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Health Insurance & Federalism-in-Fact

Radha A. Pathak* & Brendan S. Maher**

The Affordable Care Act (ACA) occasioned a constitutional federalism dispute, and there can be no doubt that the Supreme Court's ruling on the validity of the ACA deserves considerable attention.¹ In our view, however, no federalism analysis of the ACA (or any federal statute) is complete without a consideration of how the legislation inhibits—or does not inhibit—the real exercise of state power. That is, rather than devoting exclusive attention to the Court's appraisal of the ACA's legitimacy from the perspective of constitutional federalism, the ACA should be analyzed from the perspective of “federalism-in-fact”: the degree to which regulatory power is actually shared between federal and state governments. This article begins the analysis by focusing on the ACA's central feature—the regulation of private health insurance, which heretofore has been most heavily regulated by the Employee Retirement Income Security Act of 1974 (ERISA).² This article contends that when the ACA's own impact on regulation of private health insurance is analyzed, especially when such impact is compared to the extent ERISA had already federalized the regulation of private health insurance, it becomes clear that the ACA intrudes less upon state power than conventional accounts recognize.

I. A Proposed Metric: Sickness and Non-Sickness Rules

Our proposed manner of evaluating the ACA's effect on state power is to consider its effect on the two broad categories of rules that comprise the universe of all regulation of private health insurance: “sickness rules” and “non-sickness rules.” As Professor Maher has explained elsewhere, private health insurance is a bargain between the insured and the insurer.³ Bargains involve some substan-

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1. Nat'l Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

2. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829.

3. See Brendan S. Maher, *The Benefits of Opt-in Federalism*, 52 B.C. L. Rev. 1733, 1744–49 (2011) (explaining how insurance is a bargain between insured and insurer).

tive exchange between the parties—that substantive exchange is the core thing that motivated the parties to start bargaining in the first place. A health insurance bargain’s core content is coverage: what medical conditions and treatments will be covered by the policy? Insureds are interested in obtaining insurance because it offers coverage, and insurers are interested in offering a price that depends, in largest part, on the content of the coverage. We describe legal rules that govern such coverage content as sickness rules.

Health bargains also implicate many matters other than coverage, such as questions of remedy, review, notice, and funding. These matters are not the primary reason health insurance bargains are pursued in the first instance, but they are of crucial importance in consummating, performing, and enforcing the bargain. There is no perfect term for this category of items. We label them simply in deference to what they are not. They are not legal rules that specify what conditions or treatments are covered, so we call them non-sickness rules.

States have long expressed a desire to regulate sickness rules, and for some states, these rules are the central matters it may wish to regulate.⁴ Thus, states have enacted “direct” regulation of sickness rules (for example, “mandated coverage” or “required benefit” rules) that specify that a particular condition or a particular type of treatment must be covered.⁵ However, such direct regulation is only one aspect of the regulatory scheme because the inherent nature of health insurance limits the efficacy of such direct regulation. Most insurance policies premise coverage on treatment that is “medically necessary,”⁶ and the determination of “medical necessity” does not lend itself to precise *ex ante* specification,⁷ so non-sickness rules attain special significance.

Conceptually, there are two ways in which a health insurer’s payment obligation could work: as an indemnity or non-indemnity obligation. Indemnity has different meanings in different contexts, but we are using a particular definition here: an indemnity arrangement ties the insurer’s payment obligation to the insured’s actual loss.⁸ In

4. See, e.g., Amy B. Monahan, *Fairness versus Welfare in Health Insurance Content Regulation*, 12 U. ILL. L. REV. 139, 144, 147 n.34 (2012) (describing content regulation as a “high stakes” affair).

5. *Id.* at 147 (states average approximately eighteen mandated benefit rules each, with a low of two in Idaho and thirty-five in California).

6. William M. Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 599 (2003).

7. Cf. Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U.L. REV. 433, 462 (2010) (uncertainty as to the meaning of medical necessity “dwarfs” the uncertainty present in other benefit promises).

8. For example, under a motor vehicle insurance contract, the insurer’s loss obligation includes paying for the repair for physical damage to the insured’s vehicle as well as physical damage to the vehicle of another driver that was caused in an accident and for which the insured is legally responsible. A non-indemnity motor vehicle insurance arrangement would pay a lump sum for any accident, no matter how severe.

contrast, a non-indemnity payout is a predetermined sum paid upon the occurrence of a triggering loss event, without regard to the loss incurred in fact by the insured. Accordingly, non-indemnity insurance includes a determination, *ex ante*, of the insurer's cost (payout) associated with the covered loss; indemnity insurance requires a determination, *ex post*, of the insurer's cost (payout) associated with the covered loss.

Non-indemnity health insurance—in which the insurance payout is a fixed sum based on the triggering event—is impracticable for many reasons, not the least of which is that there are so many medical conditions and corresponding treatments. A comprehensive non-indemnity policy (i.e., one where the insured received some lump sum for every specific condition) would be thousands of pages long.⁹ The *ex ante* nature of non-indemnity arrangements limits their practical applicability to health insurance. Instead, indemnity arrangements are used, which connect coverage and treatment to a “medical necessity” determination.

The flexibility of a medical necessity standard can be a virtue or a vice for insurers, insureds, and policymakers. Insurance companies, concerned about paying for ineffective or unnecessary treatments deemed medically necessary by doctors sympathetic to their patients or desirous of additional work, have attempted to cabin medical necessity in a variety of ways.¹⁰ One approach is contractually to disclaim categories of treatment not covered by the promise, such as “experimental,” “investigative,” or “cosmetic” treatments. Another contractual exception is to exclude specific treatments and limit the length of services for particular ailments.¹¹

To ensure particular depth or breadth of coverage, legislatures have frequently responded with policy judgments of their own, namely that X treatment or Y condition (or X category of treatment or Y category of condition) must be covered for all policies sold in the state.¹² These particularized legislative requirements—which are sickness rules—are not atomistic and exhaustive judgments about what a policy must cover, nor, because of the nature of medical treatment, are they usually immune from case-specific distortions.¹³ State

9. There's also the diagnosis problem. A significant portion of medical expenditures involves identifying the problem. It would be nearly impossible to incorporate that into non-indemnity arrangements.

10. See generally Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992) (examining different approaches taken by the health insurance industry to rein in the meaning of medical necessity).

11. *Id.*; see also JAYNE E. ZANGLEIN & SUSAN J. STABILE, *ERISA LITIGATION* 542 (2d ed. 2005).

12. See, e.g., Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361 (2007).

13. Very specific mandates do occur, of course. But the point is that a truly comprehensive list of specific mandates immune from case-specific discretion would begin to approximate a non-indemnity approach.

benefit mandates are essentially indemnity approaches (requiring some level of ex post judgment) imbued with legislative policy judgments about categories of coverage. As a result, they ultimately must rely on non-sickness rules (i.e., rules limiting coverage discretion, impartial review, and damages) to prevent strategic play by both sides. For a proper federalism analysis, therefore, it is critical to assess the extent to which the ACA actually impedes state ability to enact both sickness rules and non-sickness rules.

II. Sickness Rules

Sickness rules—legal rules governing the motive for pursuing the health insurance bargain in the first place (i.e., coverage for conditions and treatments)—understandably attract attention. Anecdotes about certain treatments not being covered, or, conversely, about how insurance costs are skyrocketing because everything is covered, are frequent. It is therefore unsurprising that the ACA's sickness rules have attracted a great deal of attention, and the widespread belief appears to be that the federal government has nationalized all sickness rules.¹⁴ It is our contention that the ACA does leave some room for direct state regulation of sickness rules, and this regulatory freedom is considerably greater than allowed under ERISA.

A. ACA and Sickness Rules

Like the state approaches to sickness rules discussed above, the ACA combines an indemnity model with its version of legislative benefit mandates.¹⁵ The legislative mandate, however, emanates from Congress and the secretary of the Department of Health and Human Services (HHS). The latter is charged by the former with the task of creating the following sickness rule: with certain exceptions, all small group and individual policies must cover “essential health benefits” (EHB).¹⁶ EHB, in turn, are to be defined by HHS and must include services in ten legislatively specified areas.¹⁷

States lack the authority to pass sickness rules that excuse an insurance company from selling a policy on an exchange that provides less than EHB.¹⁸ Moreover, the ACA provides that, should a state mandate benefits in excess of EHB, the state will have to pay the insurer or the purchasing individual the difference in cost between covering the federal EHB and the more generous state EHB-plus

14. Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 593 (2011) (describing various objectors as decrying a “federal takeover” of health care).

15. We do not attempt in this article to describe the ACA or ERISA generally.

16. 42 U.S.C. § 300gg-6 (2006) (requiring coverage for “essential health benefits”).

17. *Id.* § 18022(b)(1).

18. *Id.* §§ 18031(d)(2)(B), 18021, 18022(b).

requirement.¹⁹ We refer to the latter requirement as the “pay-the-freight” provision. The combined facial effect of the EHB requirement and the pay-the-freight provision is to achieve a federally mandated benefit package floor that states cannot go below and are, in practice, unlikely to go above because they must pay (“defray the cost” in ACA parlance) for such generosity directly out of state coffers. Hence, the ACA appears to rob states of their traditional authority to enact sickness rules, specifically mandated benefit rules.

While there is no doubt that state regulatory power is limited by the ACA floor, the reality of remaining state regulatory authority is more complex and more favorable to states than frequently described. First, the discretion of the HHS secretary is significant. In December 2011, HHS issued a bulletin that made clear that HHS aspires to define EHB in a way that varies with and is sensitive to individual state judgments about sickness rules. Specifically, the secretary proposed that EHB in State X be defined with respect to a state “benchmark” plan, to be chosen by the state.²⁰ One of those benchmark plans includes plans offered to state employees. Accordingly, EHB would be significantly defined by state action, and the pay-the-freight provision would be triggered less than previously imagined. A state would not have to pay the freight for more generous EHB if, for example, the state included an additional benefit in its state plans and used that as its benchmark plan because EHB in the state will be defined by this benchmark plan.

Certainly the secretary could reverse course and exercise the agency’s discretion in a way less favorable to state judgments about sickness rules. And perhaps future HHS secretaries may do so; that is a possibility. But scholars have long realized that between pure federalization and pure federalism lies cooperative federalism, and that such cooperation may be driven by political and organizational advantages associated with the national government relying significantly on

19. *Id.* § 18031(d)(3)(B)(i), (ii).

20. The benchmark can be one of four possibilities: “One of the three largest small group plans in the state by enrollment; one of the three largest state employee health plans by enrollment; one of the three largest federal employee health plan options by enrollment; or the largest HMO plan offered in the state’s commercial market by enrollment.” CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., ESSENTIAL HEALTH BENEFITS BULLETIN 10 (Dec. 16, 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health&uscore;benefits_bulletin.pdf. Although states have discretion as to the benchmark chosen, the benchmark is “frozen” until 2016; they cannot add mandates to the benchmark without incurring a responsibility to pay the freight. *See* CTR. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN (Feb. 27, 2012), *available at* <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>. HHS plans to “revisit” the benchmark issue—and accordingly the effective reach of the pay-the-freight provision—in 2016. *Id.*

state judgment.²¹ Federalism interests, in short, can be served in cooperative settings. It is unwise to equate a statute like the ACA, which vests the secretary with discretion cooperatively to accommodate state regulatory preferences—a discretion Secretary Sebelius has indicated she wishes to exercise—with a statute like ERISA, which largely prevents federal agencies from accommodating state preferences.

B. ERISA Preemption and Regulatory Consequences

ERISA's explicit preemption regime consists of a three-step analysis. State laws that "relate to" employee benefit plans are preempted,²² but are nonetheless "saved" if they are laws of insurance.²³ These first two steps are not straightforward in application, but they do not provide obvious opportunities for employers to escape state regulation. It is the third step, in section 514, that provides the opportunity for regulatory choice: the "deemer" clause specifies that an employee benefit plan cannot be "deemed" by the state to be an insurer subject to "saved" laws.²⁴

This preemption scheme hinges state authority to regulate employment-based insurance on whether an employer plan self-insures (i.e., pays benefits itself to beneficiaries) or uses third-party insurance to pay beneficiaries.²⁵ If a plan is self-insured, it is beyond the reach of any state law that relates to employee benefit plans.²⁶ State sickness rules undoubtedly relate to employee benefit plans because such rules seek to govern the content of coverage (and hence the content of the plan).²⁷ As a result, state sickness rules are preempted for self-insured

21. See, e.g., Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. REV. 663 (2001).

22. 29 U.S.C. § 1144(a) (2006).

23. *Id.* § 1144(b)(2)(A). A state law will fall within the savings clause if it is "specifically directed towards entities engaged in insurance" and if it "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341–42 (2003).

24. 29 U.S.C. § 1144(b)(2)(B) (2006).

25. There are actually two paths to becoming a self-insured plan. A company may also retain stop-loss insurance, which reimburses the employer for any benefit payouts above a specified level and thus caps the self-insuring employer's exposure above a certain level. State authority to regulate stop-loss insurers is uncertain. See, e.g., Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 112–15 (2005). The majority rule is that states cannot regulate stop-loss insurers that backstop employee benefit plans. Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 251 (1997).

26. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (self-funded plans are exempt from saved state laws because of the deemer clause).

27. "A [state] law relates to an employee . . . [benefit] plan if it has 'a connection with or reference to such a plan.'" *Id.* at 58–59 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983)) (New York's Human Rights Law and Disability Benefits Law were "related to" employee benefit plans because they prohibited such plans from being structured in a way that discriminated on the basis of pregnancy and mandated employee benefits, respectively).

plans. ERISA, moreover, is characterized by a near absence of sickness rules. With a few very narrow exceptions, no coverage areas or levels of coverage are mandated.²⁸ ERISA thus does very little to regulate the content of the health insurance promise, but it also has a powerful level of preemption.²⁹ As a result of this regulatory vacuum, self-insured plans, which constitute a majority of plans,³⁰ are free to craft the content of coverage in almost any way they like.

The above discussion of ERISA's preemptive scope is sufficient to understand the current severe limits on the ability of states to enact sickness rules, but it is worth mentioning ERISA's conflict preemption here as well. Even a saved state law can be preempted if it conflicts with the purposes of ERISA.³¹ Conflict preemption has not been used thus far to invalidate state sickness rules; the rules have been allowed to operate on insured plans (but not on self-insured plans).³² It has been used, however, to curtail severely the ability of states to enact non-sickness rules. Additional causes of action or heads of damages beyond those provided for in ERISA—even if such would otherwise be saved—are preempted.³³ We turn now to a general discussion of non-sickness rules.

III. Non-Sickness Rules

Health insurance regulation in theory, history, and practice is about much more than sickness rules. How does the ACA then, from

28. There are very limited mandated benefit provisions, see 29 U.S.C. § 1185(a)–(b) (2006), as well as some limits on preexisting condition exclusions, see *id.* § 1181; a prohibition on health status discrimination, see *id.* § 1182; and limited rules pertaining to continuation of coverage, see *id.* §§ 1183, 1185; see also Peter J. Wiedenbeck, *ERISA's Curious Coverage*, 76 WASH. U.L.Q. 311, 312 (1998) (“ERISA generally monitors only the implementation or conduct of privately-constituted welfare plans, it does not control their content.”).

29. *E.g.*, *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) (broad preemption with little affirmative regulation has created a regulatory vacuum).

30. See David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14 CONN. INS. L.J. 307, 310 (2008) (fifty-five percent of workers are enrolled in self-insured plans); BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41069, SELF-INSURED HEALTH INSURANCE COVERAGE 4 (2010), available at http://www.achp.org/themes/ACPH_Main/files/CRS_Report-Self-Insured-May2010.pdf (fifty-five percent of private employees are in self-insured plans); KATHRYN LINEHAN, NAT'L HEALTH POLICY FORUM, SELF-INSURANCE AND THE POTENTIAL EFFECTS OF HEALTH REFORM ON THE SMALL-GROUP MARKET 3 (Issue Brief No. 840, Dec. 21, 2010), available at http://www.nhpf.org/library/issue-briefs/IB840_PPA_CASmallGroup_12-21-10.pdf (fifty-seven percent of employees are enrolled in a partially or fully self-insured health plan).

31. *Aetna*, 542 U.S. at 216–18.

32. See, *e.g.*, *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state mandated-benefit law was “related to” employee benefit plans but saved and thus not preempted).

33. See, *e.g.*, *Aetna*, 542 U.S. at 221 (state law tort claims challenging plan's denial of benefits were preempted); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (ERISA preempts state law wrongful termination claim based on employer no longer wanting to pay for benefits).

a federalism perspective, treat non-sickness rules? The question is exceptionally broad because virtually any legal rule or regulatory practice that affects the health care bargain can be considered a non-sickness rule.

We do not pretend to consider every non-sickness rule that the ACA does or could address. Instead, we highlight an insufficiently appreciated fact: ERISA was devastating in the effect it had on the ability of states to enact meaningful non-sickness rules. While the ACA's infringement on state non-sickness rule authority is not trivial, it pales in comparison to ERISA. As discussed above, ERISA preempts everything to which it relates, carves out exceptions, and then carves out exceptions to the exceptions. In contrast, the ACA's preemptive posture is conflict rather than field oriented: it broadly saves state law except for law that "prevent[s] the application" of the ACA.³⁴ We interpret this to mean the following: the ACA does not generally preempt state laws governing subjects that are not directly addressed by the ACA. Even regarding state laws on subjects to which the ACA directly speaks, conflict is not assumed. State law that relates to the same subject as the ACA may very well be considered a permissible "supplement" that is not preempted, or, alternatively, may be considered an exercise of state discretion that the statute tolerates.³⁵

First, the ACA's pay-the-freight provision will not impede state authority to enact non-sickness rules. As discussed above, the pay-the-freight provision, while not formal preemption (it is actually formal permission), might be considered to have a practical displacement effect because it ties legislative freedom to legislative coffers. However, as we described above, it appears federal authorities will flexibly define EHB such that state preferences will be incorporated into the EHB requirement. Moreover, even though EHB includes some non-sickness rules such as cost-sharing,³⁶ it refers almost entirely to sickness rules.³⁷

34. 42 U.S.C. § 18041(d) (2006) (Title I of the ACA was not intended to preempt any state law unless such state law "prevented the application of the provisions" of Title I of the ACA); *see also id.* § 300gg-23 (state laws not superseded unless they conflict with a specific requirement).

35. For example, the portion of the ACA speaking to the creation of exchanges commands that informational outreach be "culturally and linguistically" appropriate. *Id.* § 18031(i)(2)(A), (i)(3)(E). It seems fairly obvious that if the federal government is running an exchange in State X (because the state declined to do so) and the state government is running the exchange in State Y, then even if the states have very similar "cultural and linguistic" demographics, the federal information outreach undertaken by the federally run exchange in State X will not dictate how such outreach needs to occur in State Y.

36. *Id.* § 18022(c).

37. *See id.* § 18022(b)(1) (specifying the general categories that must be included within EHB).

Second, the reach of the ACA's formal preemption on non-sickness rules is likely to be limited because there are some important non-sickness rules that the ACA specifically avoided regulating. The most prominent examples, speaking loosely, are rules of remedy. It is mostly accurate to describe the ACA as a pass-through statute when it comes to the remedies available to individuals seeking to enforce the insurance deal.³⁸ Under the ACA approach, for policies obtained through employment, ERISA remedial law applies; for policies obtained on the individual market, state remedial law applies. For many scholars and commentators, this has gone unrecognized or acknowledged only in passing. That treatment, almost certainly, is because few understand the degree to which states in the past have attempted to regulate remedial rules in the health insurance setting, only to be excluded from doing so by ERISA's preemptive bubble. A brief review of that history appropriately frames the real world importance of the fact that the ACA leaves remedial rules to the states.

For over two decades, the ever-rising cost of health care has forced actors, policymakers, and judges to pay careful attention to every aspect of the health insurance bargain, including non-sickness rules that might otherwise be thought of as peripheral. For most working persons who were neither poor nor elderly, the only credible path to having health insurance was through one's employer,³⁹ an insurance bargain governed by ERISA. The challenge for policymakers—particularly judges, who were cast unwillingly into a prominent rule-making role in connection with ERISA health insurance claims—was that employers were not required to offer health insurance under ERISA.⁴⁰ Doing so was optional. Many employers did (and do) offer health insurance in response to labor market pressures. Employers were (and are), however, sensitive to any legal rules attending the employment insurance promise that could make insurance more costly on average, more uncertain, or both. This is because as insurance becomes more costly and more uncertain, it becomes more expensive and burdensome to administer and much less attractive for employers to offer. Thus the policy concern: if employer-provided insurance became too expensive or too difficult to administer predictably, employers would stop offering it and employees would be left with no plausible

38. See, e.g., Maher, *supra* note 3, at 1774–77.

39. See, e.g., David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 26 (2001); see also CONG. BUDGET OFFICE, CBO AND JCT'S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE tbl.2 (Mar. 2012), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf (over 150 million people are covered through employer-based insurance).

40. See *Conkright v. Frommert*, 130 S. Ct. 1640, 1648–49 (2010) (“Congress did not require employers to establish benefit plans in the first place.”).

health insurance alternative.⁴¹ This concern drove judicial articulations of the various legal rules governing ERISA bargains in a direction that few of ERISA's drafters would have predicted. To wit, a series of judicial decisions (and legislative acquiescence) embedded the ERISA health promise in a nest of legal rules that intensely favor employers and insurance providers.⁴²

Although ERISA requires a fiduciary to act in the interests of plan beneficiaries, it specifically permits health plan coverage decision makers to be employees of, or persons otherwise controlled by, the promisor.⁴³ This creates an agency cost problem: the fiduciary, who is supposed to be acting in the best interest of the beneficiaries, may have a financial interest in denying benefits.⁴⁴ Ordinarily, the judicial response to the presence of such a conflict would be—using legal rules such as burdens of proof, interpretative doctrines, standards of review, or availability of remedies—to make it more difficult for a conflicted administrator to benefit from a strategic denial. ERISA has been interpreted in precisely the opposite way.⁴⁵

Prior to seeking judicial relief, a beneficiary must exhaust internal appeals before a possibly conflicted administrator,⁴⁶ and a plan may establish filing deadlines far more demanding than otherwise applica-

41. Cf. John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 228 (1990) (positing that the price of stronger protective legal rules in the ERISA context would be fewer and less generous benefits); Norman Stein, *ERISA and the Limits of Equity*, 56 LAW & CONTEMP. PROBS. 71, 73 (1993) (discussing the challenge of ensuring adequate quality health employment benefits without discouraging employers from offering benefits at all).

42. Andrew Stumpff, *Darkness at Noon: Judicial Interpretation May Have Made Things Worse for Benefit Plan Participants Under ERISA Than Had the Statute Never Been Enacted*, 23 ST. THOMAS L. REV. 221, 223 (2011) (“[T]he federal courts have felt themselves free . . . to resolve a long series of questions under ERISA against plan participants and in favor of employers.”).

43. See Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1126 (1988) (“[T]he statute leaves the plan sponsor to pick the fiduciary and, if the sponsor pleases, to do it from the ranks of management. Sponsors routinely exercise this authority.”).

44. See, e.g., John Bronsteen, Brendan S. Maher & Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2305 (2008) (identifying how ERISA tolerates and even encourages systemic tensions between fiduciaries and beneficiaries).

45. See, e.g., Dana M. Muir, *Fiduciary Status as an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391 (2000) (discussing employers' continued ability to be opportunistic and self-interested); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 133 (2009) (“[T]he act has been interpreted by the U.S. Supreme Court over the years to be in essence an Employers' Security Act.”); Stumpff, *supra* note 42, at 231 (the judicial standard makes it difficult to overturn an administrator's decision).

46. E.g., Andrew M. Campbell, Annotation, *Exhaustion of Administrative Remedies as Prerequisite to Suit Under Employee Retirement Income Security Act of 1974*, 162 A.L.R. FED. 1 (2000).

ble statutes of limitation.⁴⁷ When an administrator's denial is reviewed by a court, the court may only set aside the administrator's determination if it was "arbitrary and capricious."⁴⁸ The deferential standard remains even if the administrator was shown to be subject to a conflict or the administrator had previously behaved arbitrarily when making the determination.⁴⁹ With respect to benefit denials, the damages that may be recovered are limited to the value of the denied benefit; consequential and punitive damages are not permitted.⁵⁰ Claims arising from other breaches of duty, other than benefit denials, are limited both generally and specifically in scope.⁵¹ In general, claimant rights are interpreted narrowly, even in areas that seem, at first glance, to be minor.

Indeed, because so many people received health care pursuant to ERISA arrangements, even facially obscure legal rules were perceived—by states and the U.S. Supreme Court—to be of significant financial and social importance. Tort subrogation rules are a perfect example. Tort subrogation refers to insurers' rights (or lack of rights) to recover monies that the insured has received from a third-party tortfeasor responsible for the insured's injuries. Because recoveries (through verdict or settlement) by injured insureds are often not enough to make the insured whole, subrogation priority matters. Many states have long regulatory histories of how tort subrogation should be handled.⁵² The Supreme Court wrestled with subrogation issues not once, but twice.⁵³ In its more recent decision on the subject,

47. Stumpff, *supra* note 42, at 234–36 (in the absence of ERISA, plaintiffs would be subject to statutes of limitations of at least six years, but ERISA allows plans contractually to set statutes of limitations that are two or three years).

48. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114–15 (1989) (allowing the de novo standard to be lowered to abuse of discretion if the terms of the plan give the decision maker "discretionary authority to determine eligibility for benefits or to construe the terms of the plan").

49. *Conkright v. Frommert*, 130 S. Ct. 1640, 1646–47 (2010) (a plan administrator, whose previous benefit denial had been judicially overturned as arbitrary and capricious, was nonetheless entitled to deferential standard of review for subsequent denial of the same benefit); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (applying a discretionary standard of review even after finding the existence of a conflict in the particular case). A reviewing court is still required to consider an administrator's conflict of interest as a factor in its review. *Id.* at 122.

50. *See, e.g., Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985) (noting an absence of rights to additional relief in ERISA).

51. *See, e.g., Brendan S. Maher*, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 WIS. L. REV. 657, 669 n.40 (discussing the "significant limitations" of other common causes of action).

52. *See Brendan S. Maher & Radha A. Pathak*, *Understanding and Problematizing Contractual Tort Subrogation*, 40 LOY. U. CHI. L.J. 49, 72–77 (2008) (reviewing the history of tort subrogation); Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case*, 29 TORT & INS. L.J. 803, 807–15 (1994) (cataloguing state treatments of tort subrogation).

53. *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006); *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

the Court held, in effect, that subrogation by contract could be used to give insurers super-priority on all recoveries (and thus reduce the amount of money an insured could keep).⁵⁴

The non-sickness legal rules described above—standards of review, damages, and subrogation—have repeatedly been targets of state action. The reason is obvious: state legislatures believed that significant numbers of their citizens were being adversely affected by the non-sickness legal rules imposed by ERISA. Currently, for example, nearly a third of states have enacted laws that do not permit insurers to use discretionary clauses in insurance policies, which are clauses in the policy that entitle the administrator of an ERISA plan to deference from reviewing courts.⁵⁵ Whether such state laws will survive judicial scrutiny depends in part on how one interprets the Supreme Court's existing ERISA preemption jurisprudence.⁵⁶ Two circuits have held that such laws survive preemption,⁵⁷ but one circuit has held that state law governing the wording of such clauses is preempted,⁵⁸ and insurance companies will certainly seek to have other circuits weigh in on the issue.⁵⁹

In sum, under ERISA, state ability to enact non-sickness rules is dramatically curtailed. In contrast, none of the non-sickness rules that have been discussed above are addressed by the ACA, and thus states remain free under the ACA to enact such rules for private health insurance not governed by ERISA. This regulatory freedom is, in our view, of tremendous practical importance. State legislatures and state decisional law have long held non-sickness rules to be worthy of action and resolution, and the Supreme Court has taken numerous cases to draw the line between state and federal authority.

The historical warrant for the societal importance of non-sickness rules has an obvious normative explanation. Non-sickness rules that address remedy speak to a core concern for individuals participating in any legal regime: fairness. Scholars can and do debate the incentive and financial effects a burden of proof or damages rule may have, but health care bargains so obviously involve personal and non-fungible

54. *Sereboff*, 547 U.S. at 368.

55. Radha A. Pathak, *Discretionary Clause Bans & ERISA Preemption*, 56 S.D. L. REV. 500, 504–06 (2011).

56. *See id.* at 507–14 (evaluating whether ERISA preempted discretionary clause regulation and concluding “the majority of state regulation . . . will survive preemption”).

57. *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 841 (9th Cir. 2009) (ERISA’s remedial provisions do not preempt state discretionary clause ban); *Am. Council of Life Insurers v. Ross*, 558 F.3d 600, 609 (6th Cir. 2009) (allowing Michigan to prohibit discretionary clauses under ERISA’s savings provision).

58. *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141, 1151–52 (10th Cir. 2009) (Utah’s rule is not saved due to a lack of “substantial effect on risk pooling”).

59. “States within the First, Second, Third, Fifth, Seventh, and Eighth Circuits have taken steps to regulate discretionary clauses.” Pathak, *supra* note 55, at 502 n.13.

stakes that perceived fairness assumes a heightened importance.⁶⁰ Legal rules that shift the bargain too far in the favor of employers and insurers are frequently the subject of state efforts because of legislatures' perceptions that their citizens are being treated unfairly, regardless of the alleged financial savings associated with strict rules. We have little doubt that an enormous majority of people who purchase and maintain health insurance intuitively ask themselves, in addition to whether the policy is affordable, two questions: (1) will this policy give me the medical treatment I need when I am sick and (2) if there is a dispute about what I'm entitled to, will there be some way to resolve it fairly?⁶¹ If the answers to either of those questions is no, complaints to local authorities will be made, and the result will be state action motivated by a desire to make insurance bargains fair.

IV. Conclusion

No one credibly suggests that the ACA is not a significant deployment of federal power; it is. But a federalism-in-fact analysis of the ACA's effect on the ability of states to regulate sickness and non-sickness rules reveals that the ACA limits state power considerably less than its detractors suggest. This is particularly true when sufficient attention is paid to the fact that the regulation of private health insurance had already been significantly federalized by ERISA.

60. See, e.g., George J. Annas, *Patients' Rights in Managed Care—Exit, Voice, and Choice*, 337 NEW ENG. J. MED. 210, 212 (1997). Cf. Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1464 (1994).

61. See, e.g., Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335, 344–45, 383 (2000) (discussing the importance of, and challenge in assuring, fairness in health insurance coverage disputes).