central to understanding the scope of federal power in the clauses of Section 8.[10]

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5. Goudy-Bachman v. U.S. Dep't of Health & Human Servs., No. 1:10–CV–763, 2011 WL 4072875 (M.D. Pa. Sept. 13, 2011); Florida *ex rel.* Bondi v. U.S. Dep't Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011), *aff'd in part, rev'd in part sub nom.* Florida *ex rel.* Att'y. Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011); Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010), *vacated and remanded for lack of standing*, 656 F.3d 253 (4th Cir. 2011).

6. The United States Court of Appeals for the Fourth Circuit ruled for the federal government on jurisdictional grounds. *See* Liberty Univ., Inc. v. Geithner, No. 10–2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011) (holding that the federal tax Anti-Injunction Act (TAIA) bars the action); Virginia *ex rel.* Cuccinelli v. Sebelius, 656 F.3d 253 (4th Cir. 2011) (holding that Virginia lacks Article III standing to bring the action). Other courts have disagreed with the Fourth Circuit's conclusion that the TAIA bars pre-enforcement challenges to the minimum coverage provision. The Supreme Court's view of the question will determine whether it reaches the merits. For an argument that the TAIA does not bar the present challenges to the minimum coverage provision regardless of whether the ACA exaction for non-insurance is deemed a TAIA "tax," see generally Michael C. Dorf & Neil S. Siegel, *"Early-Bird Special" Indeed!: Why the Tax Anti-Injunction Act Permits the Present Challenges to the Minimum Coverage Provision*, 121 YALE L.J. ONLINE 389 (2012), http://yalelawjournal.org/images/pdfs/1042.pdf.

7. *See infra* notes 175, 176, 177, and accompanying text (discussing federal and state laws guaranteeing emergency access and longstanding charitable practices of hospitals).

8. *See* Brief Amici Curiae of the American Hospital Association et al. in Support of Defendant-Appellant and Reversal at 14, *Sebelius*, 656 F.3d 253 (4th Cir. 2011) (Nos. 11-1057 & 11-1058), 2011 WL 792216 (reporting that the uninsured received $56 billion in uncompensated care in 2008).

9. *See, e.g.*, Brief for Appellant, *Sebelius*, 656 F.3d 253 (4th Cir. 2011) (Nos. 11-1057 & 11-1058), 2011 WL 686279.

10. *See* Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115 (2010). For a similar approach to the commerce power, see generally Jack M. Balkin, *Commerce*, 109 MICH. L. REV. 1 (2010).

These clauses mostly concern collective action problems created by interstate externalities and interstate markets.[11] A prominent example is the Commerce Clause, which empowers Congress to regulate commerce "among the several States" but not commerce that is internal to a state.[12] The theory of collective action federalism distinguishes activities that pose collective action problems for the states from those that do not.

This structural account of Article I, Section 8 draws substantial support from constitutional text, history, and much judicial precedent.[13] For example, the Framers understood collective action problems well; indeed, the pervasiveness of such problems among the states during the Critical Period of the 1780s inspired the Constitutional Convention.[14] This structural approach also flows directly from the relative advantages of the federal and state governments. Much of what the federal government does better than the states is solve collective action problems that the states cannot deal with effectively on their own. According to the theory of collective action federalism, the expanse and limits of congressional power in the clauses of Section 8 turn in significant part on the difference between individual and collective action by states.

In order to address multi-state collective action problems, the Constitution has long been understood to authorize Congress to mandate numerous kinds of private action. Examples include, but are not limited to, federal requirements to file a tax return,[15] respond to the census and do so truthfully,[16] report for jury duty,[17] register for selective service,[18] purchase firearms and gear in anticipation of service in the Militia,[19] turn gold currency in to the government in exchange for paper currency,[20] and surrender one's property to the federal government when it exercises the power of eminent domain pursuant to its use of the Commerce Clause.[21]

The distinction between individual and collective action by states is an appropriate place to look for limits on the commerce power. The distinction between inactivity and activity is not. Like other formal distinctions that have been introduced throughout American history to restrict the Commerce Clause,[22] the inactivity–activity distinction is arbitrary in a critical sense: It does

11. *See* Cooter & Siegel, *supra* note 10, at 144–50.

12. U.S. CONST. art. I, § 8, cl. 3.

13. *See* Cooter & Siegel, *supra* note 10, at 121–24, 144–51, 155–57, 159–80.

14. *Id*. at 121–24.

15. 26 U.S.C. § 6012 (2006) (requiring all individuals, except those with very low incomes, to file a tax return).

16. 13 U.S.C. § 221(a)–(b).

17. 28 U.S.C. § 1866(g).

18. 50 U.S.C. app. § 453.

19. *See infra* note 140 and accompanying text (discussing the Militia Act of 1792).

20. Nortz v. United States, 294 U.S. 317, 328 (1935).

21. For discussion of this example and others, see *infra* Part IV.D.

22. *See, e.g.*, Cooter & Siegel, *supra* note 10, at 118 ("The crisis of the Great Depression ultimately exploded the *Lochner* Court's categorical differentiations between 'manufacturing' and 'commerce,' 'direct' and 'indirect' effects on commerce, goods in the 'flow' of commerce and goods not in the 'flow,'

not speak to the question of why we have a federal government to begin with—it is unresponsive to the question of what the federal government can accomplish better than the states can accomplish by acting on their own.

With respect to the Commerce Clause in particular, two things must be true for federal legislation to fall within its scope. First, the object of congressional regulation must be fairly describable as "economic" in nature. This is a requirement of current law.[23] Second, Congress must have a reasonable basis to believe it is ameliorating a significant problem of collective action that exists "among the several States."[24] This is an interpretation and justification of current law. If Congress has no reasonable basis to believe it is helping to solve a significant collective action problem involving multiple states, then Congress may not invoke its commerce power.[25]

Accordingly, whether Congress is mandating private action is irrelevant to the Commerce Clause inquiry. Congress can mandate private action using its commerce power, just as it can otherwise regulate private action using its commerce power, in order to address an economic problem of collective action among the states—when the states are "separately incompetent," in the language of the Constitutional Convention,[26] to solve the problem on their own because the scope of the problem disrespects state borders. The states are "separately incompetent" when they impose significant costs on one another without paying for them.[27]

The decision whether to obtain health insurance coverage is economic in nature. It is a decision about how to manage substantial financial risk. The economic character of this decision is illustrated by the close analogy to the

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and 'harmful' and 'harmless' goods in commerce.") (footnote omitted).

23. *See, e.g.*, Gonzales v. Raich, 545 U.S. 1 (2005); United States v. Morrison, 529 U.S. 598 (2000); United States v. Lopez, 514 U.S. 549 (1995). For a discussion of the governing doctrine, see *infra* Part IV.C.–D.

24. U.S. CONST. art. I, § 8, cl. 3.

25. A key question for a collective action analysis of federal legislation is the level of judicial scrutiny and thus the degree of judicial deference to congressional judgments about reasonableness. In light of empirical uncertainties, many federal laws would flunk heightened scrutiny. Reasonableness, however, is the appropriate test. Heightened scrutiny in Commerce Clause cases is unheard of in the Court's contemporary federalism jurisprudence. *See* Thomas More Law Ctr. v. Obama, 651 F.3d 529, 564 (6th Cir. 2011) (Sutton, J., concurring in part and delivering the opinion of the court in part) ("The courts do not apply strict scrutiny to commerce clause legislation and require only an 'appropriate' or 'reasonable' 'fit' between means and ends.") (quoting United States v. Comstock, 130 S. Ct. 1949, 1956–57 (2010)).

26. For a discussion, see *infra* note 99 and accompanying text.

27. As Part V makes clear, the phrase "separately incompetent" is a term of art that is best understood in light of the historical circumstances out of which it arose. The phrase does not signify only situations in which it would be impossible for states to achieve an end through individual action. Such a demanding standard would make it difficult to justify many clauses in Article I, Section 8. For example, the colonies declared independence and successfully prosecuted a war of independence without a national government that was empowered to raise and support a military by acting directly on individuals. The states under the Articles of Confederation were similarly situated, yet there was ample reason for the Constitution to give Congress the power to raise and support a military by compelling individual behavior.

financial conduct of business enterprises that "go bare" with respect to a risk and rely on federal bankruptcy protection in the event the risk materializes.[28] Thus, the decisive commerce power question is whether Congress could reasonably conclude that a requirement to obtain health insurance coverage or pay a fee will help to solve one or more significant collective action problems involving multiple states.

The ACA minimum coverage provision is reasonably viewed as ameliorating two significant collective action problems involving multiple states. The first arises when a financially able individual declines to purchase health insurance. Such an individual is able to free ride on the benevolence of others in at least two ways. First, pursuant to federal and state law, as well as the longstanding charitable practices of most hospitals in the United States, others will pay a significant share of the cost of medical treatment rather than let an uninsured person go untreated.[29] Second, even when the uninsured individual does not receive medical care for the time being, he benefits from the existence of the healthcare infrastructure and can rely on its availability in case of emergency. A requirement to obtain health insurance coverage or pay for going without insurance is designed in part to overcome risk-taking in reliance on benevolence.[30]

Moreover, theoretical reasoning and empirical evidence suggest that this free rider problem is interstate in scope—that this collective action problem involving individuals causes a collective action problem for the states. It is interstate in scope because of the operation of many insurance companies in multiple states and the phenomenon of cross-state hospital use.[31]

The minimum coverage provision addresses another collective action problem for the states: guaranteeing access to health insurance while avoiding adverse selection in insurance markets, which occurs when healthy people delay the purchase of health insurance until they become ill. The minimum coverage provision is part of a larger—concededly constitutional—regulation of economic conduct. No one disputes that the commerce power supports the ACA provisions that prohibit insurance companies from denying coverage based on preexisting conditions, canceling insurance absent fraud, charging higher premiums based on medical history, and imposing lifetime limits on benefits.[32] These provisions solve collective action problems for the states by facilitating labor mobility, discouraging the flight of insurance companies from

28. *See infra* notes 160–163, and accompanying text (discussing the practice of "going bare").

29. *See infra* notes 175–177, and accompanying text (discussing federal and state legislation and charitable hospital practices). Of course, not all participants in the interstate healthcare market are fairly described as benevolent. They may merely be complying with the law. The benevolence is embodied in federal and state laws and charitable social practices.

30. This rationale for the minimum coverage provision obviously does not apply to individuals who go without health insurance and pay in full for the cost of their healthcare. In the event of severe injury or illness, however, such costs can bankrupt even wealthy individuals.

31. For a discussion, see *infra* Part V.A.3.

32. 42 U.S.C.A. §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-11, 300gg-12 (West 2011).

states that guarantee access to states that do not, and disincentivizing states from free riding on the more generous healthcare systems of sister states.

These ACA provisions, however, would be much less effective without the minimum coverage provision. Absent the provision, the ACA substantially increases the existing incentive for financially able individuals without insurance to free ride on healthy people with insurance by entering the market only when they expect to require expensive medical care. Insurance companies may not be financially viable if the law limits their ability to control costs but does not prevent such market-timing behavior. The close connection between the minimum coverage provision and the ACA's restrictions on insurers justifies the provision under the interpretation of the Commerce Clause in *United States v. Lopez*[33] and *Gonzales v. Raich*,[34] and under the interpretation of the Necessary and Proper Clause in *McCulloch v. Maryland*[35] and *United States v. Comstock*.[36]

Part II of this article defines a free rider problem as a kind of collective action failure and identifies the two free rider problems to which the ACA responds. Part III discusses the constitutional challenges to the minimum coverage provision, focusing on the decisions of courts that have invalidated the provision. Part IV presents the theory of collective action federalism and explains generally when Congress possesses the authority to mandate private action using its commerce power. Part V applies the theory to the minimum coverage provision.

The Conclusion suggests that the lawfulness of the minimum coverage provision solves what would otherwise be a puzzle created by the terms of the present debate over the constitutionality of healthcare reform. This puzzle is the conceded constitutionality of federal alternatives to the ACA that would displace state regulatory authority and infringe individual liberty to an equal or substantially greater extent. These alternatives include a materially equivalent scheme of taxes and tax credits, and a government-run, single-payer system of national healthcare.

II
THE MINIMUM COVERAGE PROVISION AND TWO FREE RIDER PROBLEMS

A. Free Rider Problems Created by Mandated Access to Private Goods

Positive externalities refer to unpriced benefits. They include "public goods," which are goods or services supplied by the government whose technical characteristics require financing by taxes instead of prices. Public goods are *nonrivalrous*, meaning that one person's enjoyment does not detract from another's. Moreover, public goods are *nonexcludable*, meaning that it is

33. 514 U.S. 549 (1995).
34. 545 U.S. 1 (2005).
35. 17 U.S. (4 Wheat.) 316, 405–07, 421 (1819).
36. 130 S. Ct. 1949, 1956–58 (2010).

infeasible or uneconomical to exclude individuals from enjoying the benefits generated by the goods. A classic example of a public good is national defense.

Private provision of public goods does not work because of free rider problems. When exclusion is infeasible or uneconomical, individuals have an incentive to free ride by not paying for the benefits they receive. When beneficiaries do not pay, private suppliers cannot earn a profit. Thus, the market undersupplies the good or service.[37] The government can solve the free rider problem by collecting taxes to finance public goods, thereby requiring all who benefit from their provision to pay for them.

Public goods may be analogized to, and distinguished from, mandated access to private goods. When the government and private actors mandate access to private goods, they in effect create nonexcludability by law and social practice. Nonexcludability, in turn, creates free rider problems. Once society decides—as a matter of public policy or private charity—not to allow the exclusion of anyone from access to private goods, free rider problems will exist. The free riders are individuals who obtain the private good, such as healthcare, or who benefit from its availability (even if they do not presently obtain it) without obtaining insurance coverage or otherwise paying in full for the care or access they receive. The free rider problem arises whenever the government and private entities require access to private goods.[38]

By mandating access to private goods, society causes the production of positive externalities when selectively excluding certain potential beneficiaries is technically feasible but public policy prohibits doing so. For example, selective exclusion from access to emergency healthcare is technically feasible because emergency rooms could demand payment prior to rendering service. Nonetheless, a government or hospital may decide to require emergency rooms to provide access to anyone who needs it without regard to insurance status or ability to pay.

Mandated access to a private good, however, is not a pure public good. If everyone descends on private providers of the good, at some point the good ceases to be nonrivalrous. The good is nonrivalrous only if it is used by a limited number of people. The solution to the free rider problem, however, is similar. Just as the government can prevent free riding by collecting taxes to finance public goods, so legislation can ameliorate free rider problems associated with mandated access to private goods. The ACA seeks to ameliorate two kinds of free rider problems caused by guaranteed access to private goods.

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37. Market failure provides the conventional economic justification for state supply and regulation of goods. *See, e.g.*, STEPHEN BREYER, REGULATION AND ITS REFORM (1982).

38. *See, e.g.*, CHARLES E. PHELPS, HEALTH ECONOMICS 532 (4th ed. 2010) (observing that "those without insurance act as free riders on a health care system that has built into it (as a 'safety net') many ways of providing health care to persons who 'show up at the door' of health care providers, especially hospitals and most especially emergency rooms").

B. The Affordable Care Act

The ACA is "the biggest expansion of the social safety net in more than four decades, providing greater economic security to millions of poor and working-class families."[39] A major objective of the law is to reduce the number of people living without health insurance in the United States, the only wealthy, industrialized democracy that does not guarantee its citizens basic health insurance coverage.[40] According to the U.S. Census Bureau, around 19% of the nonelderly population, or roughly fifty million people, lacked health insurance in 2009.[41] When he signed the bill into law, President Obama stated that "we have now just enshrined . . . the core principle that everybody should have some basic security when it comes to their health care."[42]

The ACA pursues this aspiration by seeking to achieve near-universal health insurance coverage. The law incentivizes, and helps, most American citizens and other legal residents to obtain adequate and affordable insurance.[43] The Congressional Budget Office projects that the ACA will increase the number of nonelderly individuals who possess insurance by roughly thirty-three million by 2019.[44] If the law operates as intended, around 95% of all legal residents will be insured.[45]

"By significantly reducing the number of the uninsured," Congress found,

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39. THE STAFF OF THE WASHINGTON POST, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL 66–68 (2010) [hereinafter LANDMARK].

40. *See, e.g.*, T.R. REID, THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE 3 (2009) ("All the other countries like us—that is, wealthy, technologically advanced, industrialized democracies—guarantee medical care to anyone who gets sick.").

41. U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 23, Table 8; *see* PHELPS, *supra* note 38, at 531 ("Recent estimates put the number of Americans without insurance at about 47 million in 2006, representing 17% of people under 65. The rate of uninsurance climbs to 30% for the 18- to 24-year-old population.").

42. LANDMARK, *supra* note 39, at 1. For an argument that "universal health insurance is essential for human flourishing," see generally J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. MED. 53 (2007).

43. In various ways, the ACA seeks to ensure that people will be able to afford insurance. First, the law provides tax credits and subsidies to help people buy private insurance in new state-based "exchanges." 42 U.S.C.A. § 18031 (West 2011). Thus Congress created federal tax credits for the premium payments of eligible individuals and families with household income between 133% and 400% of the federal poverty line who purchase coverage through an exchange. 26 U.S.C.A. § 36B(a)–(c) (West 2011). Congress also created subsidies to help cover out-of-pocket expenses like copayments or deductibles for eligible individuals who obtain coverage through an exchange. 42 U.S.C.A. § 18081 (West 2011). Second, Congress expanded eligibility for Medicaid to all individuals with income below 133% of the federal poverty line. *Id.* § 1396a(a)(10)(A)(i)(VIII). Third, Congress created tax incentives for small businesses to buy health insurance for their employees. 26 U.S.C.A. § 45R (West 2011). Finally, Congress prescribed exactions for large employers that do not offer full-time employees adequate coverage if at least one full-time employee receives a tax credit to help with the purchase of coverage in an exchange. *Id.* § 4980H.

44. Letter from Douglas W. Elmendorf to John Boehner, Speaker, U.S. House of Representatives (Feb. 18, 2011), 7–8.

45. LANDMARK, *supra* note 39, at 73.

"the [ACA] . . . will lower health insurance premiums."[46] Congress determined that, in 2008 alone, the "cost of providing uncompensated care to the uninsured was $43,000,000,000."[47] Congress further found that "health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year."[48]

Much research confirms these congressional findings. For example, the American Hospital Association calculated that hospitals furnished more than $39 billion in uncompensated care to the under- or uninsured in 2009.[49] The federal Department of Health and Human Services found that almost 20% of the nearly 120 million emergency department visits in 2006 were made by patients who lacked health insurance.[50] A standard text in the field of health economics reports on "the apparent mechanism for receiving medical care" when individuals without insurance become ill: "Commonly, these people appear either at a hospital clinic or a hospital emergency room, often leading to hospitalization."[51]

In his survey of the research, Mark Hall reports that "almost two-thirds (62.6%) of people who are uninsured at a given point in time had at least one visit to a doctor or emergency room within the prior year," and "virtually all of them (94%) receive some level of medical care at some point."[52] Moreover, "uninsured people pay for only about a third of the overall costs of the services they receive; the rest is paid by government, charity, or cost shifting to insured patients."[53]

Importantly, a significant share of the uninsured population in the United

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46. 42 U.S.C.A. § 18091(a)(2)(F) (West 2011).

47. *Id*.

48. *Id*.

49. AM. HOSP. ASS'N, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET 4 (2010), http://www.aha.org/content/00-10/10uncompensatedcare.pdf. The AHA defines "uncompensated care" as "care provided for which no payment is received . . . delivered in U.S. hospitals." *Id*. at 1. It is the sum of a hospital's "bad debt" and charity care. *Id*. Charity care is care for which a hospital expects no reimbursement. A hospital incurs bad debt when it cannot obtain expected reimbursement. *Id*.

50. U.S. DEP'T OF HEALTH & HUMAN SERVS., NEW DATA SAY UNINSURED ACCOUNT FOR NEARLY ONE-FIFTH OF EMERGENCY ROOM VISITS (July 15, 2009), http://www.ahrq.gov/news/press/pr2009/hhsuninserpr.htm.

51. PHELPS, *supra* note 38, at 532 (noting the findings that "hospital use is relatively insensitive to insurance coverage").

52. Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825, 1832 n.29 (2011) (citations and internal quotation marks omitted).

53. *Id*. (citations omitted); *see, e.g.*, FAMILIES USA, HIDDEN HEALTH TAX: AMERICANS PAY A PREMIUM 2 (2009) (finding that the uninsured in the United States received $116 billion worth of care from hospitals, doctors, and other providers in 2008; that government programs and charities paid for 26% of this care; and that around $42.7 billion was unpaid and thus uncompensated care); Sara Rosenbaum & Jonathan Gruber, *Buying Health Care, the Individual Mandate, and the Constitution*, 363 NEW ENG. J. MED. 401, 402 (2010) ("Far from being passive and noneconomic, the uninsured consume more than $50 billion in uncompensated care, the costs of which are passed through health care institutions to insured Americans. . . . [M]edical expenses not covered by insurance are one of the leading causes of bankruptcy in the United States, and the costs of resolving those bankruptcies are borne throughout the U.S. economy.").

States consists of individuals who are financially able to purchase health insurance. Researchers have estimated that as much as "20 percent of uninsured individuals have the financial means to obtain coverage but forgo it, relying instead on emergency care when they need medical treatment."[54] Although some question the extent to which there is a free rider problem involving uncompensated care,[55] economists have shown that public insurance programs, including uncompensated care reimbursement funds, reduce the purchase of private health insurance. These findings confirm the predictions of theoretical models of individual choice.[56] The import of this "crowding out" effect is that a substantial percentage of uninsured people who consume healthcare without paying for it in full have the financial means to obtain health insurance coverage and would obtain it if cost shifting were impossible.

It is uncertain and disputed how much of the cost shifting problem is attributable to individuals who have the financial means to obtain health insurance coverage. Although it is clear that many individuals who shift costs to others cannot afford to purchase private insurance, it is also clear that many individuals who shift costs to others can afford to purchase private insurance.[57] Moreover, even young and healthy people can be traumatically injured at any moment and can reasonably rely on access to life-saving treatment in case of emergency. In all likelihood, significantly fewer individuals would choose to go without insurance if they knew that they were on their own if they fell gravely ill or were severely injured.

The ACA targets this cost shifting problem with the minimum coverage

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54. Brief for America's Health Insurance Plans as Amicus Curiae in Support of Neither Party at 8–9, Virginia v. Sebelius, 656 F.3d 253 (4th Cir. 2011) (Nos. 11–1057 & 11–1058), 2011 WL 795219 [hereinafter Brief for America's Health Insurance Plans] (reporting that when uninsured individuals require care, "hospitals and other providers charge those who do have coverage higher prices"; that the "higher prices, in turn, translate into increased health insurance premiums for those who purchase insurance coverage"; and that the "insured are ultimately hit with a 'hidden tax' ranging from two to ten percent of private premiums to pay for this uncompensated care") (citations omitted).

55. Douglas A. Kahn & Jeffrey H. Kahn, Commentary, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?*, 109 MICH. L. REV. FIRST IMPRESSIONS 78, 79 (2011).

56. *See generally* Kevin N. Rask & Kimberly J. Rask, *Public Insurance Substituting for Private Insurance: New Evidence Regarding Public Hospitals, Uncompensated Care Funds, and Medicaid*, 19 J. HEALTH ECON. 1 (2000) (finding that the presence or increased generosity of public health insurance programs, whether structured as direct provision of services, as provider subsidies, or as direct insurance, lowered the likelihood of carrying private insurance coverage); *cf.* David Cutler & Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?*, 111 Q.J. ECON. 391 (1996) (finding that Medicaid expansions were associated with a significant transition from private health insurance to being uninsured).

57. *See* Mark A. Hall, *The Factual Bases for Constitutional Challenges to Federal Health Insurance Reform*, 38 N. KY. L. REV. 457, 477 (2011) ("[H]ospital administrators report that they collect only about ten percent of their charges to uninsured patients. This highly-subsidized care is not restricted to uninsured people without means to pay, but includes people well above poverty. Among adults who decline the option to enroll with employer-sponsored insurance, public sources and uncompensated care cover 72% of total costs.") (internal quotation marks and citations omitted); Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. HEALTH ECON. 225–52 (2005) (finding that individuals above 300% of the federal poverty level on average paid for only about one-half of the care they received).

provision. The provision requires nonexempted individuals to maintain a minimum level of health insurance coverage or pay a yearly fee.[58] This exaction is inapplicable to people who need not file a federal income tax return because their household incomes are too low, to people whose premium payments would be greater than 8% of their household income, to individuals who are uninsured for short periods of time, to members of Native American tribes, and to people who show that compliance with the requirement would impose a hardship.[59] The minimum coverage provision seeks to ameliorate the cost shifting that occurs when individuals who have the financial means to purchase insurance consume healthcare without insurance and do not pay in full, thereby free riding on other participants in the health insurance and healthcare markets.[60]

The minimum coverage provision also seeks to address a second kind of free rider problem: adverse selection (or self-selection) in insurance markets.[61] The problem arises, even absent mandated access to healthcare, because people know more about their own health status than insurance companies do. Before the ACA, health insurance companies had managed the costs borne by existing policyholders through an actuarial process known as underwriting.[62] Specifically, insurance companies assessed the health status of each applicant for insurance; predicted the likely medical costs associated with different health statuses; and either offered coverage to certain individuals, declined to offer coverage to certain individuals, or offered coverage subject to various exceptions and limitations. These underwriting practices ameliorated the adverse-selection problem but did not eliminate it because of the information asymmetry between insurers and potential insureds.

The ACA exacerbates the adverse-selection problem by changing the way in which private health insurance markets operate. The ACA requires insurers to provide and renew coverage to anyone who wants coverage and pays the premium.[63] The law prohibits insurers from denying coverage based on preexisting conditions, charging higher premiums based on an individual's medical history, canceling insurance absent fraud, and imposing lifetime limits

58. 26 U.S.C.A. § 5000A (West 2011). The minimum coverage provision goes into effect on January 1, 2014. It applies to U.S. citizens and legal residents. It does not apply to undocumented aliens, people in prison, and people with certain religious objections.

59. *Id.* § 5000A(e). In 2014, the annual exaction for non-insurance will be the greater of $95 or 1% of income. By 2016, the annual exaction will be the greater of $695 or 2.5% of income. *Id.* § 5000A(c).

60. It is important to distinguish between individuals who have the financial ability to purchase health insurance and individuals who do not. People who cannot afford to buy coverage still shift costs, but as noted in the text, the ACA's exaction for going without insurance does not apply to them. Moreover, they are not fairly described as *choosing* not to purchase insurance, nor are they fairly criticized for free riding on the contributions of others to collective action.

61. *See, e.g.*, PHELPS, *supra* note 38, at 318–19. For an empirical analysis of the welfare costs of the adverse selection problem in health insurance markets, see generally David M. Cutler & Sarah J. Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q.J. ECON. 433 (1998).

62. *See* 42 U.S.C.A. § 18091(a)(2)(J) (West 2011).

63. *Id.* §§ 300gg-1, 300gg-2.

on benefits.[64]

These insurance practices encourage individuals to purchase insurance before they require extensive care. Because the ACA eliminates them, insurers will instead set premiums based on the average expected costs generated by an insurance company's entire risk pool. Other things being equal, this change would render participation in the pool relatively more attractive to older, sicker individuals and less attractive to younger, healthier people. Costs would rise for individuals who have insurance and individuals without insurance would have even more incentive to remain uninsured until they become ill. The result would be even more cost shifting to other actors in the interstate healthcare market.

Once the law forbids insurers from denying coverage to sick applicants, a person who does not buy insurance until he is already sick free rides on people who buy insurance while they are still healthy. Indeed, the very concept of insuring against a risk unravels when "insurance" may be purchased after the risk has already materialized. The minimum coverage provision seeks to make it economically feasible for insurers to comply with the ACA's changes in the methods used by insurers to spread risk and price premiums. By requiring almost everyone to obtain health insurance coverage or pay a yearly fee, the provision reduces the incentive to remain uninsured until one becomes ill. Congress found that the insurance "requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs."[65]

III
THE CHALLENGES TO THE MINIMUM COVERAGE PROVISION

Although the ACA contains many provisions, the numerous constitutional challenges to the statute focus primarily on the minimum coverage provision.[66] A key question that is emerging is whether the provision is supported by the Commerce Clause[67]—either alone or in combination with the Necessary and Proper Clause.[68]

64. *Id.* §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-11, 300gg-12.

65. *Id.* § 18091(a)(2)(J).

66. Additional questions include whether the TAIA (*see supra* note 6) bars pre-enforcement challenges to the exaction for going without insurance; whether any state plaintiff has standing to sue; whether the minimum coverage provision is severable from the rest of the ACA; whether it is unconstitutionally coercive under *South Dakota v. Dole*, 483 U.S. 203 (1987), for Congress to condition all existing federal Medicaid funding on the states' acceptance of new expansions to the Medicaid program; whether Congress has authority under the Commerce Clause to mandate that employers offer employees a certain level of health insurance coverage or pay a penalty; and whether the mandate violates principles of religious freedom protected by the Free Exercise Clause, the Establishment Clause, the Fifth Amendment's Due Process Clause, or the Religious Freedom Restoration Act. In addition to the constitutionality of the minimum coverage provision, the Supreme Court has granted certiorari on the TAIA question, the severability question, and the Medicaid expansion.

67. U.S. CONST. art. I, § 8, cl. 3.

68. *Id.* at cl. 18.

To date, no federal court has upheld the minimum coverage provision as within the scope of Congress's tax power.[69] By contrast, the federal courts presently disagree about whether the provision is justified by the Commerce Clause. So far, three federal district courts and two federal courts of appeals have rejected commerce power challenges to the provision.[70] Three other federal district courts and one federal court of appeals have held that the provision is beyond the scope of the Commerce Clause.[71] The latter district courts reasoned that Congress may regulate only economic activity using its commerce power and that the provision regulates inactivity—specifically, the failure to purchase health insurance. The United States Court of Appeals for the Eleventh Circuit reasoned similarly in invalidating the minimum coverage provision.[72]

In *Virginia v. Sebelius*,[73] which involved a constitutional challenge to the ACA brought by the Commonwealth of Virginia, the district court read the Supreme Court's commerce power decisions as directing first that "the subject matter must be economic in nature and affect interstate commerce, and second, it must involve activity."[74] The court observed that "[e]very application of Commerce Clause power found to be constitutionally sound by the Supreme Court involved some sort of action, transaction, or deed placed in motion by an

69. *But cf.* Liberty Univ., Inc. v. Geithner, No. 10–2347, 2011 WL 3962915, at *16 (4th Cir. Sept. 8, 2011) (Wynn, J., concurring) ("[W]ere I to reach the merits, I would uphold the constitutionality of the Affordable Care Act on the basis that Congress had the authority to enact the individual and employer mandates under its plenary taxing power."). For an argument that the ACA exaction for non-insurance is materially equivalent to a tax, see Robert D. Cooter & Neil S. Siegel, *Not the Power to Destroy: A Theory of the Tax Power for a Court that Limits the Commerce Power*, 99 VA. L. REV. (forthcoming 2013). Commentators dispute whether the General Welfare Clause supports the minimum coverage provision. *Compare, e.g.*, Randy E. Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional*, 5 N.Y.U. J.L. & LIBERTY 581, 607–14 (2010) (arguing that the minimum coverage provision is beyond the scope of the tax power), *with, e.g.*, Brief of Constitutional Law Professors as Amici Curiae in Support of Defendants-Appellees, *Liberty Univ.*, No. 10–2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011) (arguing that the tax power authorizes the minimum coverage provision), *and* Brian Galle, *Conditional Taxation and the Constitutionality of Health Care Reform*, 120 YALE L.J. ONLINE 27 (2010), http://yalelawjournal.org/images/pdfs/889.pdf.

70. *See* Thomas More Law Ctr. v. Obama, 651 F.3d 529 (6th Cir. 2011); Seven-Sky v. Holder, 661 F.3d 1 (D.C. Cir. 2011); Mead v. Holder, 766 F. Supp. 2d 16 (D.D.C. 2011); Liberty Univ. v. Geithner, 753 F. Supp. 2d 611 (W.D. Va. 2010); Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010).

71. Florida *ex rel.* Att'y Gen. v. U.S. Dep't Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011); Florida *ex rel.* Bondi v. U.S. Dep't Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011); Goudy-Bachman v. U.S. Dep't of Health & Human Servs., No. 1:10–CV–763, 2011 WL 4072875 (M.D. Pa. Sept. 13, 2011); Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010).

72. Notwithstanding the emphasis of these courts on the coerciveness of the minimum coverage provision in their commerce power analyses, *Lochner*-style substantive due process challenges to the provision are not surviving motions to dismiss. *See, e.g.*, Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120, 1161–62 (N.D. Fla. 2010). The Supreme Court has not held that a statute violates freedom from contract since the constitutional crisis of 1937. *Compare, e.g.*, Lochner v. New York, 198 U.S. 45 (1905), *with* W. Coast Hotel Co. v. Parish, 300 U.S. 379, 391 (1937).

73. 728 F. Supp. 2d 768 (E.D. Va. 2010).

74. *Id.* at 781.

individual or legal entity."[75] Reasoning from this premise, it stated that the "constitutional viability of the Minimum Essential Coverage Provision in this case turns on whether or not a person's decision to refuse to purchase health care insurance is such an activity."[76] The court concluded that such a decision is not activity because neither the Supreme Court nor any federal court of appeals "has extended Commerce Clause powers to compel an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market."[77] It was particularly concerned that a rationale "requiring advance purchase of insurance based on a future contingency" would also "apply to transportation, housing, or nutritional decisions," and thus "lacks logical limitation."[78]

Similarly, in *Florida v. U.S. Department of Health & Human Services*,[79] a case involving a constitutional challenge to the ACA brought by the attorneys general of twenty states and the governors of six more, the district court concluded that "[i]t would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause."[80] According to the court, if Congress "has the power to compel an otherwise passive individual into a commercial transaction with a third party," then "it is not hyperbolizing to suggest that Congress could do almost anything it wanted."[81] The court raised the specter of Congress's "mandating that every adult purchase and consume wheat bread daily, rationalized on the grounds that because everyone must participate in the market for food, non-consumers of wheat bread adversely affect prices in the wheat market."[82] "Congress could," it asserted, "require that people buy and consume broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because people who eat healthier tend to be healthier, and are thus more productive and put less of a strain on the health care system."[83] According to the court, "[t]o now hold that Congress may regulate the so-called 'economic decision' to *not* purchase a product or service in anticipation of *future* consumption is a 'bridge too far.' It is without logical limitation and far exceeds the existing legal boundaries established by Supreme Court precedent."[84]

The United States Court of Appeals for the Eleventh Circuit, in partially affirming the judgment of the Florida district court,[85] purported not to rely on

75. *Id*.
76. *Id*.
77. *Id*. at 782.
78. *Id*. at 781.
79. 780 F. Supp. 2d 1256 (N.D. Fla. 2011).
80. *Id*. at 1286.
81. *Id*.
82. *Id*. at 1289.
83. *Id*.
84. *Id*. at 1294–95.
85. The Eleventh Circuit rejected the district court's conclusion that the minimum coverage

the plaintiffs' and the district court's distinction between inactivity and activity.[86] The distinction, however, did the decisive work in the court's analysis. For example, after stating that "[i]t is immaterial whether we perceive Congress to be regulating inactivity or a financial decision to forego insurance," the court insisted that "[u]nder any framing, the regulated conduct is defined by the *absence* of both commerce or even the 'the production, distribution, and consumption of commodities'—the broad definition of economics in *Raich*."[87] In passages such as this one, the court of appeals avoided characterizing the minimum coverage provision as a regulation of "inactivity" only by recasting it as a regulation of "noncommerce." But the court viewed the provision as regulating the absence of commerce only because individuals subject to it are (allegedly) *not active* in the stream of commerce.[88] The court seemed to change the terminology, not the analysis.[89]

As explained in Part V.A.2, it is far from clear that the financial decision to go without insurance is properly characterized as "inactivity" for purposes of analysis under the Commerce Clause and the Necessary and Proper Clause. Nonetheless, the ACA litigation to date invites examination of whether it matters how such conduct is characterized. I turn now to the constitutional relevance of the distinction between inactivity and activity. I begin by introducing the theory of collective action federalism.

IV
THE THEORY OF COLLECTIVE ACTION FEDERALISM

A. History

The Commerce Clause authorizes Congress to regulate "Commerce . . . among the several States."[90] It is the third clause of Article I, Section 8. The Framers wrote Section 8 in order to address several collective action problems facing the United States during the Critical Period of the 1780s.[91] They

provision was not severable from the balance of the ACA. Florida *ex rel.* Att'y Gen. v. U.S. Dep't Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011).

86. *Id*. at 1285 ("Whereas the parties and many commentators have focused on this distinction between activity and inactivity, we find it useful only to a point. . . . [W]e are not persuaded that the formalistic dichotomy of activity and inactivity provides a workable or persuasive enough answer in this case.").

87. *Id*. at 1293 (quoting Gonzales v. Raich, 545 U.S. 1, 25 (2005)).

88. The court defined "[t]he question before us" as "whether Congress may regulate individuals outside the stream of commerce, on the theory that those 'economic and financial decisions' to avoid commerce *themselves* substantially affect interstate commerce." *Florida ex rel. Att'y Gen*., 648 F.3d at 1292.

89. *Accord* Goudy-Bachman v. U.S. Dep't of Health & Human Servs., No. 1:10–CV–763, 2011 WL 4072875, at *14 (M.D. Pa. Sept. 13, 2011) ("To date, all exercises of Commerce Clause authority have proscribed or prescribed activity by individuals *already engaged* in commerce who are active in the relevant interstate market.").

90. U.S. CONST. art. I, § 8, cl. 3.

91. For a discussion, see Larry D. Kramer, *Madison's Audience*, 112 HARV. L. REV. 611, 616–23 (1999).

especially wanted to protect the states from commercial warfare against one another and from military warfare by foreigners. In the Critical Period, the states acted individually when they needed to act collectively, discriminating against interstate commerce and free riding on the contributions of other states to the federal treasury and the American military.[92] Moreover, Congress lacked power under the Articles of Confederation to address these problems.[93]

James Madison saw the collective action problems in his *Vices of the Political System of the United States*,[94] a memorandum he wrote while preparing for the Constitutional Convention.[95] Recording various problems with the Articles of Confederation,[96] Madison underscored "want of concert in matters where common interest requires it," a "defect . . . strongly illustrated in the state of our commercial affairs. How much has the national dignity, interest, and revenue suffered from this cause?"[97] When activities spilled over from one state to another, Madison and other nationalist Framers recognized that the actions of individually rational states produced irrational results for the nation. This is one kind of collective action problem. The solution lay with the establishment of a more comprehensive unit of government. The federal government would require the authority to tax, regulate interstate and international commerce, raise and support a military, and act directly on individuals.

The delegates at the Philadelphia Convention, in considering the scope of congressional power that would become Section 8, focused on collective action problems for the states.[98] The Convention instructed the midsummer Committee of Detail that Congress have authority "to legislate in all Cases for the general Interests of the Union, and also in those Cases to which the States are separately incompetent, or in which the Harmony of the United States may be interrupted by the Exercise of individual Legislation."[99] This language apprehends the need to address collective action problems facing the states.[100] Significantly, when the Committee of Detail made its report ten days later, "[i]t

92. *See, e.g.*, Cooter & Siegel, *supra* note 10, at 121–24.

93. *See, e.g.*, JACK N. RAKOVE, ORIGINAL MEANINGS: POLITICS AND IDEAS IN THE MAKING OF THE CONSTITUTION 24–28, 47–48, 102–08, 167–68, 188–89 (1996) (discussing various failures of the Articles of Confederation). Almost all of the first thirty-six essays in *The Federalist* detail the inadequacies of the Articles.

94. James Madison, *Vices of the Political System of the United States*, *in* JAMES MADISON: WRITINGS 69, 78–79 (Jack N. Rakove ed., 1999).

95. *See* RAKOVE, *supra* note 93, at 46.

96. Madison, *supra* note 94, at 69–73.

97. *Id*. at 71.

98. As Akhil Amar explains, "Federal power over genuinely interstate and international affairs lay at the heart of the plan approved by the Philadelphia delegates." AKHIL REED AMAR, AMERICA'S CONSTITUTION: A BIOGRAPHY 108 (2005).

99. 2 THE RECORDS OF THE FEDERAL CONVENTION OF 1787, at 131–32 (Max Farrand ed., rev. ed. 1966).

100. It is not clear how each part of the quoted language fits with the other parts. Donald Regan explains that "[t]he Framers themselves were unclear about the precise reach and interrelations of the various clauses." Donald H. Regan, *How to Think About the Federal Commerce Power and Incidentally Rewrite* United States v. Lopez, 94 MICH. L. REV. 554, 570 n.70 (1995).

had changed the indefinite language of Resolution VI into an enumeration of the powers of Congress closely resembling Article I, Section 8 of the Constitution as it was finally adopted."[101]

The Committee's "radical change" was uncontroversial among the delegates; the Convention "accepted *without discussion* the enumeration of powers made by a committee which had been directed . . . that the Federal Government was 'to legislate in all cases for the general interests of the Union . . . and in those to which the states are separately incompetent.'"[102] The delegates apparently grasped the link between the general principles stated in Resolution VI and the specific powers conferred in Article I, Section 8. As numerous scholars have concluded, the Committee was embracing—not rejecting—the Resolution's concern about multi-state collective action problems when it provided an enumeration.[103]

Robert Cooter and I have observed that the eighteen clauses of Section 8 mostly concern collective action problems created by two kinds of spillovers: interstate externalities and national markets.[104] Clauses 1 and 10 through 16 give Congress the power to internalize the externalities associated with providing for the common defense, establishing a postal network, and securing intellectual property rights.[105] Clauses 3 through 6 give Congress the power to combat various impediments to the successful operation of interstate markets.[106]

B. Theory

The theory of collective action federalism draws from this history, from this evidence in the constitutional text, from subsequent historical understandings and mistakes, and from economics to provide a structural account of the American federal system established in part by Article I, Section 8. The various clauses of Section 8 form a coherent set—not a heterogeneous collection of unrelated powers. Coherence comes from the connection that the specific powers have to collective action problems that the federal government can address more effectively than the states can address by acting alone.

The states often cannot achieve an end when doing so requires multiple

101. Robert L. Stern, *That Commerce Which Concerns More States Than One*, 47 HARV. L. REV. 1335, 1340 (1934).

102. *Id.*

103. *See, e.g.*, Balkin, *supra* note 10, at 11 ("[T]here is no evidence that the convention rejected the structural principle stated in Resolution VI at any point during its proceedings. Indeed, this principle was the *animating purpose* of the list of enumerated powers that appeared in the final draft . . . .") (emphasis added); Regan, *supra* note 100, at 556 ("[T]here is no reason to think the Committee of Detail was rejecting the spirit of the Resolution when they replaced it with an enumeration."); Stern, *supra* note 101, at 1340 ("If the Convention had thought that the committee's enumeration was a departure from the general standard for the division of powers to which it had thrice agreed, there can be little doubt that the subject would have been thoroughly debated on the Convention floor.").

104. *See* Cooter & Siegel, *supra* note 10, at 144–50 (analyzing the eighteen clauses of Article I, Section 8).

105. *Id*. at 147–49.

106. *Id*. at 149–50.

states to cooperate—that is, when doing so requires collective action. For example, collective action may be required in "race to the bottom" situations, when the states generally share the same objective but individually have insufficient incentives to take steps to achieve it. In this circumstance, the rational self-interest of individual states is misaligned with the collective interest of the states as a whole. Individual states may have poor incentives to act either because they can instead free ride on the contributions of other states to collective action, or because they anticipate that sister states will free ride on their own contributions to collective action.[107]

Although a race to the bottom is an important kind of collective action problem that justifies federal regulation, it is not the only one. Limiting collective action problems to races to the bottom would have radical implications for the constitutional scope of federal power. For example, collective action by the states may be required when one state or group of states imposes external costs on other states, such as by generating pollution that crosses states lines. In such a situation, the state producing the pollution and the states being polluted may not share the objective of reducing pollution. On the contrary, people in states such as Texas and California often have different views on the appropriate tradeoff between economic development and environmental protection.[108] Even so, internalizing an interstate pollution externality requires *collective action* among the affected states, which justifies federal intervention.[109]

Similarly, consider a historical example of enormous significance.[110] Racial discrimination in America during the second half of the twentieth century caused a collective action problem for the states. In the 1960s, this collective action problem was not the fact that southern states wanted to abandon

107. *See, e.g.*, Steward Mach. Co. v. Davis, 301 U.S. 548, 588 (1937) (placing special emphasis on a race to the bottom among the states in upholding the federal unemployment compensation system created by the Social Security Act).

108. Moreover, a state may not suffer the effects of pollution it creates. *See, e.g.*, JAMES SALZMAN & BARTON H. THOMPSON, JR., ENVIRONMENTAL LAW AND POLICY 22 (3d ed. 2010) (using the example of acid rain to illustrate that "[a]ir pollution, water pollution, and wildlife certainly pay no heed to state . . . borders, with the result that often the generator of the pollution is politically distinct from those harmed"); *see also* Press Release, N.Y. State Att'y Gen., Northeast States Press for Clean Air (Jan. 8, 2002), *available at* http://www.ag.ny.gov/media_center/2002/jan/jan08a_02.html (last visited Jan. 19, 2012) (quoting Rhode Island Attorney General Sheldon Whitehouse's statement that "outdated coal-fired electric plants in the Midwest make cheap power for Midwestern corporations, and prevailing winds blow their pollution onto us," and that "ozone pollution from the Midwest is so bad that even if we stopped all our in-state emissions entirely, we would still fail federal ozone standards in Rhode Island").

109. For a lucid explanation of why spillover effects justify federal regulation, see generally Richard Revesz, *Federalism and Interstate Environmental Externalities*, 144 U. PA. L. REV. 2341 (1996); *see also* Cooter & Siegel, *supra* note 10, at 172–75 (articulating a collective action rationale for federal regulation of interstate environmental externalities).

110. *See* Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964) (upholding Title II of the Civil Rights Act of 1964, which prohibited racial discrimination by places of public accommodation); Katzenbach v. McClung, 379 U.S. 294 (1964) (upholding Title II's application to a small, family-owned restaurant).

discrimination but had insufficient incentive to do so on an individual basis. No doubt most (white) voters in southern states had no desire to abandon discrimination. But the fact that some states practiced racial discrimination created a significant burden on commerce with those states that did not practice discrimination, impeding both interstate mobility and the optimal allocation of resources across state lines.[111] A remedy to this interstate externality required collective action by the states.[112] Accordingly, the theory of collective action federalism provides a justification for federal power over discrimination affecting interstate commerce.[113]

Whether the cause of a problem requiring collective action is a race to the bottom or an interstate spillover effect, the theory of collective action federalism concludes that the clauses of Section 8 empower Congress to solve the problem because it predictably frustrates the states. In the language of the Commerce Clause, such a problem is "among the several States." Conversely, a problem that does not require collective action by the states is internal to a state or local. Thus the foundation of federalism in Section 8 flows from the relative advantages of the federal government and the states. The theory of collective action federalism reads the clauses of Section 8 as giving the federal and state governments the power to do what each does best.[114]

The distinction between individual and collective action by states gives independent, sensible meaning to the phrase "among the several States" in the Commerce Clause. According to the theory of collective action federalism, the phrase "among the several States" references a collective action problem involving at least two states.[115] This is the key inquiry in determining whether

111. The briefing on the federal government's side in *Heart of Atlanta* stressed the interstate externalities caused by racial discrimination in certain states. *See generally, e.g.*, Brief for State of California as Amicus Curiae Supporting Appellee, Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964) (No. 515), 1964 WL 81384.

112. *Accord* Balkin, *supra* note 10, at 7 ("Properly understood, the commerce power authorizes Congress to regulate problems or activities that produce spillover effects between states or generate collective action problems that concern more than one state."). Whereas Balkin identifies spillover effects and collective action problems as separate categories that both fall within the scope of federal commerce power, I identify spillover effects as causing a collective action problem, which justifies federal commerce power. The result is the same.

113. Of course, the moral and historical bases for civil rights legislation lie elsewhere, which may call into question the restrictions that the Supreme Court has imposed on the enforcement clauses of the Civil War Amendments.

114. As Donald Regan has written, "[W]hen we are trying to decide whether some federal law or program can be justified under the commerce power, we should ask ourselves the question, 'Is there some reason the federal government must be able to do this, some reason why we cannot leave the matter to the states?'" Regan, *supra* note 100, at 555; *see also* Ann Althouse, *Enforcing Federalism After* United States v. Lopez, 38 ARIZ. L. REV. 793, 817 (1996) ("We should begin a reconstruction of Commerce Clause jurisprudence that looks deeply into why it is good for some matters to be governed by a uniform federal standard, why it is good for some things to remain under the control of the various states, and what effect these choices will have on the federal courts."). *See* Stephen G. Calabresi & Nicholas K. Terrell, *The Number of States and the Economics of American Federalism*, 63 FLA. L. REV. 1, 6 (2011) ("The most compelling argument in American history for empowering our national government has been the need to overcome collective action problems.").

115. Notably, Chief Justice Marshall wrote in *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 194 (1824),

"Commerce,"[116] understood under current law in terms of the Court's economic–noneconomic categorization, is interstate and thus regulable under the Commerce Clause or else is intrastate and thus beyond the scope of the commerce power.[117] Even if the economic–noneconomic categorization can suffice as a rough definition of "Commerce," it cannot define when such commerce is "among the several States" and when it is internal to one state.

From a collective action perspective, it makes little sense to conclude that only the states may address a particular problem even though the states are "separately incompetent" to handle the problem.[118] This was a fatal flaw of the *Lochner* Court's federalism jurisprudence, which rejected the idea that "the power of the federal government inherently extends to purposes affecting the nation as a whole with which the states severally cannot deal or cannot adequately deal."[119] To the *Lochner* Court, it was of little relevance to the proper scope of congressional power in Section 8 that "[t]here are many subjects in respect of which the several states have not legislated in harmony with one another, and in which their varying laws and the failure of some of them to act at all have resulted in injurious confusion and embarrassment."[120] The *Lochner* Court's federalism jurisprudence was not just bad political theory or economics. As explained by the theory of collective action federalism, it was bad constitutional law in light of a principal purpose of the clauses of Section 8: to authorize Congress to solve collective action problems facing states.

C. Doctrine

The distinction between problems that require collective action by the states and those that do not best explains why Congress may not usually use its commerce power to regulate such crimes as assault or gun possession in schools but may regulate an interstate market for guns, wheat, or drugs. In other words, the theory of collective action federalism offers a way to distinguish the "truly national" from the "truly local" in the context of the Commerce Clause,[121] justifying the outcomes in *Wickard v. Filburn*,[122] *United States v. Lopez*,[123] *United*

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that the Commerce Clause authorizes Congress to regulate "that commerce which concerns more States than one."

116. U.S. CONST. art. I, § 8, cl. 3.

117. Collective action federalism is a theory of what Section 8 means, not a theory of how vigorously the federal courts should review what Congress has purported to do using its Section 8 powers. The theory to date does not include an account of judicial deference or nondeference. *See* Cooter & Siegel, *supra* note 10, at 154.

118. 2 THE RECORDS OF THE FEDERAL CONVENTION OF 1787, *supra* note 99, at 131–32.

119. Carter v. Carter Coal Co., 298 U.S. 238, 291 (1936) ("The proposition . . . that the power of the federal government inherently extends to purposes affecting the Nation as a whole with which the states severally cannot deal or cannot adequately deal . . . ha[s] never been accepted but always definitely rejected by this court."); *see* Hammer v. Dagenhart, 247 U.S. 251, 273 (1918) ("There is no power vested in Congress to require the states to exercise their police power so as to prevent possible unfair competition.").

120. *Carter Coal Co*., 298 U.S. at 292.

121. United States v. Morrison, 529 U.S. 598, 617–18 (2000).

122. 317 U.S. 111 (1942).

States v. Morrison,[124] and *Gonzales v. Raich*.[125]

The Court offered collective action problems as a reason to uphold federal laws in many of the Commerce Clause cases decided from 1937 until the 1990s.[126] So, too, the Rehnquist Court implicitly considered collective action problems in determining the constitutionality of congressional regulation. Chief Justice Rehnquist wrote in *Lopez* that the Gun-Free School Zones Act "is not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated."[127] This statement suggests that the absence of regulation of guns near schools in one state would not undercut the effectiveness of regulations prohibiting them in other states. Justice Kennedy wrote that if a state or local government "determines that harsh criminal sanctions are necessary and wise to deter students from carrying guns on school premises, the reserved powers of the States are *sufficient* to enact those measures. Indeed, over forty states already have criminal laws outlawing the possession of firearms on or near school grounds."[128]

In *Lopez*, there was no significant spillover of welfare across state lines that caused a collective action problem. *Raich*, by contrast, did involve a potential spillover problem. Because marijuana used for medicinal purposes is indistinguishable from marijuana used for other purposes, and because the market for marijuana disrespects state borders, California's authorization of marijuana use for medicinal purposes might make it more difficult for other states to enforce their bans on marijuana use. If there is no spillover problem, states should be permitted to go their own way from the perspective of constitutional federalism (as opposed to individual rights).[129] But a spillover provides a rationale for federal intervention.

The Supreme Court also employed collective action reasoning in a recent decision construing the Necessary and Proper Clause.[130] The issue in *United*

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123. 514 U.S. 549 (1995).

124. 529 U.S. 598 (2000).

125. 545 U.S. 1 (2005).

126. *See* Cooter & Siegel, *supra* note 10, at 159–62 (discussing collective action reasoning in numerous Commerce Clause decisions decided between 1937 and 1995, including *United States v. Darby*, 312 U.S. 100 (1941), *Wickard v. Filburn*, 317 U.S. 111 (1942), *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964), *Katzenbach v. McClung*, 379 U.S. 294 (1964), and *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264 (1981)).

127. *Lopez*, 514 U.S. at 561.

128. *Id*. at 581 (Kennedy, J., concurring) (emphasis added); *see* Regan, *supra* note 100, at 566 (reading this part of Justice Kennedy's opinion from a collective action perspective).

129. A collective action approach does *not* explain the proper scope of federal powers authorized by the enforcement clauses of the Civil War Amendments. U.S. CONST

States v. Comstock[131] was whether Congress has the power under Article I, Section 8 to authorize the Attorney General of the United States to civilly commit mentally ill, sexually dangerous federal prisoners after the completion of their federal sentences if no state will accept custody of them. The Court held 7–2 that Congress has such authority under the Necessary and Proper Clause, relying in part on the fact that the case implicated a collective action problem involving multiple states.

The Court recognized the "NIMBY" problem ("not in my backyard"). After the sentence of a sexually dangerous prisoner has expired, the federal government might release him for civil commitment in any number of states, including the state where he had been tried or the state where he is presently housed. A state that agrees to assume custody of the prisoner must pay all the financial costs associated with indefinite civil commitment while other states potentially enjoy all the benefits from committing the individual, who might otherwise move out of state. If not committed, he might move out of state upon release in part because the federal government had severed the prisoner's ties to the state by incarcerating him for a long time. Rather than dwell on the fact that the federal government helped to create the problem that it now sought to solve, the Court underscored evidence that states often refuse to assume custody, potentially hoping to free ride on some other state's decision to do so.[132] Both the Court and Justices Kennedy and Alito, who concurred in the judgment, stressed the relationship between the federal statute at issue and a multi-state collective action problem, which the federal government is better situated to address than the states.[133]

D. Mandates

The clauses of Article I, Section 8 extend federal legislative authority to collective action problems involving multiple states. It is constitutionally irrelevant whether federal regulation takes the form of an "individual mandate"

131. 130 S. Ct. 1949, 1961–62 (2010).

132. *Id.* at 1959 (quoting a 1945 Judicial Conference report finding that "[s]tates would not accept an 'appreciable number' of 'mental[ly] incompetent' individuals 'nearing expiration' of their prison terms, because of their 'lack of legal residence in any State,' even though those individuals 'ought not . . . be at large because they constitute a menace to public safety'"); *id.* at 1961 ("Congress could . . . have reasonably concluded (as detailed in the Judicial Conference's report) that a reasonable number of such individuals would likely *not* be detained by the States if released from federal custody, in part because the Federal Government itself severed their claim to legal residence in any State by incarcerating them in remote federal prisons.") (quotation marks omitted).

133. Justice Kennedy emphasized that "Federal prisoners often lack a single home State to take charge of them due to their lengthy prison stays, so it is incumbent on the National Government to act." *Id.* at 1968 (Kennedy, J., concurring in judgment). Similarly, Justice Alito underscored the statute's recognition "that, in many cases, no State will assume the heavy financial burden of civilly committing a dangerous federal prisoner who, as a result of lengthy federal incarceration, no longer has any substantial ties to any State." *Id.* at 1969 (Alito, J., concurring in judgment); *see id.* at 1970 ("These federal prisoners, having been held for years in a federal prison, often had few ties to any State; it was a matter of speculation where they would choose to go upon release; and accordingly no State was enthusiastic about volunteering to shoulder the burden of civil commitment.").

or some other form. Section 8 has long been understood to authorize Congress to mandate various actions by private individuals. Examples include requiring people to file a tax return,[134] respond to the census and do so truthfully,[135] register for selective service,[136] respond to a congressional subpoena,[137] and report for jury duty.[138]

Similarly, Section 8 grants Congress the power to impose a variety of other "individual mandates" in order to secure collective action. According to venerable constitutional understandings, Congress may require individuals to aid in civilian law enforcement, including enforcement of commerce power regulations;[139] to purchase firearms and related gear in anticipation of service in the Militia;[140] to turn gold currency in to the government in exchange for paper currency;[141] and even to surrender their property,[142] thereby removing obstructions to congressional regulation (or federal construction) of the channels and instrumentalities of interstate commerce.[143]

As a coherent response to numerous collective action problems, the clauses of Section 8 authorize Congress to compel action when using the grants of

134. 26 U.S.C. § 6012.

135. 13 U.S.C. § 221(a)–(b).

136. 50 U.S.C. app § 453.

137. McGrain v. Daugherty, 273 U.S. 135 (1927).

138. 28 U.S.C. § 1866(g).

139. Hall, *supra* note 52, at 1855 (discussing THE FEDERALIST NO. 29 (Hamilton) and a provision of the Judiciary Act of 1789). *See* 28 U.S.C. § 566(c) ("[T]he United States Marshals Service . . . shall command all necessary assistance to execute its duties."). "This section is but the latest version of the authority first contained in § 27 of the Judiciary Act of 1789, which itself merely reflected the common law rule that the sheriff had the power to summon the posse comitatus and that the citizen had the duty to participate if called upon." Special Deputations of Private Citizens Providing Security to a Former Cabinet Member, 7 Op. O.L.C. 67, 69 (1983) (quoting the statement in *In re Quarles*, 158 U.S. 532, 535 (1895), that "[i]t is the right, as well as the duty, of every citizen, when called upon by the proper officer, to act as part of the posse comitatus in upholding the laws of his country"); *see also* Federal Bureau of Investigation—Statutory Jurisdiction—Authority of Agents Concerning Non-Federal Offenses, 2 Op. O.L.C. 47, 50 (1978) ("At common law, a constable or sheriff had a right to summon bystanders to aid him in apprehending a felon, and those summoned were obliged to respond. This rule retains some vitality today . . . .") (citation omitted); John Lenoir, *The U.S. Marshals' Posse: A Model for the 21st Century*, 55 FED. LAWYER, Aug. 2008, at 34, 34–35 (observing that "Marshals' authority to specially deputize a posse is derived from 28 USC § 566(c)"). The Marshals Service has long declined to require the assistance of private individuals due to concerns about the reliability of people who do not want the job. Conversation with Gerald Auerbach, Gen. Counsel, U.S. Marshals Serv. (May 2, 2011). Mr. Auerbach has been at the U.S.M.S. since 1973.

140. Hall, *supra* note 52, at 1855–56 (discussing the Militia Act of 1792, which required "every free able-bodied white male citizen" between the ages of 18 and 45 to obtain at his own expense "a good musket or firelock, a sufficient bayonet and belt, two spare flints, and a knapsack, a pouch, with a box therein to contain not less than twenty four cartridges").

141. *Id*. at 1858 (quoting Nortz v. United States, 294 U.S. 317, 328 (1935)).

142. Without the power of eminent domain, the government—whether federal, state, or local—might be unable to solve the holdout problem. For a discussion, see Cooter & Siegel, *supra* note 10, at 139–44.

143. Hall, *supra* note 52, at 1856 (observing that the Court has upheld congressional use of the eminent domain power "as a necessary and proper adjunct to the Commerce Clause, when used, for instance, to mandate the transfer of land for bridges, highways, or canals") (citations omitted).

power in the enumerated list, including the commerce power. There is no basis for treating the Commerce Clause differently from other Section 8 powers. As Chief Justice Marshall explained for the Court in *Gibbons v. Ogden*,[144] the commerce power is "the power to regulate; that is, to prescribe the rule by which commerce is to be governed."[145] Marshall, like the constitutional text he was construing, did not distinguish rule prescriptions that prohibit or permit action from rule prescriptions that compel action.[146] According to the Marshall Court, "the power over commerce . . . among the several States, is vested in Congress as absolutely as it would be in a single government."[147] Just as states may compel commercial action if they respect constitutional limits, so Congress may compel commercial action to address problems "among the several States" if Congress respects independent limits on its authority.

Moreover, it seems ad hoc to diminish the pertinence of the above authorizations to issue individual mandates by labeling them fundamental duties of citizenship.[148] The Constitution does not identify them as such or distinguish them on this ground; instead, the Constitution intermingles its licensing of federal taxation and military power with its authorization of federal regulation of other subjects that similarly implicate multi-state collective action problems. Nor is it evident why, *from a federalism perspective*, Congress should be empowered to overcome collective action problems facing the states by compelling activity with respect to fundamental duties of citizenship but not with respect to other serious societal problems that the states are unable to address effectively on their own.

An illuminating example concerns the control of communicable diseases. Imagine that, in order to prevent the spread of a deadly disease across state lines, the federal government wanted to require individuals in affected areas to get vaccinated. In light of potentially large spillover effects impinging on the general welfare, Congress should have the power to mandate vaccination under Article I, Section 8 without first deciding whether vaccination qualifies as a fundamental duty of citizenship.[149] Moreover, there is little doubt that the

144. 22 U.S. (9 Wheat.) 1 (1824).

145. *Id*. at 196.

146. As the father of two young children, I am required to regulate their behavior. I execute this responsibility by prohibiting them from doing certain things (for example, running in a parking lot), by permitting them to do certain things (for example, having a play date), and by requiring them to do certain things (for example, brushing their teeth and flossing). The requiremetns are no less regulatory than the permissions or prohibitions.

147. *Id*. at 197.

148. *See* Barnett, *supra* note 69, at 630 (arguing that the duties to "register for the draft and serve if called, sit on a jury, fill out a census form, and file a tax return" are not "imposed via Congress's power to regulate economic behavior," but instead "have traditionally been considered fundamental duties that each person owes to the government by virtue of American citizenship or residency").

149. *Cf.* 42 U.S.C. § 264(a) (2006) (authorizing the Secretary of Health and Human Services to make and enforce regulations necessary "to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession"). For a discussion of this federal quarantine statute and related measures, see generally KATHLEEN S. SWENDIMAN & JENNIFER K. ELSEA, CONG. RESEARCH

Supreme Court would uphold such congressional power, presumably under the Commerce Clause.[150] The rationale for allowing federal regulation of this interstate externality under Section 8 is clear and powerful.[151]

The above conclusions of collective action federalism are consistent with the Supreme Court's use of the phrase "economic activity" in its contemporary Commerce Clause jurisprudence. The Court in *Lopez*, *Morrison*, and *Raich* used the phrase "economic activity" to describe typical objects of congressional regulation, such as the subject matter at issue in those three cases. The Court did not impose an actus reus requirement in commerce power litigation that ruled out omission regulability.[152] Indeed, *Lopez* and *Raich* reaffirmed *Wickard*, which upheld a federal regulatory scheme that effectively required farmers to purchase wheat in the interstate market.[153] The *Wickard* Court stated that "stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon."[154]

In *Wickard*, *Lopez*, *Morrison*, and *Raich*, the Court focused decisively on the object of federal regulation to assess (1) whether it is fairly describable as "economic" in nature, and, in effect, (2) whether Congress reasonably could have determined that there is a collective action problem impeding federal regulation of interstate markets. Having "committed itself to sustaining federal

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SERV., RL 33201, FEDERAL AND STATE QUARANTINE AND ISOLATION AUTHORITY (2007), *available at* http://www.fas.org/sgp/crs/misc/RL33201.pdf

150. *Cf.* SWENDIMAN & ELSEA, *supra* note 149, at 4 ("Federal quarantine authority derives from the Commerce Clause . . . ."). *See* Transcript of Oral Argument at 21–22, 30, United States v. Comstock, 130 S. Ct. 1939 (2010) (No. 08–1224):

> GENERAL KAGAN: [S]uppose that there was some very contagious form of drug-resistant tuberculosis that had—had become prevalent in the prison system, and States were not able to deal with that, with quarantining these people upon their release date, and Congress said: You know, the best thing to do is to have the Federal Government act as the appropriate quarantining authority because we don't think that States are able to step up and deal with this problem.
>
> Would anybody say that the Federal Government would not have Article I power to effect that kind of public safety measure? . . .
>
> JUSTICE KENNEDY: Well, when I was thinking about your hypothetical, I thought, well, that's a pretty easy commerce power argument. . . .
>
> JUSTICE SCALIA: We—we have a Federal agency that's—that deals with communicable diseases. It's part of the National Institute of Health, I believe. Is that agency ultra vires? I mean, aren't communicable—I mean, if anything relates to interstate commerce, it's communicable diseases, it seems to me.

151. For an (unorthodox) argument that the General Welfare Clause might justify federal regulation in this circumstance, see Cooter & Siegel, *supra* note 10, at 178–79.

152. *See supra* Part III (discussing two district court opinions that have in effect imposed such a requirement).

153. Wickard v. Filburn, 317 U.S. 111, 129 (1942) (noting that farmers were "forc[ed] . . . into the market to buy what they could provide for themselves"); *id*. at 128–29 (concluding that "Congress may properly have considered that wheat consumed on the farm where grown if wholly outside the scheme of regulation would have a substantial effect in defeating and obstructing its purpose to stimulate trade therein at increased prices").

154. *Id*. at 128.

legislation on broad principles of economic practicality,"[155] and underscoring "the importance of a practical conception of the commerce power,"[156] the Court concluded in essence (albeit not explicitly) that Congress reasonably could have found such collective action problems in *Wickard* and *Raich*, but not in *Lopez* and *Morrison*.[157]

V
THE CONSTITUTIONALITY OF THE MINIMUM COVERAGE PROVISION

A. The Commerce Clause Solution to Cost Shifting

Part I of this article introduced the free rider problem of uncompensated care targeted by the ACA's minimum coverage provision. This free rider problem causes a collective action problem for the states. In light of the economic nature and interstate scope of this collective action problem, the Commerce Clause justifies the minimum coverage provision.

1. Noneconomic v. Economic

In order for congressional regulation to be valid under the Commerce Clause in cases allegedly involving substantial effects on interstate commerce, Supreme Court precedent requires the object of the regulation to be "commercial" or "economic" in nature.[158] The decision whether to purchase health insurance is "economic" in nature. Because the need for people to access healthcare services is inevitable, unpredictable, and potentially very costly,[159] the decision whether to obtain health insurance is a decision about how to manage substantial financial risk. Financially able individuals who decline to purchase health insurance are making the economic decision to "go bare" with respect to the risk of serious injury or illness.

There is a close analogy between the conduct of financially able individuals who decline to purchase health insurance and the decision to "go bare" in a business insurance setting.[160] "Going bare" is a colloquial term in insurance law used to describe the conduct of a business enterprise that chooses to be uninsured, or severely underinsured, regarding a risk. For example, a physician may decide to go bare rather than pay the high cost of a medical malpractice

155. United States v. Lopez, 514 U.S. 549, 571 (Kennedy, J., concurring).

156. *Id*. at 572.

157. *See* Cooter & Siegel, *supra* note 10, at 162–65 (analyzing the cases from a collective action perspective).

158. *See, e.g.*, Gonzales v. Raich, 545 U.S. 1 (2005) (stressing the economic–noneconomic distinction); United States v. Morrison, 529 U.S. 598 (2000) (same); United States v. Lopez, 514 U.S. 549 (1995) (same).

159. *See, e.g.*, Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 358 (2006) (considering "the essential features of health care delivery that distinguish its legal issues from those of other related fields," and identifying as one of them "the *high cost* of care and *wide variability* of need, which necessitate public or private insurance that fundamentally alters medical economics") (emphasis added).

160. I thank my colleague Jonathan Wiener for informing me of the practice of "going bare."

insurance policy.[161]

An individual or enterprise that goes bare is understood to be making the economic decision to self-insure, relying either on personal financial resources or on the protections afforded by federal bankruptcy law in the event the risk materializes.[162] Businesses that go bare are often viewed as engaging in a course of conduct that entails potentially high economic risk to themselves and others.[163] If bankruptcy results, the costs associated with this financial risk will have to be paid by creditors.

2. Inactivity v. Activity

Critics of the minimum coverage provision emphasize that it regulates inactivity. According to these critics, the Supreme Court held in *Lopez*, *Morrison*, and *Raich* that Congress may regulate only "economic activity" using its commerce power.[164] It follows, they reason, that Congress may not regulate inactivity using the Commerce Clause. To reiterate the Florida district court's holding, "It would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause."[165]

A key premise of critics of the minimum coverage provision is that constitutional analysis should focus on health *insurance* markets, not the health*care* market.[166] If one focuses on health insurance markets, then the provision may seem to "regulate inactivity" or "compel an otherwise passive individual into a commercial transaction with a third party."[167] Individuals subject to the provision may be characterized as inactive in the sense that they do not presently participate in a health insurance market. The provision may be described as a regulation of inactivity in the sense that it requires such individuals to obtain health insurance coverage or pay a fee each year.

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161. *See, e.g.*, Brian S. Kern, *The Naked Truth Behind Going Bare* (Jan. 31, 2011), http://mymedicalmalpracticeinsurance.com/news/?p=1442 ("Have you considered 'going bare'—or without medical liability insurance?") (sidenote).

162. Rosie Cisneros, *Malpractice Insurance Costs and Going Bare*, LODMELL & LODMELL (June 8, 2007, 11:39 AM), http://www.lodmell.com/malpractice-insurance-cost-going-bare ("Malpractice costs have become so expensive that more and more physicians are seeking alternatives wherever they can find them. Some are so angry and frustrated by soaring insurance premiums that they are going 'bare,' foregoing costly insurance—relying instead, in some cases, on the threat of bankruptcy to bail them out of any hefty patient claims. This is a risky choice, indeed.").

163. *Id*. ("Going 'bare,' especially when it comes to medical malpractice insurance, has never seemed advisable."); Kern, *supra* note 161 ("At first glance, it might seem appealing: you would save a lot of money by not having to pay liability insurance premiums and you are a far less attractive malpractice target, as your pockets (and your practice's) are significantly less deep than your insurance company's pockets. But, upon closer look, it is almost never worth it.") (sidenote).

164. *See, e.g.*, United States v. Morrison, 529 U.S. 598, 613 (2000) ("Gender-motivated crimes of violence are not, in any sense of the phrase, economic activity."); United States v. Lopez, 514 U.S. 549, 567 (1995) ("[P]ossession of a gun in a local school zone is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce.").

165. Florida *ex rel.* Bondi v. U.S. Dep't Health & Human Servs., 780 F. Supp. 2d 1256, 1286 (N.D. Fla. 2011).

166. *See* Brief Amici Curiae of the American Hospital Association, *supra* note 8.

167. *Florida ex rel. Bondi*, 780 F. Supp. 2d at 1286.

Defenders of the minimum coverage provision object to the relatively narrow level of abstraction at which opponents characterize the object of congressional regulation. Defenders argue that Congress and the President were concerned about the health*care* market when they enacted the ACA.[168] Defenders observe that almost all Americans participate in this market.[169] Millions of individuals without health insurance—a significant percentage of whom can afford to purchase insurance—obtain billions of dollars' worth of healthcare services each year and do not pay for them, shifting the costs to other participants in the healthcare market, including the federal and state governments.[170] Defenders insist that consuming goods or services without paying is economic activity and that the minimum coverage provision seeks to regulate this activity.

The above arguments of critics and defenders of the minimum coverage provision share the premise that it matters whether Congress is regulating inactivity, as opposed to activity, in relying on its commerce power. This premise is mistaken. The theory of collective action federalism explains why the distinction between inactivity and activity has nothing to do with the limits of the commerce power.

3. Individual v. Collective Action

There appears to be a broad legal consensus that no constitutionally protected rights are at stake in the litigation over the minimum coverage provision. Notwithstanding the rhetorical emphasis of opponents of the ACA on themes of individual liberty and freedom from coercion,[171] most do not raise economic substantive due process objections to the minimum coverage provision, and those who do are rebuffed by otherwise sympathetic judges.[172] An implication of this consensus is that government at some level may require individuals to obtain health insurance coverage. The question is which level.

The constitutional answer ought to turn on which level of government is best situated to address the free rider problem of uncompensated care that an insurance requirement is designed in part to alleviate. As explained in Part II, collective action problems include the free rider problems that unavoidably result once a society mandates access to healthcare in a medical emergency. Anyone can be grievously injured or fall ill at any moment; such injury or illness

168. *See* 42 U.S.C.A. § 18091(a)(2)(A) (West 2011) (finding that the minimum coverage requirement regulates "economic and financial decisions about how and when health care is paid for").

169. *See, e.g.*, Wendy K. Mariner & George J. Annas, *Health Insurance Politics in Federal Court*, 363 NEW ENG. J. MED. 1300, 1301 (2010) ("There are few nondiscretionary national markets in which virtually all Americans inevitably participate.").

170. *See supra* notes 47–53 and accompanying text (documenting these facts).

171. For discussions, see generally Jedediah Purdy & Neil S. Siegel, *The Liberty of Free Riders: The Minimum Coverage Provision, Mill's "Harm Principle," and American Social* Morality, 38 AM. J.L. & MED. (forthcoming 2012); Bryan Leitch, *Where Law Meets Politics: Freedom of Contract, Federalism, and the Fight over Health Care*, 27 J.L. & POL. 177 (2011).

172. *See* Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120, 1161–62 (N.D. Fla. 2010).

can be ruinous financially,[173] and almost all who are ill or grievously injured will end up at emergency rooms where they will expect to receive treatment regardless of whether they are insured.[174] This is because the national political community is committed to providing stabilizing care for such people regardless of their ability to pay or insurance status. Federal law requires hospitals that participate in Medicare and offer emergency services—that is, almost all hospitals in the United States—to provide stabilizing care to patients who enter their emergency rooms while experiencing medical emergencies regardless of their ability to pay.[175] This collective commitment is further reflected in state legislation and tort law,[176] as well as in the longstanding mission of most hospitals in America to provide care to individuals who are unable to pay fully or at all.[177]

When financially able individuals decline to purchase health insurance and then consume healthcare without paying in full, they free ride on benevolence.[178] Free riding on benevolence can occur when people fail to insure against harm or reduce its probability and magnitude. The materialization of a risk generates claims by an unprepared victim on the benevolence of society, which is embodied in statutes and charitable social practices.[179] People who have the means to purchase health insurance but decline may end up free riding on the federal and state governments, healthcare providers, insured individuals, or taxpayers. These participants in the healthcare system will pay much of the cost

173. *See* 42 U.S.C.A. § 18091(a)(2)(G) (West 2011) ("[Sixty-two] percent of all personal bankruptcies are caused in part by medical expenses.").

174. *See, e.g.*, Brief Amici Curiae of Economics Scholars in Support of Appellant, Virginia v. Sebelius, 656 F.3d 253 (4th Cir. 2011) (Nos. 11-1057 & 11-1058) ("[T]he health care market is characterized by five unique factors—the unavoidable need for medical care; the unpredictability of such need; the high cost of care; the inability of providers to refuse to provide care in emergency situations; and the very significant cost-shifting that underlies the way medical care is paid for in this country—which do not obtain in other markets.").

175. Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986, 42 U.S.C. § 1395dd (2006).

176. *See, e.g.*, Brief for Appellant at 42, *Sebelius*, 656 F.3d 253 (Nos. 11–1057 & 11–1058) (discussing state tort liability for failure to provide emergency care).

177. *See, e.g.*, CHARLES ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM 347 (1995) (observing that "the hospital never assumed the guise of rational and rationalized economic actor during the first three-quarters of the twentieth century"; it "continued into the twentieth century, as it had begun in the eighteenth, to be clothed with public interest in a way that challenged categorical distinctions between public and private"; and "[p]rivate hospitals had always been assumed to serve the community at large—treating the needy"); *id*. at 352 (seeing "little prospect of hospitals in general becoming monolithic cost minimizers and profit maximizers," and predicting that American society "will feel uncomfortable with a medical system that does not provide a plausible (if not exactly equal) level of care to the poor and socially isolated").

178. *Cf.* PHELPS, *supra* note 38, at 533 (noting that a solution to the free rider problem "of course, is to eliminate all laws requiring hospitals (and others) to treat those in need but without the means to pay for care, but our society appears unwilling to do this"; that "[u]nder current arrangements, hospitals (and others) must provide this care, and its costs are built into the prices charged to all paying customers"; and that "[c]reating universal insurance solves this problem because every citizen thereby is insured automatically, eliminating the free ride").

179. I thank Robert Cooter for his help in developing the concept of free riding on benevolence.

of medical treatment rather than let uninsured individuals—the beneficiaries of benevolence—go untreated.[180]

The law can diminish free riding. To overcome risk taking in reliance on the benevolence of others, the law can require imprudent people to purchase health insurance.[181] Free riding on benevolence provides a reason for action by government at some level.[182]

To determine which level, the key constitutional question, as explained in Part IV, is whether the states are well situated to diminish free riding on benevolence by acting alone. The decisive inquiry, in other words, is captured by the distinction between individual and collective action by states, not the distinction between inactivity and activity. Free riders may be inactive in a market for the time being, but this inactivity itself may be a serious problem—not a reason why Congress is powerless to offer a particularly effective solution. Using its commerce power, Congress may offer such a solution if the external costs imposed by free riders spill across state borders, thereby generating a collective action problem for the states.

When the external costs imposed by free riders spill across state borders, one state is necessarily free riding on the benevolence of another state. There are two collective action problems at play: (1) a collective action problem involving individuals that disrespects state borders, and (2) a collective action problem involving states. These collective action problems are related. The collective action problem involving individuals *causes* the collective action problem involving states. For example, an uninsured individual in State A may go to State B for medical care, either temporarily or permanently, because the publicly financed care options in State A are less available or less generous. In this situation, the uninsured individual in State A is free riding on insured individuals in State B, *and* State A is free riding on State B by not providing public benefits sufficient to prevent an exodus of its own residents to State B. The same is true of many other interstate movements.

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180. Free riding by beneficiaries causes a second kind of free riding on benevolence—a race to the bottom among potential benefactors. This race occurs when people shift claims on their benevolence to others. For example, a wealthy individual who declines to contribute to medical care for the indigent free rides on the benevolence of others who will pay so that the poor receive care. This race to the bottom suggests that the demand for benevolence often will exceed the supply, resulting in too little benevolence. *See, e.g.*, FAMILIES USA, *supra* note 53, at 4 ("We know that uninsured people often do not receive health care when they need it.").

181. To overcome attempts to shift the burdens of charity to others, the law can make everyone who is financially able contribute to helping others, such as by financing healthcare for the poor through a tax on income. Medicaid, for instance, avoids this race to the bottom.

182. EMTALA might be viewed as a way in which Congress is bootstrapping its way into a collective action problem. Free riding on benevolence results not only from the failure of financially able individuals to obtain health insurance coverage but also from a federal statutory requirement to treat them. Part of the answer to this bootstrapping objection is that valid federal legislation provides a permissible baseline against which Congress may use its Section 8 powers. *See infra* notes 266, 267, 270–272, and accompanying text (analyzing this issue). Another part of the answer is that EMTALA reflects a pervasive and longstanding commitment of American society, *see, e.g.*, *supra* note 177, so that it is inaccurate to view Congress as determining the constitutional scope of its own authority.

Thus, whether the minimum coverage provision is within the scope of the Commerce Clause turns on whether a collective action problem exists "among the several States"[183] or instead is internal to each state. Two pieces of evidence suggest that the free rider problem of uncompensated care—free riding on benevolence—exists among the states generally.

First, it is well known that many insurance companies operate in multiple states.[184] It likely follows that the scope of the problem of free riding on benevolence transcends state borders. When uninsured individuals obtain care without paying, the actors to whom they shift costs include providers, who raise their prices, and insurance companies, which raise the insurance premiums that individuals and families must pay.[185] Because many of these insurance companies operate in multiple states, this cost shifting likely disrespects state boundaries.[186]

To be sure, even in the post-ACA world, insurance pools and the regulation of insurance remain substantially state specific.[187] States could impose regulations that prohibit multi-state insurers from shifting costs from out of state to their residents.[188] Even so, the effects of cost shifting are unlikely to be state-contained. The overall capital reserves of insurance companies constitute a larger pool that undergirds all their market segments. Thus, just as market investments can hurt the overall financial health of insurers, so can poor loss ratios in one state hurt the ability of insurers to remain in more marginal markets in other states. Poor loss ratios in a particular state may stretch the overall reserves of insurance companies.[189] Accordingly, the problem of uncompensated care in State A likely affects the premiums paid by individuals and families in State B when the same insurance company offers policies in both states.[190]

Second, free riding on benevolence likely shifts costs across state lines because of interstate migration. It is empirically uncertain how frequently different state healthcare regimes cause interstate migrations of individuals on a

183. U.S. CONST. art. I, § 8, cl. 3.

184. *See infra* note 205 and accompanying text (documenting this fact).

185. *See supra* notes 47–53, 170, and accompanying text (documenting these facts).

186. *Cf.* Balkin, *supra* note 10, at 30 (reading the phrase "among the several states" in the Commerce Clause so that "Congress can regulate interactions that extend in their *operation* beyond the bounds of a particular state") (emphasis added).

187. In useful conversations, Abigail Moncrieff has pressed the argument to which I respond in the text.

188. For example, a state could decline to approve premiums that are higher than necessary to cover their own residents.

189. E-mail from Mark A. Hall, Professor of Law & Pub. Health, Wake Forest Univ. (Oct. 12, 2011) (on file with author).

190. *Cf.* United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 541 (1944) (observing that insurance involves "a continuous and indivisible stream of intercourse among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts").

permanent basis.[191] It is well documented, however, that residents of one state often move interstate temporarily to access needed medical care. For example, residents of southwestern Pennsylvania make more than 1,500 emergency room visits each year to a teaching hospital in West Virginia—the West Virginia University Hospital.[192] Similarly, Harborview Medical Center in Seattle, which is run by the University of Washington, constitutes the only Level 1 Trauma Center for a region of the country that includes Washington, Alaska, Montana, and Idaho.[193] "Uninsured individuals who suffer catastrophic injuries from accidents and other unpredictable events are transported to Harborview for the care it can uniquely provide. In 2009, Harborview cared for 12,028 patients from states in the region outside of Washington."[194] Likewise, healthcare providers in the nation's capital, which "has made a heroic effort to insure all residents, treat thousands of residents from Maryland and Virginia, whose public insurance programs are far less generous."[195] It would be useful if future research could produce comprehensive data on cross-state hospital use in the United States. It would also be useful to know how many Americans live close to an interstate border.[196]

The Supreme Court, in a famous "right to travel" case, recognized that different state healthcare regimes might encourage individuals to move interstate. In *Memorial Hospital v. Maricopa County*,[197] the Court addressed a county's concern that providing free medical care to indigents would encourage individuals from out of state to relocate to the county. The Court rejected this rationale for a one-year residency requirement, declaring a violation of the

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191. Andrew Koppelman cites a possible example:

> [T]he heavy burdens borne by Tennessee's health care system may be related to the fact that its most populous city, Memphis, is bordered by Mississippi and Arkansas, which offer much lower benefits. TennCare insurers are also concerned that patients from other states may be establishing residency in Tennessee in order to obtain coverage for organ transplants.

Andrew Koppelman, *Bad News for Mail Robbers: The Obvious Constitutionality of Health Care Reform*, 121 YALE L.J. ONLINE 1, 16–17 (2011), http://yalelawjournal.org/images/pdfs/981.pdf (citing, *inter alia*, WILLIAM M. MERCER INC., EVALUATION OF CRITICAL ISSUES FACING THE TENNCARE PROGRAM—REPORT 9 (1999)). This report wondered "if providers in these bordering states are encouraging patients to relocate to Tennessee in order to access TennCare." *Id.*

192. Amicus Brief on Behalf of the Governors of Washington, Colorado, Michigan, and Pennsylvania in Support of Defendants' Motion for Summary Judgment at 9, Florida v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011) (No. 3:10–cv–91–RV/EMT).

193. *Id.*

194. *Id.*

195. Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, NEW ENG. J. MED., (Feb. 25, 2010), http://www.nejm.org/doi/full/10.1056/NEJMp1001439.

196. True, states end up bearing some of the costs when their residents access healthcare in other states for which they do not pay. For example, when a New Hampshire resident cannot pay off a large debt to a Massachusetts hospital, the resident may have to declare bankruptcy, and many of the costs associated with bankruptcy will stay in New Hampshire. But this just means that New Hampshire's free riding is not entirely free. New Hampshire is still paying less than the full cost of the conduct of its resident because the hospital's uncompensated costs stay in Massachusetts. Moreover, many of the resident's creditors may not be in New Hampshire.

197. 415 U.S. 250 (1974).

fundamental right to travel. Notably, however, the Court did not dispute the factual premise of interstate migration. Instead, the Court seemed to accept its validity but deemed it constitutionally irrelevant to the scope of the individual right at issue.[198] "An indigent who considers the quality of public hospital facilities in entering the State," the Court wrote, "is no less deserving than one who moves into the State in order to take advantage of its better educational facilities."[199] Thus the Court in 1974 took seriously the concern that people may migrate to obtain better healthcare. In view of advancements in technology, communication, and transportation over the past thirty-eight years, it is more likely that such interstate migrations occur today. Moreover, the right to travel would prohibit states from preventing individuals from moving into the state and taking advantage of its more generous healthcare benefits.

B. The Commerce–Sweeping Clause Solution to Adverse Selection

Just as the minimum coverage provision responds to the two free rider problems identified in Part II (cost shifting and adverse selection), so there are at least two sources of congressional power in Article I, Section 8 that support the provision.[200] In addition to being within the scope of the commerce power standing alone, the minimum coverage provision is independently justified by the Commerce Clause in combination with the Necessary and Proper Clause (also called the Sweeping Clause).[201] There is a straightforward argument that the provision is necessary and proper for carrying into execution the ACA's commerce power regulations of the health insurance industry, thereby ameliorating the adverse-selection problem that undermines health insurance markets.

No one disputes that the commerce power supports the ACA provisions that prohibit insurance companies from denying coverage based on preexisting conditions, canceling insurance, discriminating based on medical history, and imposing lifetime benefit limits.[202] The Court has long held that Congress may use the Commerce Clause to regulate insurance markets. "Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business," wrote the Court in 1944.[203] "This business," the Court continued, "is not separated into forty-eight distinct territorial compartments which function in isolation from each other. Interrelationship,

198. *Id*. at 263–67.

199. *Id*. at 264.

200. This article does not address whether the tax power, U.S. CONST. art. I, § 8, cl. 1, independently justifies the minimum coverage provision. For an affirmative answer, see generally Cooter & Siegel, *supra* note 69.

201. U.S. CONST. art. I, § 8, cl. 18.

202. 42 U.S.C.A. §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-11, 300gg-12 (West 2011).

203. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 540 (1944) ("Insurance touches the home, the family, and the occupation or the business of almost every person in the United States."); *see also* 42 U.S.C.A. § 18091(a)(3) (West 2011) (citing *South-Eastern Underwriters Ass'n* as authority for the proposition that "insurance is interstate commerce subject to Federal regulation").

interdependence, and integration of activities in all states in which they operate are practical aspects of the insurance companies' methods of doing business."[204]

The theory of collective action federalism endorses this doctrinal conclusion because different state regulations of insurance companies can cause collective action problems. The theoretical rationale for this proposition begins with the reality of a robust interstate healthcare market in a nation consisting of demilitarized borders among the states. Insurance companies are mobile (meaning they can pull up stakes) and often conduct business in several or many states.[205] Private healthcare providers are also potentially mobile, as are many unhealthy and healthy individuals. The combination of open interstate borders and potentially mobile participants in the healthcare market means that the states are likely to get in one another's way—they are likely to impose significant costs on one another without paying for them—when one or more states enact healthcare reforms on their own, including by guaranteeing access to health insurance and imposing a minimum coverage provision to combat free riding within their jurisdictions.

Imagine, for example, that a state (call it M) imposes a minimum coverage provision and prohibits insurance companies from denying individuals coverage based on preexisting medical conditions. In addition, imagine that State M helps residents to obtain insurance through a series of tax credits and subsidies, and through a requirement that private employers provide a certain level of healthcare to their employees.

Now consider what will likely happen. Because most states today allow health insurance companies to deny coverage or charge higher premiums based on preexisting conditions,[206] some number of unhealthy individuals are likely to move into State M.[207] Moreover, some number of healthy individuals may move out and relocate in medically underwritten states, especially if they work in industries that employ younger, highly skilled labor such as the computer industry. (The number of people moving interstate likely will depend in part on

204. *South-Eastern Underwriters Ass'n*, 322 U.S. at 541.

205. *See* § 42 U.S.C.A. § 18091(a)(2)(B) (West 2011) ("[M]ost health insurance is sold by national or regional health insurance companies . . . ."); Hall, *supra* note 52, at 1845 ("[T]he insurance markets in many states are dominated by insurers owned by large national firms.") (citations omitted); *see, e.g.*, *Aetna*, MAPS OF WORLD, http://finance.mapsofworld.com/company/aetna.html ("Aetna [Health Insurance] operates in all 50 states . . . .").

206. DEP'T OF HEALTH & HUMAN SERVS., COVERAGE DENIED: HOW THE CURRENT HEALTH INSURANCE SYSTEM LEAVES MILLIONS BEHIND 1 (2009) ("In 45 states across the country, insurance companies can discriminate against people based on their pre-existing conditions when they try to purchase health insurance directly from insurance companies in the individual insurance market. Insurers can deny them coverage, charge higher premiums, and/or refuse to cover that particular medical condition."); *id*. ("A recent national survey estimated that 12.6 million non-elderly adults—36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market—were in fact discriminated against because of a pre-existing condition in the previous three years.").

207. Although sick entrants will have to obtain health insurance coverage and pay premiums, they will still be free riding on individuals who obtained coverage when they were healthy. The premiums that sick entrants pay will be lower than the cost of care they will require.

the size of the exaction imposed by State M for going without insurance.) In addition, some number of insurers in State M will likely move to states that do not prohibit coverage denials based on preexisting conditions.[208]

Now consider the likely effects on individual workers and firms. Residents of State M with health problems may find it difficult to relocate to states that offer less generous healthcare benefits, even to pursue better work opportunities. Healthy residents of other states may be disinclined to relocate to State M if doing so means having to purchase health insurance or pay a fee. Out-of-state firms may be disinclined to move to State M if doing so will raise the cost of their healthcare obligations to employees.

All of these interstate movements (or immobility) are not mere interstate effects. They are spillover effects (interstate externalities) because they impose unpriced costs or benefits on the residents (or treasuries) of different states. For instance, when sick individuals migrate to State M just because State M prohibits insurance companies from denying coverage based on preexisting conditions, more financial pressure is placed on State M's healthcare system. The risk pool is now occupied by higher-cost insureds; insurance premiums likely will rise for everyone already in the system; the exaction for going without insurance may have to increase to induce more healthy people to enter the risk pool; and state taxes may need to increase, either to subsidize the acquisition of healthcare for those who cannot afford to buy insurance or to pay the costs of emergency care for uninsured individuals. The states from which the sick migrants come do not pay for any of the costs imposed on State M as a result of the migration,[209] even though the existence of comparatively less attractive healthcare regimes in these states caused the migration.[210]

The interstate scope of the collective action problem might be more obvious if, say, the State of Florida attempted to run the scheme described above and northern states determined that they could reduce budgetary pressures by paying their indigent senior citizens to relocate in Florida. "The existence of such a system" would become "a bait to the needy and dependent elsewhere,

208. *See* Rosenbaum, *supra* note 195 ("Even if individual states are willing to intervene, insurers are free to evade state regulation simply by pulling up stakes in any jurisdiction with an unappealing political and regulatory climate.").

209. *See, e.g.*, Brian Galle, *The Taxing Power, the Affordable Care Act, and the Limits of Constitutional Compromise*, 120 YALE L.J. ONLINE 407, 411–12 (2011), http://yalelawjournal.org/images/pdfs/971.pdf (arguing that "[t]he structure of health care produces a race to the bottom that diminishes state autonomy" because "some states provide care for the uninsured," which "creates a cross-border moral hazard, allowing neighboring states to offer fewer free services but permitting citizens of the low-service states to cross the border when they fall ill"); *id.* (observing that "the pressure on each state is to free ride on the efforts of its neighbors" because "states that offer better services attract migrants that drive up prices, taxes, or both").

210. It is not true, as certain of my interlocutors have urged, that federal power is limitless if it is ever justified "merely" by interstate migration in response to different state regulatory regimes. To justify federal intervention, the amount of migration at issue may not be trivial. For example, the phenomenon of "job lock" in response to different state healthcare regimes is well documented. *See, e.g.*, JONATHAN GRUBER, PUBLIC FINANCE AND PUBLIC POLICY 424 (2d ed. 2007) (finding that "workers with health insurance are about 25% less likely to change jobs because of that insurance").

encouraging them to migrate and seek a haven of repose."[211] Even where the external costs are less obvious, states may still face difficulties in attempting to overcome the collective action problem on their own. "Only a power that is national can serve the interests of all."[212]

Evidence past and present supports many of the theoretical predictions offered above. Historically, progressive legislation passed by one state or region sometimes gave an advantage to other states or regions in interstate economic competition. For example, there is a well-understood connection between Progressive Era reform and manufacturing capital flight from the Northeast and Midwest to the South. During the late nineteenth century and early twentieth century, northern states were enacting progressive labor laws while southern states imposed few legal constraints.[213] (The Supreme Court's key invalidations of federal child labor legislation, enacted in part to counteract the race to the bottom, arose out of North Carolina.[214]) One consequence of this divergence in state laws was a movement of economic enterprises from the North to the South.

One contemporaneous commentator, Edward Porritt, discussed the relationship between labor progressivism and capital flight in the context of textile looms moving southwards.[215] Writing in 1896, Mr. Porritt observed that "[t]he greatest emphasis is laid by the [New England] manufacturers on the fact that there are no labor laws worth speaking about in the South."[216] One manufacturer confessed that he did

> not care whether the working day is ten hours or nine hours, provided it is made the same for everybody. Then we would all stand on one level. But now the man in the South is not afraid of legislation, because it comes to him last. The man who is afraid is the man to whom legislation comes first; he is the man who has

211. Helvering v. Davis, 301 U.S. 619, 644 (1937) (upholding the Social Security Act's old-age pension program).

212. *Id*. For a discussion of the collective action reasoning in *Helvering* and *Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937), see Cooter & Siegel, *supra* note 10, at 168–69.

213. *See, e.g.*, Philip M. Holleran, *Family Income and Child Labor in Carolina Cotton Mills*, 21 SOC. SCI. HIST. 297, 301 (1997) (focusing "on mill families in North Carolina and South Carolina, where child labor and the family labor system were most deeply entrenched"); *id*. ("The two states ranked second and first, respectively, in the nation in employment of children in cotton mills from 1899 through 1914.").

214. *See* Hammer v. Dagenhart, 247 U.S. 251 (1918) (invalidating a federal ban on the shipment in interstate commerce of goods produced by child labor); Bailey v. Drexel Furniture Co. (*Child Labor Tax Case*), 259 U.S. 20 (1922) (invalidating a federal excise "tax" on the net profits of employers that employed children based on a distinction between impermissible "regulatory" and permissible "revenue raising" exactions).

215. Edward Porritt, *The Cotton Mills in the South*, 18 NEW ENG. MAG. 575, 575 (1896) ("Not a little New England capital has already been invested in some of the new southern [cotton manufacturing] enterprises; and in Massachusetts especially there has been much discussion, both among mill owners and among working men, of the conditions of manufacture and labor in the South, as affecting a possible large transfer thither of the cotton industries of the North."). I thank Ed Balleison for this reference.

216. *Id*. at 578.

> to carry the load.[217]

Northern states paid a price for their (relative) humanity. They suffered financially by putting businesses that initially were located there at a competitive disadvantage relative to businesses in the South.[218] Mr. Porritt concluded his remarkable account by observing that the states would not address the collective action problem on their own any time soon:

> At the present time, when southern cotton mills are driving as hard as they can go, and the South is in the enjoyment of a new prosperity, the southern cotton states would be even less disposed to go into an interstate conference than were some of the European nations to discuss international labor problems at the suggestion of the Emperor of Germany.[219]

Fast forwarding to the present, it is well known that the general welfare suffers when individuals decline better job opportunities in another state because they cannot afford the loss of health insurance benefits they would suffer if they moved.[220] Health economists call this phenomenon "job lock."[221] Moreover, it is well documented that numerous insurers moved to other states when their home state banned coverage denials based on preexisting conditions. For example, almost every insurer left the state when Kentucky passed reform legislation; only one private insurer and one state-run insurer remained.[222] Insurers also left Washington,[223] New York,[224] and several other states.[225]

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217. *Id*.

218. *See, e.g.*, HUGH D. HINDMAN, CHILD LABOR: AN AMERICAN HISTORY 59 (2002) (observing that Massachusetts was no longer the most progressive state on child labor matters after 1900 because it was "[t]ied so heavily to the textile industry, the tremendous growth of the industry in the South presented a competitive menace," and "part of the South's competitive advantage derived from pervasive child labor," so that "Massachusetts found itself unable to continue advancing its child labor standards without harm to industrial interests"); STEPHEN B. WOOD, CONSTITUTIONAL POLITICS IN THE PROGRESSIVE ERA: CHILD LABOR AND THE LAW 9 (1968) (noting the charge of "northern manufacturers," including "the New England textile industry," that "the south's competitive advantage resulted principally from the exploitation of children and the consequent depressed scale of adult wages," and concluding that "[t]his explanation was close to the truth").

219. Porritt, *supra* note 215, at 586. Of course, interstate capital migration did not end with the Progressive Era. For example, Jefferson Cowie offers a rich comparative social history of industrial relocation from the 1930s to the 1990s. He chronicles one major corporation's migrations from the Northeast to the Midwest, then to the South, and finally to Mexico in search of stable, cheap, and pliable labor. *See generally* JEFFERSON COWIE, CAPITAL MOVES: RCA'S SEVENTY-YEAR QUEST FOR CHEAP LABOR (1999).

220. *See, e.g.*, Rosenbaum, *supra* note 195, at e29(3) ("[I]n a modern economy, people need to be able to move interstate in order to pursue economic opportunities and participate in a changing labor market."); *cf.* Cooter & Siegel, *supra* note 10, at 149 ("In the eighteenth century, America faced the problem of creating a unified market for goods, capital, and labor. Legal obstacles to the movement of resources inhibit national markets. In contrast, a uniform regulatory framework lubricates national markets for some goods.").

221. *See, e.g.*, PHELPS, *supra* note 38, at 324–25. Congress attempted to address the matter in the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936.

222. *See* Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. HEALTH POL., POL'Y & L. 133 (2000).

223. *Id*.

224. Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. HEALTH POL. POL'Y & LAW 71 (2000).

225. *See infra* note 250 (discussing surveys reporting similar results of healthcare reform in several

These states, however, did not impose a minimum coverage provision, and Congress found that Massachusetts has been substantially more successful in preventing an exodus of insurers by imposing one.[226] The question is whether other states would be able to enact similar healthcare legislation—and if not, why not? Does the apparent success of Massachusetts in achieving near-universal coverage without causing insurers to leave demonstrate that the interstate spillover effects are modest at best, such that states can "go it alone" without incurring prohibitive costs?

There are several reasons to believe that few states could achieve what Massachusetts achieved. Some of these reasons do not appear attributable to the existence of sister states.[227] They include the relatively low number of uninsured residents in Massachusetts when it enacted reform. Only 9% of its residents were uninsured when the state adopted universal coverage in 2006 compared with 15% in the nation as a whole today.[228] Moreover, Massachusetts had a relatively healthy economy and ample financial resources when it acted.[229] By contrast, Texas and California together were home to 12.7 million uninsured individuals in 2008, and their financial resources are severely constrained.[230] In addition, healthcare costs in Massachusetts are continuing to rise.[231] For example, "per capita spending on health care in Massachusetts is 15% higher than in the rest of the nation, even when accounting for the state's wages and spending on medical research and education."[232]

Federalism problems may also be impeding other states from attempting to replicate the Massachusetts experiment. Strikingly, Massachusetts is the only state that has succeeded in passing healthcare reform legislation that shares the basic objectives and approaches of the ACA. (Contrast this situation with the

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states).

226. 42 U.S.C.A. § 18091(a)(2)(D) (West 2011) ("In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased."); *see* Amitabh Chandra et al., *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293, 295 (2011) (offering evidence suggesting that the Massachusetts "mandate had a causal role in improving risk selection").

227. *See, e.g.*, Rosenbaum, *supra* note 195 ("Today, between the surging numbers of uninsured, collapsing state economies, and a decided shift in the culture and politics of government intervention, another Massachusetts is out of the question.").

228. LANDMARK, *supra* note 39, at 90.

229. Rosenbaum, *supra* note 195 ("Massachusetts must be understood as the rarity rather than the norm.").

230. *Id*.

231. "Massachusetts is grappling with escalating health care costs which are consuming a greater portion of the economy and lowering real wage growth." STANLEY S. WALLACK ET AL., MASSACHUSETTS HEALTH CARE COST TRENDS PART I: THE MASSACHUSETTS HEALTH CARE SYSTEM IN CONTEXT: COSTS, STRUCTURE, AND METHODS USED BY PRIVATE INSURERS TO PAY PROVIDERS (February 2010), http://www.mass.gov/eohhs/docs/dhcfp/r/cost-trends-files/part1-system-in-context.pdf.

232. DIV. OF HEALTH CARE FIN. & POLICY, MASSACHUSETTS HEALTH CARE COST TRENDS: 2010 FINAL REPORT (April 2010), http://www.mass.gov/eohhs/docs/dhcfp/cost-trend-docs/final-report-docs/health-care-cost-trends-2010-final-report.pdf.

more than forty states that had enacted laws banning guns in schools when Congress passed the Gun Free School Zones Act of 1990.[233]) The explanation for this state of affairs is not lack of political support for the ACA in every state except Massachusetts. The ACA was no bolt from the blue. The President (like his Democratic rivals for the 2008 presidential nomination) campaigned on healthcare reform, and the ACA was approved by well more than a majority (albeit a partisan majority) of the Senate.[234] Moreover, the nation remains divided over the law. A March 2012 poll found that, "[o]f those who say they understand the law, 45 percent approve and 51 percent oppose."[235] In all likelihood, part of the explanation for the current situation at the state level is that the federalism problems associated with state-by-state solutions are significant—and are perceived by state legislators to be significant.[236]

To fully answer the question, however, further information about what is going on in Massachusetts would be helpful. The theory of collective action federalism directs research towards the question whether healthcare reform in Massachusetts has been causing migration to and from the state by healthy individuals, sick individuals, insurers, and providers.[237] There presently do not exist good data on mobility in and out of Massachusetts caused by the state's legislative efforts.[238] Opponents of the ACA would be well served if they could show that spillover effects and free riding by sister states have not been substantially undermining the efficacy of Massachusetts's own attempt to

233. *See supra* note 128 and accompanying text (quoting Justice Kennedy's legislative count in *Lopez*).

234. The ACA received 60 votes in the Senate (58 Democrats, 2 Independents). *See Senate Vote on Passage: H.R. 3590 [111th]: Patient Protection and Affordable Care Act*, GOVTRACK.US, http://www.govtrack.us/congress/vote.xpd?vote=s2009-396. The vote in the House of Representatives was 219 to 212. *See House Vote #165 (Mar. 21, 2010)*, GOVTRACK.US, http://www.govtrack.us/congress/vote.xpd?vote=h2010-165. The House vote was so close in part because of the opposition of some Democrats to the Senate healthcare bill, on which the House was voting. These Democrats wanted the bill to include tighter limits on insurance coverage for abortions. *See* David M. Herszenhorn & Robert Pear, *Democrats Rally to Obama's Call for Health Vote*, N.Y. TIMES, Mar. 21, 2010, *available at* http://query.nytimes.com/gst/fullpage.html?res=9904E5DC1039F932A15750C0A9669D8B63&pagewanted=all.

235. Dalia Sussman, Helene Cooper & Kate Phillips, *Most Oppose at Least Part of Overhaul, Poll Finds*, N.Y. TIMES, Mar. 26, 2012, *available at* http://www.nytimes.com/2012/03/27/us/most-americans-want-health-care-law-overturned-or-changed-poll-finds.html?_r=2&sq=health.

236. *See* Koppelman, *supra* note 191, at 17–18 (arguing that the factual uncertainty about the existence and scope of a race to the bottom is part of the collective action problem).

237. *Cf.* Cooter & Siegel, *supra* note 10, at 154 (calling for extensive fact finding on the scope of public goods, externalities, and markets).

238. E-mail from Jonathan Gruber, Professor of Econ., Mass. Inst. of Techn. (Apr. 26, 2011) (on file with author). The present size of the exaction in Massachusetts—roughly $1,000, *see* LANDMARK, *supra* note 39, at 91—may be too small to be causing relatively young and healthy individuals to leave the state who would otherwise stay. Other expenses, like relative local tax burdens, may be more significant to an individual's financial calculation, yet also may not cause substantial flight in light of all the other reasons (such as job opportunities and family ties) that determine an individual's place of residency. By the same token, the modest size of the Massachusetts exaction for noncompliance may be causing older, unhealthy individuals to move to the state. Only time (and research) will tell. If it turns out that there is little in-migration of sick people, part of the explanation may be that Medicare and Medicaid already solve the worst of the federalism problem.

provide universal access to healthcare. Defenders of the ACA would be well served if they could show the opposite.[239]

This available evidence, however, makes out a reasonably strong prima facie case for federal regulation—at least as strong as what one usually encounters to justify use of the commerce power.[240] Accordingly, the commerce power supports the ACA's effort to broaden the availability of health insurance by imposing specific terms on health insurance contracts sold throughout the country. The Commerce Clause gives Congress the power "to govern affairs which the individual states, with their limited territorial jurisdictions, are not fully capable of governing."[241]

Notably, constitutional critics of the ACA do not tend to argue that preventing insurers from denying coverage to people is best left for the states to address on an individual basis. For example, Tea Party activists who issued the "Contract from America" called for replacing the ACA "with a system that actually makes health care and health insurance more affordable by enabling a competitive, open, and transparent free-market health care and health insurance system *that isn't restricted by state boundaries*."[242] It is not evident how the states acting individually possess either the authority or the ability to accomplish this result. Unlike in past constitutional litigation over guns in schools, violence against women, and medical marijuana, the opponents of the federal law do not attempt to explain how, if a state or local government "determines that [insurance market reforms] are necessary and wise to deter

239. A 2005 Report of the Inspector General of Massachusetts may suggest problems with out-of-state residents using the state's more generous healthcare system. The report examines the Massachusetts safety net pool prior to the 2007 reforms. The state's Uncompensated Care Pool "provides reimbursement to hospitals, hospital-based clinics, and community health centers for providing free or partially-subsidized medical services to uninsured or underinsured patients." OFFICE OF THE INSPECTOR GEN., COMMONWEALTH OF MASS., ONGOING REVIEW OF THE UNCOMPENSATED CARE POOL PURSUANT TO CHAPTER 240 OF THE ACTS OF 2004: SECOND REPORT TO THE HOUSE AND SENATE COMMITTEE ON WAYS AND MEANS 1 (Nov. 2005), *available at* http://www.mass.gov/ig/publ/poolrpt.pdf. Although the report does not specifically find abuse from out of state, it does identify problems with the documentation of the residency status of claimants:

> The audit firm contracted by the Inspector General reviewed Uncompensated Care Pool claims, comparing the address on the application with the backup documentation provided to the hospital as required by pool regulations. Documents proving residency include copies of drivers' licenses, utility bills, pay stubs, voter identification cards, and affidavits. . . . For hospital fiscal years 2003, 2004, and the first five months of 2005, the auditors found that 12.9 percent, 5.5 percent, and 6.4 percent respectively of the claims tested lacked adequate documentation supporting residency status.

Id. at 49–50.

240. In *Raich*, for example, Justice O'Connor disagreed with the deference exhibited by the Court in upholding federal power to regulate medical marijuana use authorized by state law. She conceded that the Court's "arguments about the effect of the [California law] on the national market . . . are plausible; if borne out in fact they could justify prosecuting [state] patients under the federal CSA." But she insisted that "without substantiation, they add little to the CSA's conclusory statements." Gonzales v. Raich, 545 U.S. 1, 56–57 (2005) (O'Connor, J., dissenting).

241. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 525 (1944).

242. THE CONTRACT FROM AMERICA, http://www.contractfromamerica.com/Idea.aspx (emphasis added).

[insurers from denying people coverage], the reserved powers of the States are sufficient to enact those measures."[243] This may be because "[s]tates have had decades to enact broad reforms, yet the record has been one of futility despite enormous effort."[244] The states may be too interdependent for each one to solve the problem on its own.

Although Congress had the authority to enact the ACA's restrictions of insurance companies, it would have been foolish to pass them without also enacting the minimum coverage provision. Insurance companies may not be financially viable if the law denies them the capacity to control costs through coverage restrictions without preventing market timing behavior.[245] As Congress found, "[I]f there were no [coverage] requirement, many individuals would wait to purchase health insurance until they needed care."[246]

As explained in Part II, this adverse-selection problem occurs when individuals with higher expected healthcare costs are more likely to purchase insurance than individuals with lower expected costs. The market for health insurance attracts adverse selection, even absent the ACA's restrictions on insurers but especially with them, because individuals know more about their health status than insurance companies do.[247] This information asymmetry creates an incentive for individuals to free ride by entering the market only when they expect to require expensive care. The minimum coverage provision is designed in part to combat this free rider problem.[248] The predicted consequence of the adverse-selection problem absent an insurance requirement is a substantial rise in insurance rates.[249] Much empirical evidence confirms this

243. United States v. Lopez, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring).

244. Rosenbaum, *supra* note 195.

245. *See* Brief for America's Health Insurance Plans, *supra* note 54, at 3 ("Without an individual mandate requirement, more individuals will make the rational economic decision to wait to purchase coverage until they expect to need health care services. If imposed without an individual mandate provision, the market reform provisions would reinforce this 'wait-and-see' approach by allowing individuals to move in and out of the market as they expect to need coverage, undermining the very purpose of insurance to pool and spread risk.").

246. 42 U.S.C.A. § 18091(a)(2)(I) (West 2011). Congress further found that "[b]y 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," and that "[t]he requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." *Id*; *see also id.* § 18091(a)(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

247. *See* PHELPS, *supra* note 38, at 318 (noting the "risk . . . that insurance companies will put an insurance plan into the market that uses one set of actuarial projections about the costs of insured people but ends up attracting a special subset of the population with unusually high health care costs").

248. *See id*. at 533 (describing the market failure resulting from asymmetric information as "[p]erhaps the most substantial argument for universal insurance"). For the classic article on asymmetric information, which earned its author the Nobel Prize in Economics, see George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970).

249. *See, e.g.*, CONG. BUDGET OFFICE, EFFECTS OF ELIMINATING THE INDIVIDUAL MANDATE TO OBTAIN HEALTH INSURANCE 2 (June 16, 2010) (predicting a 15 to 20% increase in premiums for new

prediction.[250] Because of the close connection between the minimum coverage provision and the ACA provisions that restrict insurers, the Necessary and Proper Clause offers a strong constitutional justification for the provision.[251]

One federal court that invalidated the provision erred in asserting that "[i]f a person's decision not to purchase health insurance at a particular point in time does not constitute the type of economic activity subject to regulation under the Commerce Clause, then logically an attempt to enforce such provision under the Necessary and Proper Clause is equally offensive to the Constitution."[252] From *McCulloch v. Maryland*[253] to *United States v. Comstock*,[254] the Supreme Court has understood the Sweeping Clause differently. It has understood the clause to authorize Congress to employ means that are otherwise outside the scope of Section 8 in order to achieve regulatory objectives that are within the scope of Section 8 (or some other part of the Constitution).[255] This is why, under a Necessary and Proper Clause rationale, it does not matter whether the minimum coverage provision itself solves a collective action problem facing the states.[256] To be authorized by the Sweeping Clause, it suffices that the provision is a useful adjunct to the commerce-power regulations of the insurance industry, which do solve collective action problems for the states.

Critics might respond that if the minimum coverage provision were held

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nongroup policies relative to current law absent the mandate); Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the ACA*, NEW ENG. J. MED. (Feb. 23, 2011), http://www.nejm.org/doi/full/10.1056/NEJMpv1101519 (noting the estimation of MIT economist Jonathan Gruber that only eight million people (instead of thirty-two million) would join the ranks of the insured if the ACA had no mandate); Brief for America's Health Insurance Plans, *supra* note 54, at 13–15 ("[T]he common theme in the economic and actuarial literature is that premiums increase and coverage rates fall when insurance market reforms are enacted without an individual mandate.").

250. Rosenbaum & Gruber, *supra* note 53, at 403 ("Five states have tried to undertake reforms . . . without enacting an individual mandate; those five states are now among the eight states with the most expensive nongroup health insurance."); Brief for America's Health Insurance Plans, *supra* note 54, at 15–26 (surveying the experience of Maine, New Jersey, Kentucky, New Hampshire, Washington, New York, Vermont, and Massachusetts in passing reform legislation without a mandate and finding a common trend of "destabilization of individual markets, increases in premiums, and declines in enrollment").

251. One could also invoke the comprehensive regulatory scheme rationale of *Lopez* and *Raich*. *See supra* note 127 and accompanying text (quoting the majority opinion in *Lopez*).

252. Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 779 (E.D. Va. 2010).

253. 17 U.S. (4 Wheat.) 316, 405–07, 421 (1819).

254. 130 S. Ct. 1949, 1956–58 (2010).

255. For example, in *Comstock* the Justices debated the standard of review courts should apply to federal legislation that is defended as resting on the Necessary and Proper Clause. The majority, consisting of Chief Justice Roberts and Justices Stevens, Ginsburg, Breyer, and Sotomayor, stated that "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Id.* at 1956 (citation omitted). By contrast, Justice Kennedy would insist on "a demonstrated link in fact, based on empirical demonstration." *Id.* at 1967 (Kennedy, J., concurring in judgment). Justice Alito seemed to endorse Justice Kennedy's more demanding standard. *Id.* at 1970 (Alito, J., concurring in judgment).

256. Once Congress prohibits the underwriting practices of insurers, each state has an incentive to impose a minimum coverage provision (or to search for an effective substitute) in order to prevent insurers from moving to sister states that require residents to possess health insurance.

unconstitutional, Congress could try to combat the adverse-selection problem in other ways. For example, Congress could provide higher subsidies to tempt healthier individuals into the insurance pool.[257] Congress, however, could always spend more money on a problem, including by guaranteeing every American free and comprehensive access to healthcare and raising taxes to finance the program. The proper constitutional inquiry does not question the amount of money that Congress elected to spend.

Alternatively, Congress could automatically enroll individuals in insurance as a default but allow them to opt out if they do not want coverage.[258] Congress could also impose limited open-enrollment periods and penalties for late enrollment.[259] Medicare uses some of these approaches.[260] The context of private health insurance, however, is significantly different; it is uncertain whether these alternative methods would be nearly as effective in achieving high rates of enrollment as the minimum coverage provision.[261] The answer would depend in part on the size of the exactions for going without insurance.[262] Economist Jonathan Gruber of the Massachusetts Institute of Technology—a defender of the minimum coverage provision—examined auto-enrollment and late enrollment penalties, finding that "both alternatives significantly erode the gains in public health and insurance affordability made possible by the Affordable Care Act."[263]

However this forecasting debate turns out, there is little doubt that the minimum coverage provision satisfies the deferential *McCulloch* standard recently reaffirmed in *Comstock*.[264] The provision would also likely survive a

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257. *See, e.g.*, Chandra et al., *supra* note 226 (analyzing the approaches of mandates and subsidies and concluding that "the higher the subsidies, the smaller the role for an individual mandate").

258. *See* Jonathan Gruber, *Health Care Reform Without the Individual Mandate: Replacing the Individual Mandate Would Significantly Erode Coverage Gains and Raise Premiums for Health Care Customers*, CTR. FOR AM. PROGRESS, 3–5 (Feb. 2011) http://www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf.

259. *See* Herring, *supra* note 249; Gruber, *supra* note 258, at 5–7.

260. Medicare Part B, which covers outpatient costs for individuals enrolled in Medicare, combines auto-enrollment with a late enrollment penalty of ten percent of premiums for each year of delay. *See* Herring, *supra* note 249; Gruber, *supra* note 258, at 5. Moreover, the Medicare Part D prescription drug plan imposes a penalty for late enrollment. *See id.*

261. *See* Gruber, *supra* note 258, at 3–4 (discussing differences between the two settings, including the incentive of employers to encourage participation and the likelihood that young employees have already considered participation).

262. For an analysis of the efficacy of individual mandates in various contexts, see generally Sherry A. Glied et al., *Consider It Done? The Likely Efficacy of Mandates for Health Insurance*, 26 HEALTH AFF. 1612 (2007). The authors find that the efficacy of an individual mandate turns on the cost of compliance, the exactions for noncompliance, and the extent to which compliance is enforced in a timely manner. *Id*. at 1613.

263. Gruber, *supra* note 258, at 1. Specifically, Gruber found that "no alternative to the individual mandate can cover more than two-thirds as many uninsured as the Affordable Care Act does"; that "no alternative to the mandate saves much money"; and that "any alternative imposes much higher costs on those buying insurance in the new health insurance exchanges as the healthiest opt out and the less healthy face increased premiums." *Id*. at 7.

264. *See supra* note 255 (discussing the standard of review articulated by the Court in *Comstock*).

more demanding means–ends test, such as Justice Kennedy's insistence on "a demonstrated link in fact, based on empirical demonstration."[265]

Critics of the provision also object that Congress may not invoke the Necessary and Proper Clause to cure an adverse-selection problem that Congress itself has largely created by using its commerce power. In the view of critics, Congress may not invoke the Sweeping Clause to justify legislation that ameliorates a problem of its own making. "[R]ather than being used to implement or facilitate enforcement of the Act's insurance industry reforms," the Florida district court wrote, "the individual mandate is actually being used as the means to avoid the adverse consequences of the Act itself."[266] The court reasoned that Congress may not use the Sweeping Clause this way because it "would have the perverse effect of enabling Congress to pass ill-conceived, or economically disruptive statutes, secure in the knowledge that the more dysfunctional the results of the statute are, the more essential or 'necessary' the statutory fix would be."[267]

Similarly, Randy Barnett cautions that Americans should "[l]ook at what is happening here. Congress exercises its commerce power to impose mandates on insurance companies, and then claims these insurance mandates will not have their desired effects unless it can impose mandates on the people—which would be unconstitutional if imposed on their own."[268] Barnett submits that "[b]y this reasoning, the Congress would now have the general police power the Supreme Court has always denied it possessed," for "[a]ll Congress need do is adopt a broad regulatory scheme that won't work the way Congress likes unless it can mandate any form of private conduct it wishes."[269]

The foregoing concerns about bootstrapping are problematic because it is often difficult to accomplish much good in the world without also doing some bad.[270] Many actions have both desirable consequences and negative side effects, and the Court from *McCulloch* to *Comstock* has recognized this fact, allowing Congress to address both. (In this regard, federal laws are like many medical interventions.) If American constitutional law were otherwise, *Comstock* would have come out the other way, for the federal statute under review addressed a collective action problem caused in part by Congress when it authorized long periods of incarceration in remote federal prisons.[271] If the law were otherwise, Congress would be precluded from banning the exclusionary practices of

265. United States v. Comstock, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring in judgment).

266. Florida *ex rel.* Bondi v. U.S. Dep't Health & Human Servs., 780 F. Supp. 2d 1256, 1297 (N.D. Fla. 2011).

267. *Id.*

268. *Hearing On The Constitutionality Of The Affordable Care Act Before the United States Senate Committee on the Judiciary* (2011) (statement of Randy E. Barnett), *available at* http://www.judiciary.senate.gov/pdf/11-02-02%20Barnett%20Testimony.pdf.

269. *Id.*

270. *See* Koppelman, *supra* note 191.

271. *See supra* note 131–133, and accompanying text (discussing the multi-state collective action problem that Congress helped to create by severing state ties through long federal prison terms).

insurers unless it were willing to run the risk of destroying health insurance markets.[272]

In any event, concerns about bootstrapping are beside the point in the context of healthcare reform. This is because the adverse-selection problem that undermines insurance markets long predates the ACA. Accordingly, the minimum coverage provision is justified by the Necessary and Proper Clause even without reference to the ACA's prohibitions on underwriting. This is an underappreciated constitutional rationale for the provision.

Although the bootstrapping objection is misguided, the concern animating it—fear of unlimited federal power—warrants consideration. The Supreme Court has addressed this concern by distinguishing economic subject matter from noneconomic subject matter. The theory of collective action federalism addresses this concern by distinguishing problems that require individual action by states from problems that require collective action.

VI
CONCLUSION

In at least two independently sufficient ways, the minimum coverage provision encounters no constitutional impediment sounding in federalism. It would be perplexing to conclude otherwise in light of the conceded constitutional validity of other potential approaches to healthcare reform. These alternatives include raising everyone's taxes by the amount of the exaction for non-insurance in the ACA and then providing a federal tax credit only to insured individuals that equals the amount of this exaction. A requirement to obtain healthcare coverage or pay $X is materially equivalent to a requirement that only insured individuals need not pay $X in taxes.[273]

Another concededly constitutional alternative to the ACA is more ambitious. Under longstanding Supreme Court precedent,[274] Congress could pass a statute establishing "a government-run, 'single-payer' system such as Canada's—the 'Medicare for all' approach advocated by many American liberals for years, but sharply opposed by insurers and many medical providers."[275] Instead of securing a much larger role for the federal government

272. Or, as Andrew Koppelman has pointed out, Congress would be prohibited from criminalizing robbery of the mails because such a problem does not arise until Congress elects to establish a post office. Koppelman, *supra* note 191.

273. For an analysis of the material equivalences between taxes and regulations backed by certain exactions, see generally Cooter & Siegel, *supra* note 69.

274. *See, e.g.*, Helvering v. Davis, 301 U.S. 619 (1937) (upholding the Social Security Act's old-age pension program); *see also* Mark A. Hall, *Health Care Reform—What Went Wrong on the Way to the Courthouse*, 364 NEW ENG. J. MED. 295 (2011) ("Under long-established Supreme Court precedent, Congress would have authority, if it wanted, to enact a single-payer socialized insurance system, using its powers to tax and spend 'for the general welfare.'"); Mariner & Annas, *supra* note 169, at 1301 ("Other clearly constitutional approaches were available, including Medicare for All, or simply raising the income or payroll tax to pay for health benefits, but these would have been even more objectionable to those who are raising Commerce Clause problems with the ACA.").

275. LANDMARK, *supra* note 39, at 68.

in the interstate healthcare market,[276] Congress passed the ACA, which "seeks to expand the number of people covered and begin the work of restraining costs by building on the existing structure of private insurance."[277]

The ACA, in other words, is a "market-based approach" that "bears clear resemblance to the leading Republican alternative to the Clinton plan, to proposals developed by the conservative Heritage Foundation, and to the 2006 legislation signed by Republican Governor Mitt Romney that created universal coverage in Massachusetts."[278] If the constitutional concern raised by the minimum coverage provision is limitless federal power—a rationale for congressional authority that lacks "logical limitation"[279]—then it is puzzling why Congress may more completely displace the states (and more substantially restrict individual liberty) by authorizing a greater role for the federal government in regulating private conduct.[280]

The solution to this puzzle is straightforward: Either making the financial decision to go without insurance qualifies as "activity," as others have argued, or the constitutionality of the minimum coverage provision does not turn on whether Congress is regulating "inactivity," as I have shown here. The inactivity–activity distinction does not even partially define the limits of the Commerce Clause. Rather, as identified by the theory of collective action federalism, a better constitutional distinction is between individual action and collective action by states. This is a structurally sound place to look for limits on the commerce power.

The subject matter targeted by the minimum coverage provision is economic in nature. Moreover, Congress reasonably concluded that the provision addresses two collective action problems for the states: preventing cost shifting and guaranteeing access to health insurance while avoiding adverse selection. Accordingly, the minimum coverage provision is within the scope of the Commerce Clause, either alone or in combination with the Necessary and Proper Clause.

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276. *See, e.g.*, Hall, *supra* note 274, at 295 ("Far short of [a single-payer socialized insurance system], the complex blend of regulation, subsidies, and an individual mandate included in the [ACA] is vastly more protective of insurance markets and individual freedoms.").

277. LANDMARK, *supra* note 39, at 68.

278. *Id.*; *see also id.* at 6 (noting that President Nixon's healthcare reform "architecture formed the basis for what Obama would pursue three decades later"); *Hearing on the Constitutionality Of The Affordable Care Act Before the S. Comm. on the Judiciary* (2011) (statement of Sen. Patrick Leahy, Chairman, S. Comm. on the Judiciary), *available at* http://leahy.senate.gov/press/press_releases/release/?id=debc354f-02d2-4d2b-b564-f4e372381147 ("Ironically, the so-called individual mandate now under partisan attack in the courts has long been a Republican proposal."); *cf.* DAVID BLUMENTHAL & JAMES A. MORONE, THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE vii (2010) (viewing Obama's plan upon taking office as "well to the right of Nixon's 1974 proposal").

279. *See supra* notes 78, 84, and accompanying text (quoting two district courts that have invalidated the minimum coverage provision).

280. For an argument that the minimum coverage provision is compatible with a national government of limited and enumerated powers, see generally Neil S. Siegel, *Four Constitutional Limits that the Minimum Coverage Provision Respects*, 27 CONST. COMMENT. 591 (2011).