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Beyond Payment and Delivery Reform: The Individual Mandate's Cost-Control Potential

Abigail R. Moncrieff[†] & Manisha Padi^{††}

I. INTRODUCTION

In a symposium¹ focused on healthcare cost control, most of our authors have unsurprisingly highlighted and assessed Obamacare's payment and delivery reforms—the supply-side efforts to decrease costs of medical treatment.² But there is another party in healthcare decision-making who is equally or even more important: the patient. The question we will tackle here is whether the individual mandate and its accompanying patient-centered insurance reforms might decrease costs for patients in ways that ought to matter in assessing Obamacare's cost control provisions.

The individual mandate's³ cost control potential lies in its reduction or even elimination of patients' decision costs. The mandate, together with its minimum coverage requirements and a handful of the statute's substantive insurance reforms, combats demand-side inefficiencies that might arise from patients' bounded rationality.⁴ Decisions about whether to buy commercial insurance, how much insurance to buy, whether to consume preventive care, and how much to pay for that care are all difficult decisions. In order to make optimal choices, patients need a lot of information that is costly to obtain and to evaluate.⁵ Although patients, left to

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¹ Symposium, *Improved Health at a Reduced Cost? Economic Perspectives on the Patient Protection & Affordable Care Act*, 40 AM. J.L. & MED. 178 (2014).

² *Id.*; see also generally Stacy Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 471 (2012); Joel Teitelbaum et al., *Translating Rights into Access: Language Access and the ACA*, 38 AM. J.L. & MED. 348 (2012).

³ 26 U.S.C. § 5000A (2012).

⁴ See *id.*; 42 U.S.C. § 18022 (2012); Abigail Moncrieff, *The Individual Mandate as Healthcare Regulation: What the Obama Administration Should Have Said in NFIB v. Sebelius*, 39 AM. J.L. & MED. 539, 544-47 (2013) (discussing healthcare market failures from consumers' optimism bias, hyperbolic discounting, and credence goods).

⁵ See Abigail Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) it Might be Good for Health Law*, 90 B.U. L. REV. 2323, 2346 (2010) ("[H]ealthcare markets are fraught with information and agency costs that prevent individual voters and consumers from representing their own interests.").

their own devices, might nevertheless make perfect choices, they likely would balance the costs from less-than-perfect choices with the cognitive costs of discovering optimal choices. Furthermore, even if unregulated patients did invest in optimal decision-making and therefore made perfectly efficient choices, regulation might be able to improve efficiency if the government can make optimal choices for patients at a lower total and average cost.⁶

Obamacare's individual mandate,⁷ minimum coverage requirements,⁸ elimination of cost-sharing for preventive care,⁹ and minimum medical loss ratios¹⁰ work together to decrease patients' decision costs,¹¹ steering patients to particular choices that Congress deemed most efficient.¹² If those regulations succeed in improving the efficiency of patients' healthcare and insurance choices, then the resulting demand-side forces can help to decrease prices. This brief Essay does not attempt to evaluate the regulations' success; it merely highlights the cost-control implications of Obamacare's demand-side measures, noting that discussions of cost control should not focus exclusively on the statute's supply-side effects.

II. TRIPARTITE DECISION-MAKING AND INFORMATION COSTS

Medical markets involve three important decision-makers: patients, doctors, and payers.¹³ Self-insured patients are their own payers, but most American patients rely on third-party payers, either governmental or private insurers.¹⁴ In an unregulated market, patients would need to decide whether to hire a third-party payer to bear the risk of bad medical shocks;¹⁵ they would need to decide which potential shocks to cover through insurance; and they would need to decide how much to pay for that risk-bearing function. They would also need to decide how much control to give their payers over their medical consumption choices, and when their payers did not exercise such control, they would need to decide when, whether, and how much medical treatment to consume. All of these decisions are quite costly to make.

A. INSURANCE CHOICES

On the question of whether to buy insurance in the first place, the patient needs to know how likely it is that she will suffer a bad health shock, and she needs to know whether, in the absence of insurance, she would have enough money to pay for

⁶ See *id.* at 2365-68 (arguing that federal agency regulation of health care decreases information costs and promotes efficiency through expertise and economies of scale).

⁷ 26 U.S.C. § 5000A.

⁸ *Id.* § 18022.

⁹ *Id.* § 300gg-13.

¹⁰ *Id.* § 300gg-18.

¹¹ See *The Patient Protection and Affordable Care Act: Detailed Summary*, DEMOCRATIC POL'Y CTR., available at <http://www.dpc.senate.gov/healthreformbill/healthbill04.pdf> (last accessed May 13, 2014) ("The Patient Protection and Affordable Care Act will ensure that all Americans have access to quality, affordable health care . . .").

¹² See *infra* Part II.B.

¹³ See David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance*, in HANDBOOK OF HEALTH ECON. 563, 588-89 (A.J. Cuyler & J.P. Newhouse eds., 2000), available at <http://www.nber.org/papers/w7176> (discussing principal-agent relationships among doctors, payers, and patients).

¹⁴ See *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/total-population/> (last visited May 13, 2014) (reporting that eighty-four percent of Americans had third-party insurance in 2012).

¹⁵ See Cutler & Zeckhauser, *supra* note 13, at 588-89.

the treatment required when such a shock arose. The probability of a shock depends on complex information about family history, relationship of family history to individual risk, any non-hereditary predispositions to particular health shocks, and environmental and behavioral contributors to risk.¹⁶

There are three distinct barriers to acquiring and using that information. First, many patients cannot spare the cognitive resources required to access and comprehend the medical information available about health risks.¹⁷ It is more efficient for them to use cognitive resources in other ways because it is usually more costly per unit to do a task one time than it is to do that task one hundred times.¹⁸ Unless a patient is a healthcare or insurance professional, he is likely to find it very costly to make these assessments himself, and he likely would rather spend his cognitive resources on his job, allowing him to make enough money to hire someone else to assess his medical risk.

Second, even the patients who do have the resources required to understand their health risks suffer from cognitive limitations in the form of heuristics and biases¹⁹—most famously optimism bias²⁰—that they must overcome when evaluating their true risks. Overcoming those biases might impose distinct cognitive costs; for example, it might be depressing to make realistic rather than optimistic assessments of one's current health state and future health risks.²¹

Third, medical science does not understand the cause of some health risks, making it impossible to estimate one's individual risk of suffering those shocks any more specifically than population-level incidence. For example, science does not yet know whether liposarcoma, a particular soft-tissue cancer, is hereditary, environmental, behavioral, or none of the above;²² all we know is that it is generally rare in humans.²³

¹⁶ Tomas J. Phillipson & George Zanjani, *Economic Analysis of Risk and Uncertainty Induced by Health Shocks: A Review and Extension*, in HANDBOOK OF THE ECONOMICS OF RISK AND UNCERTAINTY 453, 465-66 (Mark J. Machina & W. Kip Viscusi eds., 2014).

¹⁷ See generally Punam A. Keller et al., *Depressive Realism and Health Risk Accuracy: The Negative Consequences of Positive Mood*, 29 J. CONSUMER RES. 57 (2002) (showing that individuals with good mental health were overconfident in assessing health risks, as opposed to depressed individuals, who were accurate); John Mirowsky, *Subjective Life Expectancy in the US: Correspondence to Actuarial Estimates by Age, Sex and Race* 49 SOC. SCI. & MED. 967, 967-79 (1999) (showing overconfidence in subjective assessment of life expectancy); Leslie Alderman, *Getting a Guide for the Jungle of Individual Health Policies*, N.Y. TIMES (Sept. 10, 2010), <http://www.nytimes.com/2010/09/11/health/11patient.html>.

¹⁸ See generally Kalanit Grill-Spector et al., *Repetition and the Brain: Neural Models of Stimulus-Specific Effects*, 10 TRENDS COGNITIVE SCIS. 14 (2006); *Find an Agent Database*, NAT'L ASSOC. HEALTH UNDERWRITERS, <https://www.nahu.org/consumer/findagent.cfm> (last visited April 11, 2014).

¹⁹ See Amos Tversky & Daniel Kahneman, *Judgment under Uncertainty: Heuristics and Biases*, 185 SCI. 1124, 1124 (1974) (showing that, when making decisions under uncertainty, "people rely on a limited number of heuristic principles which reduce the complex tasks of assessing probabilities and predicting values to simpler judgmental operations").

²⁰ See generally TALI SHAROT, THE OPTIMISM BIAS: A TOUR OF THE IRRATIONALLY POSITIVE BRAIN (2011); see also Neil D. Weinstein, *Reducing Unrealistic Optimism About Illness Susceptibility*, 2 HEALTH PSYCHOL. 11, 11-12 (1983) ("For many health and safety threats . . . people tend to believe that they are less at risk than others around them.").

²¹ See Cass R. Sunstein, *Choosing Not to Choose* 3-4 (Harvard Pub. L., Working Paper No. 14-07, 2014), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2377364 ("Some people choose not to choose . . . [because] [t]hey might be aware of their own lack of information or perhaps their own behavioral biases (such as unrealistic optimism).").

²² *What is Liposarcoma?*, LIDDY SHRIVER SARCOMA INITIATIVE (2012), available at <https://web.archive.org/web/20140327144350/http://sarcomahelp.org/liposarcoma.html> (last visited

In short, when assessing the actuarial value of insurance for various health risks, the information costs can be extremely high and, for many patients, insurmountable. Patients might therefore rationally choose to delegate the decisions of whether to buy insurance and how much insurance to buy to a fourth party²⁴—not themselves, their doctors, or their insurers, but someone else. Sidestepping doctors and insurers may be efficient because their incentives are not likely aligned with patients' incentives to stay healthy at minimum out-of-pocket cost. Indeed, the American market has relied on such delegates for most private insurance choices: employers.²⁵ Human resources departments at most large employers in the United States have developed expertise in compiling and understanding their employees' group-level risks²⁶ (an easier task than estimating individual risks, given the law of large numbers), and employees have relied on that expertise in making insurance choices.²⁷

Of course, many individuals are self-employed or unemployed,²⁸ or they work for employers that have been unwilling or unable to take on this role,²⁹ leaving those Americans to fend for themselves in the complex health insurance market. In a market with such high information costs,³⁰ many of those patients likely make inefficient insurance choices,³¹ buying too little or too much insurance, in order to save on decision costs. In other words, we can expect many individuals rationally to suffer some costs from making imperfect insurance choices in order to save the even higher cost of making perfect choices.

May 10, 2014) (hosting a copy of the webpage, as it appeared on Mar. 27, 2014, which is no longer available on the SarcomaHelp website) (“Scientists do not yet know the cause of liposarcoma.”).

²³ *Id.*; Debra Kessler, M.D., *Salem Health: Cancer, Liposarcomas*, SALEM PRESS, http://salempress.com/store/samples/cancer/cancer_liposarcomas.htm (last accessed May 11, 2014) (“Annually 2.5 cases [of liposarcoma] occur per 1 million population.”).

²⁴ See Avik Roy, *Health Care and the Profit Motive*, NAT’L AFF. (2010), <http://www.nationalaffairs.com/publications/detail/health-care-and-the-profit-motive> (last accessed April 11, 2014).

²⁵ See *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/total-population/> (last visited May 3, 2014) (finding that 48% of the 85% of Americans with third-party insurance have employer-provided insurance).

²⁶ See Moncrieff, *supra* note 5, at 2353 (“Part of the value of the ESI system, then, is that employers (and other large-group purchasers) are well-positioned to aggregate information across employees and over time.”).

²⁷ See Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 MILBANK Q. 5, 15-16 (2000) (“Most employees [surveyed] were of the opinion that their employers were far more knowledgeable about health insurance plans and were much better equipped to sort through the plans and options than they were individually.”).

²⁸ See *Labor Force Statistics from the Current Population Survey*, BUREAU LAB. STAT., <http://www.bls.gov/web/empsit/cpseea08.htm> (last modified May 2, 2014) (reporting over 9 million self-employed workers in 2014); *Labor Force Statistics from the Current Population Survey*, BUREAU LAB. STAT., <http://www.bls.gov/cps/cpsaat01.htm> (last modified February 26, 2014) (reporting 11 million unemployed workers in 2013).

²⁹ See *Percent of Private Sector Establishments That Offer Health Insurance to Employees*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/percent-of-firms-offering-coverage/> (last visited May 1, 2014) (reporting that only 50% of private firms offer health insurance coverage).

³⁰ See Moncrieff, *supra* note 5, at 2352 (“[T]he . . . insurance market . . . is fraught with information costs, preventing individual patients . . . from judging the quality of a given insurance contract.”).

³¹ See Moncrieff, *supra* note 4, at 557 (“[T]he vast majority of self-insured individuals are also underinsured.”).

One key function of the individual mandate is to put government in the role of delegatee for the Americans whose employers were not playing that role.³² After Obamacare, federal and state governments will make the same insurance choices that many employers have long made for most privately insured Americans. Obamacare's individual mandate, which in the statute is termed the "minimum essential coverage requirement" and encompasses the statute's "minimum essential benefits" provisions,³³ eliminates (or at least greatly reduces) decision costs on the questions of whether to buy insurance and how much insurance to buy. Once it comes into full force, the penalty for failure to buy insurance will render most patients monetarily indifferent to carrying or not carrying insurance;³⁴ it will transform their choice into the choice between paying money to an insurance company for the benefit of risk transfer or paying the same amount of money to the federal government for no benefit at all. Furthermore, although the mandate leaves individuals with a choice among levels of actuarial value, it requires all complying insurance policies to cover a basic set of medical treatments,³⁵ essentially requiring individuals to insure themselves against a common set of potential health shocks. Effectively, the penalty for failure to carry minimum coverage attaches a monetary cost to the choice *not* to hire a third-party payer, making the decision much easier for most Americans.³⁶

B. CONSUMPTION CHOICES

On the question of whether to consume a given medical treatment, Americans face a whole other set of decision and information costs. Here, there are two levels of choice that a patient would need to make in an unregulated market: what to consume and whom to trust.

First and most obviously, a patient left to her own devices would need to know what her current medical condition is, what medical interventions could potentially improve her current condition, how likely those interventions are to help, how much risk there is that those interventions will hurt, and how much various alternative interventions cost. Only with all of that information will a patient be able to make an ideal choice about whether to consume a given medical treatment.

³² See *id.* at 558 ("The problem that Obamacare sought to fix, then, is not just that the self-insured consume care they cannot afford; it is also that they do a bad job of consuming care they *can* afford.").

³³ 26 U.S.C. § 5000A (2012).

³⁴ The mandate penalty maxes out in 2016 and beyond at the greater of 2.5% MAGI or \$695, but cannot exceed the national average cost of a bronze-level plan. So, the highest earning individuals will be indifferent (because their contribution will be capped by the cost of a bronze plan), but middle-income (paying 2.5% MAGI) and low-income (paying \$695) individuals will face a penalty less than the cost of a bronze plan. See ANNIE L. MACH, CONG. RESEARCH SERV., R41331, INDIVIDUAL MANDATE UNDER ACA 2 (March 6, 2014), available at <http://www.fas.org/sgp/crs/misc/R41331.pdf>.

³⁵ 42 U.S.C. § 18022 (2012).

³⁶ Of course, Tea Party Americans experience a non-monetary cost from losing the battle in a majoritarian system and a separate non-monetary cost from the imposition of the government as their delegate in this choice. They must now decide whether the hedonic injury of complying with majoritarian-induced government directives is worth more or less to them than the cost of paying the penalty for failure to insure. That decision is not an easy one and imposes its own cognitive costs; they might choose to comply but feel depressed by the sense of defeat and compulsion in making that choice.

Because that decision is so complex, patients often give their agents discretion to guide their medical consumption.³⁷ One agent that patients frequently trust is their doctor, which is why payment and delivery reform are so important to cost control.³⁸ But another agent that often steers a patient's consumption is her payer.³⁹ Health insurers, including the Medicare and Medicaid programs,⁴⁰ engage in some degree of medical necessity review and refuse to cover treatments that are not medically indicated,⁴¹ even though the insurance policy would cover the same treatments if they *were* indicated.⁴² Ideally, before choosing a particular insurer, the patient would be able to determine whether the company generally served as a faithful agent for its patients, helping patients to avoid consumption of low-value medical interventions while facilitating consumption of high-value interventions.

Unfortunately, that kind of monitoring is quite costly.⁴³ Even if an insurance company developed a reputation for rejecting medical claims, prospective customers would not know whether the rejected claims should have been granted. Perhaps the insurer tends to attract hypochondriacs who get mad when the insurer rejects their illegitimate claims. Or perhaps the reputation emerged from a handful of very loud hypochondriacs who don't represent most of the insurer's customers.⁴⁴ In short, market information about an insurer's habits is not worthless, but it is not entirely reliable, either.

The American market for private insurance has solved this monitoring problem in the same way that it has solved the problem of insurance purchasing decisions: through delegation to employers.⁴⁵ Most Americans who are privately insured rely on their employers to choose among competing claims administrators for their

³⁷ See Cutler & Zeckhauser, *supra* note 13, at 588-89 ("Patients, physicians, and insurers are in a *principal-agent* relationship: the patient (principal) expects the doctor (agent) to act in his best interest when he is sick.").

³⁸ See *id.* at 588 ("In most cases of serious expenditure, it is the doctors who make the resource-spending decision, with patients and insurers bearing the costs; patients usually do not know the charge until the bill comes.").

³⁹ See *id.* at 590 ("Increasingly, insurers attempt to provide incentives for providers to limit spending.").

⁴⁰ See 42 U.S.C. § 1395y(a)(1)(A) (providing that Medicare will not make payments that "are not reasonable and necessary for the diagnosis or treatment of illness or injury"); *Beal v. Doe*, 432 U.S. 438, 444-45 (1977) ("Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the [Social Security] Act for a State to refuse to fund unnecessary though perhaps desirable medical services.").

⁴¹ See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PENN. L. REV. 1637, 1647 (1992) ("By the end of the 1970s, many insurers had adopted two new contractual revisions in response to this additional round of losses: first, they specified that medical necessity is to be determined in the insurer's judgment, and second, they explicitly excluded payment for 'experimental' or 'investigational' procedures.").

⁴² See *id.* at 1645-46.

⁴³ See Moncrieff, *supra* note 5; see also Gavin Mooney & Mandy Ryan, *Agency in Health Care: Getting Beyond First Principles*, 12 J. HEALTH ECON. 125, 127, 132 (1993) (observing that it is difficult and costly for principals to monitor their agents, particularly in the healthcare context).

⁴⁴ See Bradley Dowden, *Fallacies: Unrepresentative Sample*, INTERNET ENCYCL. OF PHILOSOPHY, <http://www.iep.utm.edu/fallacy/#UnrepresentativeSample> (last visited May 11, 2014) ("Knowingly selecting atypical members of the population produces a biased sample.").

⁴⁵ See Pamela B. Peeler et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 MILBANK Q. 5, 7 (2000) (finding employers are effective agents for their employees if "[e]mployers understand their employees' health plan preferences[;] . . . incorporate employee preferences into their health plan designs[;] . . . [and] establish mechanisms for soliciting and understanding their employees' preferences and provide useful information to their employees about their health insurance offerings.").

medical benefits.⁴⁶ As in the case of the purchasing decision, employers are in a better position to engage in costly monitoring of claims processing habits because their human resources departments have developed expertise in understanding and monitoring health insurance.⁴⁷

But, as in the prior case, not all employers have been willing and able to take on this role,⁴⁸ and many Americans have therefore lacked an agent for monitoring their insurers' claims processing. Because that monitoring is so costly, those Americans have likely made a rational choice to suffer some negative effects from imperfect monitoring because it is cheaper to bear the negative effects than to monitor or switch insurers.

Under Obamacare, however, federal and state governments have stepped in as agents for the Americans who lack employer-sponsored insurance.⁴⁹ This time, it is the insurance reforms rather than the mandate that serve this function. Obamacare requires insurers to spend a certain percentage of their money on medical claims;⁵⁰ they may not use premiums for administrative costs or profits.⁵¹ They now lack their erstwhile incentive to abuse agency slack by rejecting worthy medical claims.⁵²

Of course, this solution is incomplete. Patients still have to make difficult decisions about which medical interventions to consume. Even when the insurers' medical review incentives are more closely aligned with their patients' incentives, the information costs of assessing consumption choices remain quite high. Insurers have more expertise than patients in assessing doctors' treatment suggestions,⁵³ but they have less information than the doctor and patient about the patient's symptoms because they do not interact with the patient directly.⁵⁴ Therefore, there is still

⁴⁶ See Moncrieff, *supra* note 5, at 2352 ("The market for employer-sponsored health insurance is undoubtedly a competitive one, with many MCOs and other insurers trying to sell their products to many employers.").

⁴⁷ See *id.* at 2353 ("Part of the value of the ESI system, then, is that employers (and other large-group purchasers) are well-positioned to aggregate information across employees and over time."); Peele et al., *supra* note 45, at 15-16 ("Most employees [surveyed] were of the opinion that their employers were far more knowledgeable about health insurance plans and were much better equipped to sort through the plans and options than they were individually.").

⁴⁸ See Paul Fronstin, *Employment-Based Health Benefits: Trends in Coverage, 1997-2010*, 370 EBRI ISSUE BRIEF 1 (Apr. 2012), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_04-2012_No370_HI-Trends.pdf (finding that "[b]etween 1997 and 2010, the percentage of workers offered health benefits from their employers decreased from 70.1 percent to 67.5 percent."); Steven Greenhouse & Reed Abelson, *Wal-Mart Cuts Some Health Care Benefits*, N.Y. TIMES (Oct. 21, 2011), available at <http://www.nytimes.com/2011/10/21/business/wal-mart-cuts-some-health-care-benefits.html> ("After trying to mollify its critics in recent years by offering better health care benefits to its employees, Wal-Mart is substantially rolling back coverage for part-time workers and significantly raising premiums for many full-time staff.").

⁴⁹ 42 U.S.C. § 300gg-41 (2012).

⁵⁰ *Id.* § 300gg-18.

⁵¹ *Id.*

⁵² See SUZANNE M. KIRCHOFF & JANEMARIE MULVEY, CONG. RESEARCH SERV., R42735, MEDICAL LOSS RATIO REQUIREMENTS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA): ISSUES FOR CONGRESS 1 (2012), available at <http://www.fas.org/spp/crs/misc/R42735.pdf> ("In general, the higher a plan's [medical loss ratio], the more value a consumer is receiving (i.e., the more each dollar of premiums paid goes toward health benefits and not towards overhead).").

⁵³ See Cutler & Zeckhauser, *supra* note 13 at 590 ("The medical care system is a network, with patients, monies and information flowing from one party to another. The information flow to insurers, however, is not so rich that they can guarantee that only cost-effective care will be provided.").

⁵⁴ See *id.*

significant slack allowing doctors to steer consumption, which is, again, why payment and delivery reform are so important.⁵⁵

One of the most costly choices that patients and their insurers face is whether a particular patient should consume preventive care.⁵⁶ Any benefits from such care are long-term, which makes them hard for the patient to perceive and monetize⁵⁷ and which makes it unlikely that the patient's current insurer will realize any cost-saving benefits of such consumption.⁵⁸ Most Americans switch insurers when they switch employers, and they all switch from private to public insurance when they reach age sixty-five. Furthermore, the choice to consume preventive care requires patients to confront the possibility that they are sick without realizing it or that they will soon become sick if they do not change their behaviors. This decision might be especially cognitively costly because it requires patients to overcome tendencies towards optimism bias and hyperbolic discounting.⁵⁹

Obamacare addresses and mitigates that decisional burden for all American patients, whether covered by employer-sponsored insurance or not.⁶⁰ The statute requires payers to cover preventive services without patient cost-sharing,⁶¹ at least so long as the United States Preventive Services Task Force agrees that the services are worth covering.⁶² This provision eliminates decision costs for the insurers, who would otherwise need to determine how many of their patients are likely to stay with them until they were sixty-five and how many of those patients are likely to suffer ill health and high medical claims from lack of preventive consumption in younger age. The requirement also decreases decision costs for patients by turning the monetary cost of consumption into a sunk cost; patients must now pay the full cost of preventive care in premiums rather than reserving a portion of that cost for a copay or deductible at the time of consumption.⁶³ Patients therefore no longer need to decide whether preventive care's long-term and uncertain benefits are worth more or less than the cash they would lose to cost-sharing.

⁵⁵ See *id.* at 588 ("In most cases of serious expenditure, it is the doctors who make the resource-spending decision, with patients and insurers bearing the costs; patients usually do not know the charge until the bill comes.").

⁵⁶ See Moncrieff, *supra* note 31, at 548 ("If individuals are not required to spend money on this kind of future-regarding care, they will consume systematically too little of it.").

⁵⁷ See *id.* at 549 ("[B]ecause of hyperbolic discounting, the longer timescale between present investment and future reward causes a bigger gap between optimal and actual present valuation.").

⁵⁸ See Bradley Herring, *Suboptimal Provision of Preventive Healthcare Due to Expected Enrollee Turnover Among Private Insurers*, 19 HEALTH ECON. 438, 447 (2010) ("[E]nrollee turnover among private insurers results in a disincentive to provide socially optimal levels of preventive care.").

⁵⁹ See generally SHAROT, *supra* note 20; David Laibson, *Golden Eggs and Hyperbolic Discounting*, 112 Q. J. ECON. 443, 446 (1997) ("Hyperbolic discount functions are characterized by a relatively high discount rate over short horizons and a relatively low discount rate over long horizons. This discount structure sets up a conflict between today's preferences, and the preferences that will be held in the future."); Neil D. Weinstein, *Reducing Unrealistic Optimism About Illness Susceptibility*, 2 HEALTH PSYCHOL. 11, 11-12 (1983) ("For many health and safety threats, though not all, people tend to believe that they are less at risk than others around them[.]").

⁶⁰ See 42 U.S.C. § 300gg-13 (2012). *But see* Hobby Lobby Stores, Inc. v. Sebelius, 723 F.3d 1114 (10th Cir. 2013), *cert granted* 134 S. Ct. 678 (2013); Petition for Writ of Certiorari at I, *Hobby Lobby*, 723 F.3d 1114 (No. 13-354) (petitioning as to the constitutionality and legality of rule requiring most employee health plans to offer free contraceptive services).

⁶¹ 42 U.S.C. § 300gg-13.

⁶² U.S. PREVENTIVE SERVS. TASK FORCE, <http://www.uspreventiveservicestaskforce.org/> (last visited May 12, 2014) ("The USPSTF strives to make accurate, up-to-date, and relevant recommendations about preventive services in primary care.").

⁶³ 42 U.S.C. § 300gg-13 (providing that insurers "shall not impose any cost sharing requirements" for preventive care).

III. COST-CONTROL IMPLICATIONS

The relevant question for assessing Obamacare's demand-side measures is whether the government's decision costs, including its error costs, are lower than the aggregated private decision costs would have been. There are two components to this question: How much is the government spending on decisions, and how close is it coming to making perfect choices for regulated individuals? As noted above, individuals probably buy too little or too much insurance and consume too little or too much healthcare relative to the optimum because it is cheaper to bear the error costs than to incur the information costs required to make perfect choices.⁶⁴ Perhaps, though, the government's information costs are lower than individuals' aggregate information costs such that government can come closer to optimality than individuals can.

The likelihood of that possibility depends on the homogeneity, or lack thereof, of individuals' insurable risks and treatment benefits.⁶⁵ Imagine, for example, that family history, individual behavior, and proximal environment have no impact on overall cancer risk; once all cancers are taken into consideration, everyone's risk of developing cancer is basically identical to the overall population incidence of cancer. In that case, everyone should make the same decision about whether to buy cancer coverage and how much to pay for it. If that were true, then the government would benefit from economies of scale in measuring the value of cancer coverage in health insurance contracts. Government could, in one fell swoop, impose a uniform mandate for cancer benefits at a particular price point, and that choice would be optimal for all Americans.

At the other end of the extreme, imagine that both overall and specific cancer risks depend entirely on individual genetics, behavior, and environment. An active vegetarian with no family history of cancer who lives far from environmental carcinogens experiences a much lower risk of all cancers than a lazy omnivore whose father died young of cancer and who grew up near a paint factory. In that case, the actuarial value of cancer coverage would be different for every individual, and a uniform mandate at a uniform price point would impose error on many Americans. That system might still be welfare enhancing on a Kaldor-Hicks model⁶⁶ if the benefit to high-risk patients of mandated coverage was greater than the harm to low-risk patients, but assessing the results would be much harder than if everyone's cancer risks were the same.

⁶⁴ See *supra* Part II.B.

⁶⁵ See generally David R. Williams & Chiquita Collins, *U.S. Socioeconomic and Racial Differences in Health: Patterns and Explanations*, in RACE, ETHNICITY, AND HEALTH: A PUBLIC HEALTH READER 375 (Thomas LaVeist & Lydia Isaac, eds., 2d ed. 2002); Ichiro Kawachi, et al., *Health Disparities by Race and Class: Why Both Matter*, 24 HEALTH AFF. 343 (2005).

⁶⁶ The Kaldor-Hicks efficiency criterion states that an intervention is efficient if individuals that are made worse off from the intervention can be compensated for their loss by those who are made better off from the intervention, in utilitarian terms. That is, the winners gain more than the losers lose. It has been considered an alternative to the Pareto efficiency standard, which has long been the gold standard for economists, which states that an efficient intervention makes some people better off without making anyone worse off. The Kaldor-Hicks standard is often more practicable. See, e.g., Guido Calabresi, *The Pointlessness of Pareto: Carrying Coase Further*, 100 YALE L.J. 1211, 1221-27 (1991) (discussing the superiority of the Kaldor-Hicks model over the Pareto model); Amartya Sen, *The Discipline of Cost-Benefit Analysis*, 29 J. LEGAL STUDS. 931, 947 (2000) (discussing the compensation criterion of the Kaldor-Hicks model). But see Edward Stringham, *Kaldor-Hicks Efficiency and the Problem of Central Planning*, 4 Q. J. AUSTRIAN ECON. 41, 48 (2001) (arguing that "Kaldor-Hicks is an unusable standard").

For similar reasons, it is possible that the government benefits from economies of scale in deciding that everyone should consume certain forms of preventive care. If most or all people share similar risks from lack of those preventive services or gain similar benefits from consumption of those services, then government can make and impose a single decision more cheaply than if everyone came to the same decision independently. On the other hand, if everyone suffers different risks or gains different benefits from consuming preventive care, then individuals might make choices more cheaply than government. In that case, a uniform mandate would create error costs for some Americans, which would be welfare-enhancing only if total benefits outweighed total costs such that beneficiaries could theoretically reimburse victims.

IV. CONCLUSION

It is possible that Obamacare's demand-side measures, especially the individual mandate and its accompanying minimum essential coverage provisions, will decrease decision and error costs in the markets for health insurance and medical treatment. In discussions about healthcare cost control and Obamacare's impact thereon, it is important to consider these effects as well as the supply-side effects from Obamacare's limited attempts at delivery and payment reform.