2013

Constitutional Uncertainty and the Design of Social Insurance: Reflections on the ACA Case

Michael J. Graetz
Columbia Law School, mgraet@law.columbia.edu

Jerry L. Mashaw
Yale Law School, jerry.mashaw@yale.edu

CHAPTER 17

Constitutional Uncertainty and the Design of Social Insurance

REFLECTIONS ON THE ACA CASE

Michael J. Graetz and Jerry L. Mashaw

1. Introduction

Let us begin this essay with a confession, an observation, and an echo. First, the *confession*: we were surprised that the majority of the Supreme Court found that the individual mandate of the Patient Protection and Affordable Care Act (ACA) exceeded Congress's Commerce Clause powers, including Congress's ability to adopt legislation that is "necessary and proper" to regulate commerce effectively. Writing separately and together, we have argued for mandating—and subsidizing—individual and family health insurance purchases to prevent the unraveling of private health insurance through risk segmentation.[1] While the form of health insurance we recommended varies from that of the ACA, the individual mandate we proposed (as in the ACA) would be coupled with provisions requiring insurers to take all comers, without regard to any preexisting conditions, and to eschew medical underwriting.

As we have argued in detail elsewhere, universal participation is properly a hallmark of social insurance, as is broad distribution of its burdens and benefits. To be sure, an individual mandate—whether to purchase health or automobile insurance, vaccinate your children before sending them to school, or pay taxes—sometimes involves intrusive enforcement and evasion.[2] But as long as our nation continues to provide emergency medicine to all of its citizens and residents regardless of their ability to pay, prudence requires that everyone pay a fair share of the costs of their medical care.

The consequences of inaction here are dramatic. Virtually every American will use the health care system at some point, and people who have no health

The Health Care Case. Nathanie Persily, Gillian E. Metzger and Trevor W. Morrison.

insurance and are unable to pay for their health care services will receive health care services anyway. This is not true of broccoli, automobiles, or virtually any other product. Health care providers cannot provide their services for free: there are costs involved. Those costs must and will be borne by the people who pay for health care services either directly or indirectly though taxes. Reasonable estimates of the current burden on persons having health insurance of paying for the uncompensated care of the uninsured are roughly $1,000 per year. No one denies that health insurance is interstate commerce. Nor does anyone deny that the cross-subsidies from paying customers to nonpaying customers are very substantial.

The constitutional question is whether the thing that is being regulated substantially affects interstate commerce. Even without relying on the recharacterization of the failure to buy health insurance as a decision to self-insure, failure to buy health insurance clearly does affect interstate commerce. That it is in some sense "inaction" rather than "action" should be a distinction without a difference for Commerce Clause analysis. Imagining a Congress mandating Americans to buy broccoli or to buy automobiles is to leave the real world far, far behind.

When we first made these points in the 1990s and early 2000s, no serious constitutional objection had been advanced against requiring all citizens and residents to purchase some specified minimum level of health insurance. The individual mandate idea had been proposed by the Heritage Foundation, supported by dozens of Senate Republicans, and only at the very last minute removed from the final 1992 health insurance proposals of President George H. W. Bush. Massachusetts enacted such a regime in 2006 and its then-governor, Mitt Romney, subsequently urged it as a model for national legislation.[3] Like virtually everyone else who had thought about it, we believed that the constitutionality of such a mandate had been settled in the legal contests over the New Deal.[4] Indeed, as we discuss further below, one of the objectives of our social insurance analysis and proposals was to liberate state-based unemployment insurance from the archaic structure imposed upon it by long-gone constitutional constraints on the federal government.[5]

Second, an *observation*: like many others writing for this volume, the Court's Commerce Clause analysis is not our only cause for puzzlement in this set of opinions. Take three prominent examples: (1) Justice Roberts's unnecessary dicta telling us that he would strike down the statute on Commerce Clause grounds in an opinion upholding the law under Congress's tax powers; (2) the willingness of the four dissenting justices to abandon the Court's previous jurisprudence and traditions on severability and urge striking down the entire statute, not just the mandate (the only provision which they found constitutionally objectionable), nor just the mandate and its related health insurance requirements of guaranteed coverage and community rating (as the government had

urged); and (3) the seven-to-two vote, holding for the first time that a federal-state cooperative program was so coercive as to be constitutionally infirm and doing so long before any federal administrator had exercised her statutory discretion to cut off any state funds. More on the last below.[6]

Third, an *echo*, with an elaboration. We would emphasize, as does Professor Charles Fried,[7] that the gravamen of the constitutional complaint against the individual mandate is its supposed intrusion on personal freedom. But, as Fried points out, "the argument was not made because it would have to be made under the Liberty Clause of the Fifth Amendment, and this would have carried over to the similar clause in the Fourteenth and therefore rendered any such a scheme enacted by a state, as in Massachusetts, similarly invalid."[8] When all was said and done, no one attacked a state government's requirement that individuals must purchase health insurance, nor advanced any constitutional limitation on the states doing so. All we have is a holding that if the federal government wishes to do the same, it must exercise its powers to tax and spend, not its power to regulate. The ACA case then is best understood as a legal attack on the *means* but not the goals of the health care legislation.

This emphasis on means rather than ends and on state over federal powers potentially poses significant risks for the complex institutional arrangements for social insurance that now exist and may imply harmful constraints on how Congress can restructure these programs to better meet the needs of the American people in our twenty-first-century economy. Not coincidentally, the new constitutional framework announced in the ACA decision favors those who want to dismantle rather than strengthen our nation's social insurance protections. We will explain why this is so with regard not only to health insurance, but also unemployment insurance and Social Security. Doing so requires a bit of background.

2. The Institutional and Normative Complexity of U.S. Social Insurance

What do we mean by social insurance? The critical risk that social insurance addresses is the risk of inadequate labor income. For some, loss of access to labor income may be complete and permanent, such as when death or permanent disability strikes. Others may lose labor income only episodically and temporarily through unemployment or less severe illnesses or injuries. This risk also occurs as part of the normal progress of the life cycle: both youth and old age put one out of the labor market.

"Private insurance" is a contract to pool common risks so that statistically predictable economic losses will be experienced as small subtractions from all

insured persons' wealth rather than as calamities for an unfortunate few. "Social insurance" also pools risks. But social insurance depends on government action, directed at a particular class of risks and designed to pursue societal purposes that could not or would not be achieved through individual contracting in private insurance markets. Social insurance is not merely a variation on private insurance. It is a different product—a social rather than an individual (or group) contract.

Social insurance in the United States is a twentieth-century creation, largely a product of the Great Depression. Before that, economic security was mostly a family responsibility. Children worked beside their parents on the farm or in the family's business after school. Family members who became too old to work were cared for by the next generation; the pastoral image was Grandpa at the fireside waiting to greet his hardworking children and grandchildren as they returned from the fields. (Grandmas never retired from housework and other chores.) Family members who became disabled were cared for within the family. Private philanthropy sometimes provided additional assistance.

Throughout the nineteenth century American governments had taken responsibility only for their military and civilian employees, who were sometimes protected by federal or state pensions and health and disability insurance. (Merchant seamen were a special case having had a compulsory federal health insurance scheme since the 1790s.) A number of states did provide cash assistance for widows and orphans. A few large employers had introduced some pension benefits. Anyone else without an income was supported by relatives or was relegated to the "poorhouse."

President Roosevelt's 1935 Committee on Economic Security proposed a comprehensive scheme of social insurance to provide protections against what were then perceived to be life's major threats to family income: loss of parental income support, old age, death of the family breadwinner, disability, illness, and unemployment. But that scheme was never completed. Over the years, Americans—benefited and burdened by the New Deal legacy—have continued to add and subtract, modify and reaffirm a vision that has been all but lost behind the details and political struggles surrounding particular programs.

The basic purpose of social insurance is income security. To realize that purpose, social insurance must cover common risks to income security across the life cycle of individuals. If it is to fulfill its social purposes effectively, social insurance must be universal in coverage. To provide an adequate level of protection, social insurance must recognize and facilitate two different forms of redistribution—redistribution of resources across the lifetime of individuals and redistribution from families that have not incurred the insured risks to those that have.

In the United States, we provide social insurance through a complex mixture of mandatory and voluntary mechanisms, financed through both public and

private budgets, and with a dizzying array of functions allocated between the states and the federal government. This institutional complexity is not only a function of historical and political contingencies, including pre–New Deal constitutional doctrine, but also of conflicting normative commitments. Health insurance alone, for example, reflects commitments to the moral worth of every person's life; to individual and collective responsibilities; to a competitive market for health insurance; to consumer choice; to professional integrity; to individual and physician autonomy; and to budgetary constraints.[9]

Let us briefly review the techniques for providing social insurance now prevalent in the United States. We start with public provision: the government can run a social insurance program and require participation by all workers. This is the current U.S. approach to risks of old age, death (survivorship), disability, and certain medical expenses in old age (OASDHI)—the familiar programs embodied in the Social Security and Medicare Acts. But even these familiar social insurance programs employ more heterogeneous mechanisms than are generally acknowledged.

Medicare Part A (hospital care) and Part B (physician services) are important examples. Part A is a mandatory program financed through a wage tax on employers and employees. Part B is a voluntary program financed through relatively small premiums coupled with large subsidies from general federal revenues. Both programs were designed to ameliorate the threat to family income security that medical costs pose for the retired population. Normal insurance market segmentation in the private health insurance markets would produce high costs for a group like the elderly that, on average, combines high risks with low incomes.

Over time, the Part B subsidies became more and more generous—growing from 50 percent of premiums to 75 percent—so that today Part B coverage is nearly universal. And shifts in medical treatment modalities over time have made out-of-hospital care both medically more important and financially more burdensome. The current scheme may be outmoded, even after the 2003 addition of a complex drug benefit (Part D)—or poorly designed from the beginning—but the point of this example remains. Public provision of insurance coverage need not be of one type, either in its regulatory or its financial arrangements.

Alternatively, insurance coverage can be mandated by law. Some current American social insurance programs use mandates, either to require employer-based coverage or to compel individual participation in a state-run scheme. Workers' compensation offers a ready example of the employer-mandate mode. But mandates can be used as well to require individual purchases of private insurance protection. Automobile liability insurance is a standard U.S. example. Individual mandates are also quite common in the pension and health insurance regimes of other nations. Conservative critics have long urged reforming Social

Security pensions by substituting or including mandatory individual accounts that function somewhat like Individual Retirement Accounts (IRAs).

The IRA suggests yet another common technique for socializing insurance markets: public subsidies. Medicare Part B may be the United States' most conspicuous and successful example of social insurance financed largely by subsidies out of general revenues. But direct subsidies are not the only alternative; much U.S. social insurance protection is subsidized through targeted tax breaks. Tax subsidies for voluntary employment-based regimes have tended to work rather badly, but they are a way for government to "sponsor" and subsidize social insurance without making the size of "government" appear bigger.[10] The tax subsidies for employment-based health insurance and retirement income are now the federal government's largest "tax expenditures," eclipsing the deductibility of home mortgage interest.

Not all subsidies to social insurance are from general revenues. Cross-subsidies within insurance pools are a common response to undesirable private insurance market segmentation. Higher earners can subsidize lower earners through premium or payment arrangements in virtually any social insurance scheme, just as high earners subsidize low earners in the current Social Security pension system. Low-risk elders subsidize those with high risks in the Medicare system. Nor are cross-subsidies limited to public insurance programs. Mandated "community rating," as is common in many states and required under the ACA, for example, can force cross-subsidies within private insurance pools that would otherwise generate differential premiums.

Much social insurance protection for health coverage during Americans' working years and for their retirement income is provided through employer-sponsored, tax-favored health insurance and retirement funds. This coverage is far from universal, turning on the worker's connection to a particular employer. The spotty and inadequate coverage, however, only signals that this kind of social insurance is inadequate; it does not negate its social insurance nature.

Finally, means-tested, noncontributory programs for dependent children and the aged were a part of the original Social Security Act. Indeed, old-age assistance based on need is Title I of the Social Security Act of 1935 and is the part of the Act that had the broadest public support when the statute was enacted. Means-tested support for the blind as well as the totally and permanently disabled became part of the Social Security Act nearly a decade before contributory, earnings-related disability insurance was added. The Earned Income Tax Credit (EITC) has become an increasingly important wage subsidy for low-income families with children. Indeed, what we may now think of as the conventional conception of social insurance through taxing and spending—mandatory, contributory, earnings-related, universal or near universal programs, such as Social Security's OASDI—accounts for less than half of all social insurance transfers in the United States.

In summary, social insurance is a distinctive set of programs designed to moderate the risks of current income loss or inadequacy by providing secure cash or near-cash entitlements on the occurrence of specified risks. Although the general risk to be insured is simply the lack of labor income, the ways that risk materializes are diverse and alter over the lifetimes of individuals and families. Risks also are often different for each individual and family, and they change over time as social and economic conditions evolve.

This diversity of risks requires multiple techniques for providing social insurance. It is impossible to know yet just how the Court's ACA decision may inhibit the federal government's future flexibility in employing these techniques; too much ambiguity remains. But it is not too soon to explore the potential implications of the constitutional limitations embraced by a majority of the Court. We will consider three contexts: (1) health insurance; (2) retirement income security; and (3) unemployment insurance.

3. Health Insurance

In the health arena, our institutional arrangements have long been inadequate.[11] No domain of American social insurance has rivaled the incompetence of American health insurance. We have year after year left forty to fifty million persons uninsured and many millions more with inadequate or insecure coverage. Yet the United States spends nearly twice the share of its economic output on health as other industrial nations with little or nothing in measurably improved health outcomes to show for it.

The ACA culminated nearly a century of efforts to reform our nation's system of providing health insurance. Proposals for major change by virtually every president, Democrat or Republican, since FDR were all defeated. Only Lyndon Johnson enjoyed a major success, creating Medicare and Medicaid in 1965, to which George W. Bush managed to add both prescription drug coverage and "Medicare Advantage" on a quite different model. As we have said, Part A, hospital care, is mandatory and financed by payroll taxes. Part B, physician services, is voluntary and subsidized from general revenues. Both Parts A and B are administered by the federal government as insurer, although much of the actual claims processing is contracted out to private insurance companies. Part D, prescription drug coverage, is voluntary and subsidized from general revenues, but provided by highly regulated private insurers, as is Part C, so-called Medicare Advantage, which allows Medicare beneficiaries to opt into a private insurance plan whose premiums are paid by Medicare.

Medicaid is a joint federal-state program for poor persons and certain others who meet specified eligibility criteria. Medicaid coverage is often broader than

Medicare, especially for long-term care. Some poor elderly patients are eligible for both Medicare and Medicaid, but since Medicaid income and assets eligibility tests vary across the states, there is great interstate variation in who qualifies and for what benefits. Because of its income and resources criteria for coverage, Medicaid coverage frequently creates "income cliffs" for low-income workers. A few more dollars of income can mean complete loss of coverage, which means that a good job opportunity, if it does not include adequate health insurance, may be too risky to take. Workers with health insurance coverage rely predominantly on voluntary tax-subsidized employer plans. But these subsidies are distributionally regressive and inadequate to make health insurance affordable for many small businesses or the self-employed. Moreover, both eligibility and coverage vary from state to state under general federal criteria. Complexity reigned long before enactment of the ACA.

Critical examination of the pre-ACA system of American health insurance reveals the limits of private insurance, federal tax subsidies, state financing, and voluntariness when attempting to fulfill the normal social insurance goals of universality and progressivity. Although, as Medicare Part B demonstrates, if everyone's subsidies are large enough and financed by progressive taxation, one can approach universality with some progressivity. Because Medicaid provides coverage for low-income families, the groups generally made worst off in a complex health insurance system like ours are not the poor, but rather those struggling to become or remain middle class.

The U.S. health insurance system has managed to combine large and accelerating medical expenditures with stagnant or decreasing insurance coverage. The ACA endeavors to increase coverage and limit medical inflation while maintaining the vast majority of existing institutional arrangements. New and stronger federal regulatory mechanisms were an essential element of cost control in this context, and the individual mandate was considered necessary to move toward universal coverage in a marketplace of private insurers.

On the Supreme Court's current view, a so-called "single-payer system," like Medicare for all, would not have raised the constitutional objections lodged against the ACA, even though it would have been a far more aggressive federal intervention in the private marketplace. The conventional wisdom, of course, is that no constitutional roadblocks are needed here—insurance industry political muscle and conservative ideological resistance will do the job nicely. In this context a program as comically complex as the ACA begins to look like the only path to universal coverage—and maybe cost control.

There is, of course, no constitutional difficulty with shifting more of the current health insurance responsibilities of the federal government to the states or to private actors (including employers) acting voluntarily. Devolving the purchase and financing of health insurance and medical care to the states and private

parties is at the core of conservative proposals for health insurance reform, such as Paul Ryan's premium support plan for individuals to replace Medicare and block grants to the states to replace Medicaid.[12] All U.S. experience suggests that shifting more of these responsibilities to the states and to private parties will serve to increase the gaps and differences in coverage and reduce or eliminate the redistribution of risks.

At stake in the ACA litigation then was an effort to create a constitutional barrier to what had been only a political challenge, not only to the means of providing social insurance, but to its core goals, especially universal coverage. If Medicare for all is barred politically, any improvements in the ACA will somehow have to use the taxing and spending power to further support access to private health insurance. If, for political reasons, taxes cannot be called taxes, one wonders whether legislation can be crafted that is both effective and meets the fragmented Supreme Court's test for recognizing a tax as a tax. At some point—perhaps we have already reached it—Americans will have many health insurance choices and little prospect of understanding either their entitlements, their options, or the adequacy of their coverage. Other key pillars of our nation's social insurance system, such as Social Security and unemployment insurance, face similar challenges in this new constitutional environment.

4. Insuring Adequate Retirement Income

Social Security has long been America's most successful social insurance program. Ninety-five percent of working Americans are now covered by the retirement, disability, and survivors' benefits of Social Security (OASDI), and no one doubts the program's success in diminishing poverty among our nation's elderly. But as ongoing demographic changes reduce the ratio of workers to retirees, Social Security's financial challenges have recently come to the fore in our national debates. This, in turn, has created an opportunity for some of Social Security's political opponents—former vice presidential candidate Paul Ryan and President George W. Bush are notable recent examples—to urge substituting private savings accounts, self-protection through thrift, for at least some substantial portion of Social Security's retirement benefits.

Why retirement—a routine and largely predictable event—is not an appropriate occasion for such self-protection through savings does not readily lend itself to a short, simple answer. But its essence lies in the uncertainty about future economic conditions and the risks of longevity; the risks of outliving one's savings.[13] Every Organization for Economic Cooperation and Development (OECD) nation and many others have instituted some form of social insurance to promote retirement security. In the United States, we have relied on what has

long been labeled a "three-legged stool," composed of (1) the inflation-adjusted, universally available, defined benefit of Social Security, (2) voluntary, tax-advantaged, employer-based private pensions (which now largely take the form of defined contribution plans), and (3) private savings. The fundamental debate of recent decades has been whether and how to change this mix.

Interestingly, while liberals and conservatives have split over the importance of retaining (and perhaps even strengthening) Social Security's provision of retirement income, Democrats and Republicans have agreed on the importance of strengthening private savings for retirement. Moving toward universal savings accounts has served as a rallying cry for both the Left and the Right. The critical distinction has been that the latter have proposed such accounts in lieu of at least some portion of current Social Security, while the former have pushed for mandatory private accounts on top of existing Social Security protections.

In our prior work, we have urged some specific reforms to put Social Security on a sounder financial footing and, in addition, proposed additional mandatory personal investment accounts.[14] The purposes of the latter proposal were to increase prefunding of retirement income, allow wider participation in the benefits of capital appreciation, and enhance personal responsibility for retirement.[15] (We also have urged using such accounts to reduce the moral hazard of other social insurance protections, such as unemployment insurance; more about that later.) Mandatory personal accounts would provide for all workers a second tier of retirement savings that could fill gaps in current employer-based pension coverage—coverage that now strongly favors higher-paid, better-educated, and older workers, as well as workers employed by large firms.

While some other proponents of individual accounts have urged voluntary rather than mandatory accounts, our nation's experience with IRAs demonstrates that universality can be accomplished only by mandating that each individual have an account. Low-wage workers, of course, would have difficulty funding such accounts if payroll deductions in addition to current Social Security and Medicare taxes are required. Thus, subsidies for such workers funded from general tax revenues would be necessary. As with health insurance, such a program, coupled with voluntary, rather than mandatory, accounts would produce important gaps in coverage and adequacy for middle-class workers and their families.

Along with individual account proponents from both the left and the right, before the ACA litigation we saw no constitutional objections to mandating such accounts. But it is somewhat more difficult to link mandatory personal savings to interstate commerce than the purchase of health insurance. In the wake of the Court's health insurance decision it seems clear that a majority of the current Court would hold that a federal mandate for personal savings accounts could be accomplished only indirectly through the Taxing and Spending Clauses, not by a straightforward requirement that everyone save a specified amount.

The standard technique would be to impose a tax that is completely forgiven by putting an equivalent amount into a savings account for specified purposes. However, Chief Justice Roberts's opinion, which emphasizes the small size of the ACA penalty (the tax) relative to the cost of purchasing the ACA's mandated health insurance coverage, raises the possibility that a larger penalty-to-benefit ratio (even if located in the tax code) might be viewed as a substitute for regulation, and run afoul of the Court's new Commerce Clause limitations.[16]

If it turns out that a direct mandate of savings for specified purposes is now viewed by the Court as beyond the federal government's regulatory powers, but not as overstepping its taxing and spending powers, it would, again, seem that only the means, not the ends, of such a policy have been limited by the Court's ACA decision. But the practical and political limitations implied by the Court's decision may, nevertheless, loom large. It was the allergic reaction of congressmen and senators to the "T" word that caused the ACA "tax" to be presented as a "penalty." If individual accounts can be implemented only through taxation, they may be politically impossible. The potential implications of the Court's decision for modernizing unemployment insurance may be even greater.

5. Unemployment Insurance

Unemployment insurance (UI), a centerpiece of the original 1935 Social Security Act, was an essential response to the Great Depression. Ever since, UI has provided crucial support for American workers in recessionary periods. But the Great Recession has surely demonstrated what policy analysts have long understood: our system of UI needs to be modernized. Today, UI undoubtedly should be a national program. In our nation's economy, with its single currency, macroeconomic shocks affect the entire country. But there are very substantial regional variations in an economic downturn's timing and intensity. These variations argue for including the whole nation in the insurance pool; otherwise regional demands will be greatest when regional capacity is weakest.

But unemployment insurance, as it was constructed in the 1930s and as it remains today, is a set of diverse state programs for which the federal government offers a peculiar incentive. The UI program was structured as a national tax on employers who fund their employees' unemployment benefits, modeled—for reasons of both politics and constitutional law—after a federal-state estate tax arrangement that had been upheld by the pre–New Deal Supreme Court. The federal tax is waived for any employer whose state imposes a similar unemployment tax and establishes an UI benefits program that conforms to the broad contours of the federal statute. That every state would act on this incentive was guaranteed by the unnecessarily high rate set for the federal tax. States can

virtually always make their employers, or at least some substantial number of them, better off by having a state system of their own.

Franklin Roosevelt understood as well as anyone the difficulties with this design. While governor of New York, he attempted to convince his fellow governors to institute parallel UI systems in every state. As he told them then, unless we all act together, none of us can act at all.[17] Roosevelt's reasoning was unassailable. The inexorable logic of interstate competition for mobile business capital makes it problematic for states to go it alone in a program like unemployment insurance. That same logic also suggests that states will continuously be tempted to improve their "business climate" by reducing the burden of UI on existing and prospective employers. Such a "race to the bottom" tends to undermine both the economic security and the macroeconomic stabilization purposes of the UI program, as well as its effectiveness. States have ended up with remarkably different UI systems. But the general trend over time has been to reduce both coverage and benefits and to fail to respond to changes in labor markets that put more and more low-wage, part-time, and part-year workers outside the system.

The Great Recession and its halting recovery have exposed major flaws in the current structure. Benefits paid to unemployed workers are frequently inadequate to keep their families afloat and to facilitate their search for a new job. Many workers find themselves without any coverage at all.

While state administration of UI is appropriate, there is little or no case to be made for state financing. The current financing structure is a creature of archaic constitutional constraints. And we find nothing in the Court's ACA opinion that would bar federalization of UI financing and eligibility rules. Again, only the techniques for doing so are potentially called into question. Federal repeal and replacement of existing arrangements is not barred. But more incremental—and therefore potentially more politically palatable—changes, such as eliminating the federal credit for state UI taxes unless specified conditions are met, may be questionable. If thought by a majority of justices to cross the vague barrier against "coercion" of the states found applicable to the ACA's changes in Medicaid, they would be barred. The power of the UI program's tax incentive may make it irresistible—and, therefore, on at least one reading of the ACA opinion, unconstitutional. Given the ambiguities of the Court's opinions, it is impossible to know for sure.

In addition to its unique structural defects, UI confronts especially large problems of moral hazard. People are more likely to stop working when the costs of doing so are cushioned by replacement of much of their wages. In addition, private insurance companies suffer in economic downturns just as claims for UI rise. As we have seen recently, insurers can go bankrupt in a deep recession. Hence, even if private insurance could solve the moral hazard problem, private

unemployment insurance would be inadequate. Unsurprisingly, private UI is virtually unknown.

To limit the potential for moral hazard, we have suggested combining expanded UI coverage with a system of individual accounts for each worker. In such a system, each employee would be required to contribute, say, 3 percent of wages to her account in order to help fund both periods of unemployment and retirement.[18] If a worker experiences a period of compensated unemployment, his or her account would be reduced by, say, 20 percent of the costs of the unemployment compensation paid. Workers whose accounts are insufficient to fund the required copayment would face a surcharge on their wages when reemployed, which would be paid until such time as the individual's account had an adequate balance. Upon retirement or death, amounts left in the worker's account would be paid in retirement benefits or as a death benefit to the worker's heirs.[19]

The Supreme Court's ACA decision obviously introduces new constitutional uncertainties into this kind of much-needed modernization of our nation's system of unemployment insurance. Changes such as we have suggested here may remain possible, but now apparently must be grounded in Congress's taxing power—the power Congress is most reluctant to use. It is difficult to know why this is a sensible or appropriate reading of the Constitution.

6. Conclusion

Health insurance is just one component of a modern system of social insurance—protection of some degree of income security for all Americans in the face of risks common in a dynamic market economy. None of the risks to loss of wage income that we have discussed here—illness, retirement, or unemployment—ever have been or ever will be adequately protected through private insurance alone.[20] Transferring responsibilities from the federal government to state governments or from governmental risk-spreading arrangements to individuals or families inevitably weakens these protections. When states are responsible for financing basic social insurance protections, families' economic security depends on which side of a river they call home. State-based financing also introduces the potential for destructive interstate races to the bottom.

A common feature of the ACA and our proposals for improving retirement security and unemployment insurance is their incremental nature: they largely build on existing institutional arrangements rather than starting anew. The ACA and our retirement security proposals, in particular, fall in the middle between the more radical public provision and privatization proposals advanced in

Washington in recent years. It would be ironic indeed if one consequence of the Supreme Court's ACA decision were to rule out-of-bounds those kinds of incremental changes that are most consonant with the checks and balances at the heart of the democratic structure of our nation's Constitution.

The originalist constitutional vision, embodied in the constitutional challenge to the ACA and found in both Chief Justice Roberts's and the dissenting justices' opinions, ignores the necessity in today's economy of placing both the power and responsibility for social insurance with the federal government. It is a mystery to us why, when it comes to social insurance protections, key politicians seem to believe that state governments always function better than the national government—or, even if not, that our Constitution commits us to a national government of quite limited power and functions in this arena.

To be sure, a majority of the Supreme Court, in refusing to strike down the individual mandate of the ACA, rejected that view. But in doing so, the Court introduced important new uncertainties into the constitutionally permissible *techniques* by which the national government can fulfill its social insurance goals.

Make no mistake: the constitutional challenge to the ACA and the complementary political efforts to devolve social insurance responsibilities to the states and to individuals poses a challenge to the very idea of social insurance. If our individual freedom includes the liberty to opt out of participation in the universal risk-pooling and to evade the intertemporal and interfamily redistribution that sits at the core of our social insurance protections, the very idea of providing social insurance is threatened. Social insurance allows us to thrive in an economic system where only some members of society enjoy financial success because both effort and luck play a crucial role. Social insurance is at base a deeply conservative idea. By protecting family incomes from common risks in a market economy, it simultaneously provides a critical political protection for that same market economy. Why a conservative Court or conservative politicians should want to make the American social insurance system less effective or more difficult to reform is a mystery.

Acknowledgment

Much of this essay is based on our book Michael J. Graetz & Jerry L. Mashaw, True Security: Rethinking American Social Insurance (1999). See also Jerry L. Mashaw, *Legal, Imagined and Real Worlds: Reflections on the Supreme Court's Decision in* National Federation of Independent Business v. Sebelius, Secretary of Health and Human Services, J. Health Pol'y Pol. & L. (forthcoming 2013).

Notes

1. See Michael J. Graetz, *Universal Health Coverage Without an Employer Mandate*, 2 Domestic Affairs 79 (1993); Michael J. Graetz & Jerry L. Mashaw, True Security: Rethinking American Social Insurance 1–46 (1999).
2. See Graetz & Mashaw, *supra* note 1, at 178.
3. See Mitt Romney, *Mr. President, What's the Rush?* USA Today, July 30, 2009, *available at* http://mittromneycentral.com/op-eds/2009-op-eds/mr-president-whats-the-rush/.
4. For further discussion, see Charles Fried's chapter in this volume, The June Surprises: Balls, Strikes, and the Fog of War.
5. See Graetz & Mashaw, *supra* note 1, at 69–91, 188–209.
6. For discussion elsewhere, see chapters 1 through 9 of this volume.
7. See Fried, *supra* note 4.
8. See Fried, *supra* note 4.
9. These conflicts are elaborated in Michael J. Graetz & Jerry L. Mashaw, *Ethics, Institutional Complexity and Health Care Reform: The Struggle for Normative Balance*, 10 J. Contemp. Health L. & Pol'y 93 (1994).
10. See Graetz & Mashaw, *supra* note 1, at 61–64, 299–303.
11. Our social insurance conception of health insurance is a "catastrophic" loss, defining catastrophic as income-based.
12. See H. Comm. on the Budget, The Path to Prosperity: A Blueprint for American Renewal (Fiscal Year 2013 Budget Resolution), *available at* http://paulryan.house.gov/uploadedfiles/pathtoprosperity2013.pdf (last visited August 31, 2012).
13. For more detail, see Graetz & Mashaw, *supra* note 1, at 92–111.
14. *Id.* at 254–263.
15. *Id.* at 263–267.
16. Even mandated savings demonstrates the emptiness of the action vs. nonaction distinction. Savings for retirement (or a period of unemployment) is a deferral of consumption so requiring savings can be viewed as equivalent to limiting current consumption, certainly a constitutionally appropriate use of the taxing power, given the long history of both broad consumption taxes and narrow taxes on the consumption of specific items (such as tobacco and tires).
17. Graetz & Mashaw, *supra* note 1, at 75 (citing Daniel Nelson, Unemployment Insurance: The American Experience 1915–1935 (1969)).
18. Graetz & Mashaw, *supra* note 1, at 263–267, 292.
19. *Id.* at 208.
20. Both short- and long-term disability constitute additional examples of the kind of risks at stake here, but we do not discuss those issues here.