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THE BENEFITS OF OPT-IN FEDERALISM

BRENDAN S. MAHER*

Abstract: The Affordable Care Act (“ACA”) is a controversial and historic statute that mandates people make insurance bargains. Unacknowledged is an innovative mechanism ACA uses to select the law that governs those bargains: opt-in federalism. Opt-in federalism—in which individuals may in part choose between federal and state rules—is a promising theoretical means to make and choose law. This Article explains why and concludes that the appeal of opt-in federalism is independent of the ACA. Whatever the statute’s constitutional fate, future policymakers should consider opt-in federalist approaches to answer fundamental but exceedingly difficult questions of health and retirement law.

INTRODUCTION

Few national debates have rivaled the intensity of those regarding the Patient Protection and Affordable Care Act (“ACA”).¹ It is not difficult to see why. *Sickness spares no one.* Nor, some fear, does the federal government. The ACA involves both.

* © 2011, Brendan S. Maher, Assistant Professor, Oklahoma City University School of Law, J.D., Harvard Law School; A.B., Stanford University. This Article is the latest in a series analyzing the importance of the Supreme Court, federalism, choice, and legal rules regarding the provision of retirement income and health care in America. *See generally* 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 (2008); Brendan S. Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 *WIS. L. REV.* 657; Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 *WASH. U. L. REV.* 433 (2010). The series, and this paper, also draws upon research undertaken in connection with litigating *Conkright v. Frommert*, 130 S. Ct. 1640 (2010) and *LaRue v. DeWolff, Boberg, & Associates, Inc.*, 552 U.S. 248 (2008), two recent cases before the U.S. Supreme Court. Many thanks to the participants at the Washington University Junior Scholars workshop, as well as Tom Baker, Brian Galle, Abbe Gluck, Elizabeth Leonard, Abigail Moncrieff, Paul Secunda, Daniel Schwarcz, and Peter Stris, for their comments and criticism.

¹ The landmark legislation is actually two acts: the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Herein I refer to the two pieces of legislation collectively as “ACA” rather than “PPACA.” The former is easier to read and say.

Lines in the sand have been drawn over the ACA's constitutionality.² Prominent law professors and dozens of state attorneys general are on one side; equally prominent law professors, as well as the Obama administration, are on the other.³ Given the split among federal judges to have considered the question, most cannot help but wonder on which side Justice Anthony Kennedy will fall.⁴ The resolution of these constitutional battles will be of unquestionable historic importance.

The constitutional dispute is part of a larger argument that is perhaps America's oldest: what is the proper role of the federal government?⁵ In these debates, the federal government is often cast as either a tyrant or a savior.⁶ Much of the current thinking about the ACA proceeds along these lines.⁷ Yet there is a third role for the federal government: enabler.

Imagine if the federal government deployed its power to *increase* the ability of individuals and states to choose law. That is precisely what the ACA in part contemplates. Using a legal structure this Article de-

² Legislators are readying for battle as well. See Kate Pickert, *Obamacare Goes Under the Knife*, TIME, Jan. 17, 2011, at 48, 48 ("[T]he enactment of [the ACA is] less like the dawn of a new era and more like the start of a long partisan war over whether reform should proceed at all.").

³ Compare Randy Barnett, Editorial, *The Insurance Mandate in Peril*, WALL ST. J., Apr. 29, 2010, at A19 (arguing that the mandate is unconstitutional), with Laurence Tribe, Op-Ed., *On Health Care, Justice Will Prevail*, N.Y. TIMES, Feb. 8, 2011, at A27 (arguing that the mandate is constitutional).

⁴ See Tribe, *supra* note 3, at A27 (noting that Justice Kennedy has been portrayed as the "swing vote" in a closely divided Supreme Court). Compare *Mead v. Holder*, 766 F. Supp. 2d 16, 33–34 (D.D.C. 2011) (holding the individual mandate constitutional), and *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 893–95 (E.D. Mich. 2010), *aff'd*, 651 F.3d 520 (6th Cir. 2011) (same), with *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1295, 1298, 1305 (N.D. Fla. 2011), *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir. 2011) (holding the individual mandate and entire legislation unconstitutional), and *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 782, 786–88 (E.D. Va. 2010), *vacated* 656 F.3d 253 (4th Cir. 2011) (holding individual mandate unconstitutional).

⁵ See, e.g., RUFUS DAVIS, *THE FEDERAL PRINCIPLE: A JOURNEY THROUGH TIME IN QUEST OF A MEANING* 86–96 (1978) (describing the debate amongst the founding fathers over the role of the federal government and noting the ambiguities that remained regarding the roles of and relationships between the federal and state governments); see also Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 572 (2008) (noting that it is unclear whether the solution for improving health care access is more or less federal government involvement).

⁶ See, e.g., James F. Blumstein & Michael Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL. POL'Y & L. 382, 388 (1979) (noting the image of government as "provider of life-sustaining support" because the government has become more predominant in financing health services).

⁷ See, e.g., Pickert, *supra* note 2, at 48 (noting that "Democrats found themselves under fire for backing a new expansion of federal entitlements").

scribes as “opt-in federalism,” the ACA permits individuals to choose, in some respects, whether to be governed by federal or state rules.⁸ Few if any observers are acknowledging or seriously examining this important development. This Article does both, and in closing considers the intriguing possibility that opt-in federalism will also be of use in addressing the country’s other multi-trillion-dollar question of “benefits,” namely, how to provide retirement income in an aging America.⁹

The Article proceeds as follows:

Benefit law can be intimidating in its complexity and detail. Necessary to any disciplined discussion is an organizing theory that aids clear thinking about benefit mechanisms and the legal rules governing them. Part I offers a general theory of benefits that explains, broadly, the role of individuals, government, and law in providing health care and retirement income.¹⁰

This Article identifies and explains three different models for providing citizens with health care and retirement benefits: the individual reliance model, the multilateral bargain model, and the public entitlement model.¹¹ The oldest and simplest model, the individual model, relies on the individual’s saved or current personal resources to address retirement or health care needs.¹² The second model, the multilateral model, relies on enforceable bargains between two or more players to supply the beneficiary with retirement and health benefits.¹³ The third model, the public model, provides retirement and health care pursuant

⁸ See *infra* notes 223–339 and accompanying text.

⁹ Some may wonder why matters so different in character—retirement and health—are so often discussed together as “benefits” or “entitlements.” The answer is not straightforward; in many ways they *are* so different that it is a conceptual mistake to treat them similarly. See, e.g., Brendan Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 451–64 (2010) (discussing the different nature of health and retirement promises). But legally they have been bundled together for decades; they occupy a joined space in the national dialogue on social and fiscal reform; and they undeniably share a heightened level of life significance for essentially everyone. As political scientist Jacob Hacker put it, the study of America’s retirement and health regimes is necessarily linked because in both cases citizens’ “life fortunes depend[] crucially on social benefits that they receive[]” JACOB S. HACKER, *THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SOCIAL BENEFITS IN THE UNITED STATES* 6 (2002). For reasons I explain in Part I, this Article largely focuses on private benefit arrangements.

¹⁰ See *infra* notes 29–90 and accompanying text.

¹¹ See *infra* notes 29–90 and accompanying text.

¹² See Colleen Medill, *The Individual Responsibility Model of Retirement Plans Today: Conforming ERISA Policy to Reality*, 49 EMORY L.J. 1, 4 (2000); *infra* notes 34–46 and accompanying text.

¹³ See Maher & Stris, *supra* note 9, at 437–48 & 448 n.18 (describing the benefit trade-off that is bargained for in employer-provided pensions and noting that benefits are “bargained for”); *infra* notes 47–75 and accompanying text.

to entitlement promises made by the government as sovereign.¹⁴ Most societies rely on some combination of the three, including the United States.

This conceptual scheme weaves together long-running threads of benefit theory and tracks implicit fault lines in national benefit debates. And the instrumental value of the taxonomy is significant. It clarifies at what level a particular benefit debate is occurring and appropriately frames legal and policy discussions. For example, my theory makes clear that the ACA is a legislative endorsement of the bargain model in the health benefit context.¹⁵ That Congress should have instead chosen an entitlement model is one type of criticism; that the ACA does a poor job of improving health bargains is quite another. One can, and some do, believe the former is true but not the latter. Moreover, as the theory explains, that Congress has embraced the bargain model means that particular care must be given to the selection of legal rules governing the bargain players.

Part II draws upon my theory of benefits to explain important features of the pre-ACA benefit landscape in the United States.¹⁶ To an unusual degree, the United States has relied and continues to rely upon private bargains to provide benefits to its citizens.¹⁷ Perhaps equally unusual, given the nation's professed admiration for federalism, is that the American bargain model was heavily national. Via the Employee Retirement Income Security Act of 1974 (ERISA),¹⁸ the nation relied upon the federal government, and to a large degree federal

¹⁴ See, e.g., Patricia Dilley, *Taking Public Rights Private: The Rhetoric and Reality of Social Security Privatization*, 41 B.C. L. REV. 975, 979 (2000) (describing Social Security, an example of the entitlement model); *infra* notes 76–90 and accompanying text.

¹⁵ ACA is not exclusively about bargains; for example, it also expanded Medicaid, which is an entitlement program. But a central feature of the legislation is that it embraced the bargain model for the vast majority of those not already eligible to participate in an entitlement program. See *infra* notes 29–90 and accompanying text.

¹⁶ See *infra* notes 91–222 and accompanying text.

¹⁷ See 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, 2298–99 (2008) (noting that private health insurance is the “cornerstone” of U.S. health care); *infra* notes 96–129 and accompanying text.

¹⁸ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829. Easily the most thorough and fascinating account of ERISA's political history was written by Professor James Wooten. See generally JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, A POLITICAL HISTORY* (2004). ERISA was expected to be a landmark reform statute, but its ultimate effects were larger than even its drafters imagined. See 29 U.S.C. § 1001 (2006) (stating the purpose of the Act); Maher & Stris, *supra* note 9, at 435 (describing ERISA as a “landmark statute”); *infra* notes 91–122 and accompanying text.

judges, to select the legal rules that govern most benefit bargains.¹⁹ ERISA's specific legal rules have been sharply criticized, but, for many reasons, there has been little opportunity to meaningfully reform America's benefit bargain regime.²⁰ Part II closes by examining ERISA's shortcomings in the hopes of addressing the larger problems—what *are* the optimal legal rules for benefit bargains and *who* should choose those rules?—that have long challenged would-be reformers.²¹

Part III examines an innovative solution to the problem: opt-in federalism, namely, vertical regime choice by individuals.²² The matter is far from academic. Although the ACA is perhaps the most discussed law in recent history, there has been little acknowledgment that the legislation in theory instantiates a form of regime competition by permitting legal rule choice regarding the health bargain.²³ It does that by creating an accessible individual health insurance market, and, in significant part, by allowing employed individuals who purchase insurance on this individual market to partially opt-out of federal law and into state law.²⁴

Whatever the ACA's imperfections, the theoretical appeal of opt-in federalism is strong.²⁵ Opt-in federalism is likely to maximize individual preferences, promote desirable evolution of legal rules, restore to the states their traditional function of regulating important aspects of local insurance arrangements, and constructively accommodate uncertainty and legitimate disagreement about what the optimal legal rules are.²⁶ Although not without drawbacks, opt-in federalism is a promising approach to answering benefit questions in both the health care and retirement contexts.²⁷

¹⁹ See *infra* notes 130–179 and accompanying text. In 2010, most private health insurance in America was supplied through employer-based (and thus overwhelmingly ERISA-governed) arrangements. See CONG. BUDGET OFFICE, SELECTED CBO PUBLICATIONS RELATED TO HEALTH CARE LEGISLATION, 2009–2010, at 23 tbl.4 (2010), available at <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf> (indicating 150 million people were covered through employer-based insurance in 2010).

²⁰ See *infra* notes 180–222 and accompanying text.

²¹ See *infra* notes 180–222 and accompanying text.

²² See *infra* notes 223–329 and accompanying text.

²³ See 42 U.S.C.A. § 18032(a)(1) (West Supp. 2011) (allowing individuals to choose in which type of qualified health plan to enroll); *infra* notes 228–252 and accompanying text.

²⁴ See *infra* notes 228–251 and accompanying text.

²⁵ See *infra* notes 253–293 and accompanying text.

²⁶ See *infra* notes 253–293 and accompanying text.

²⁷ In many ways, retirement security is where health care was in the early 1990s: a looming crisis with no consensus regarding the answer. Opt-in federalism, which leverages the power of aggregative policymaking in an appealing way, see *infra* notes 223–329 and

Vigorous challenges to the ACA have been mounted.²⁸ Regardless of the legislative or constitutional fate of the ACA, however, the legislation should be of enormous interest to observers concerned with retirement and health care in the twenty-first century and the division of power between federal and state governments. It is a singularly useful vehicle through which we can refine and modernize benefit theory; acknowledge the important role choice, uncertainty, and diversity play in the selection of legal rules; and imagine additional reforms—whether alternative or supplemental—that are rooted in notions of personal autonomy and local rulemaking. Should the ACA be legislatively modified or held constitutionally invalid, whatever arises in its place would benefit from a careful consideration of using opt-in federalist approaches to answer fundamental but exceedingly difficult questions regarding health and retirement law.

I. A THEORY OF BENEFIT MODELS

For modern societies, the future is somewhat predictable. Whatever surprises lurk beyond the horizon, it is certain that there will be citizens who age, can no longer work, and need replacement income. It is equally inevitable that there will be citizens who fall ill, wish to get care, and need to pay for treatment.²⁹ How can, and should, a society allocate resources to address these inevitable contingencies?

This Article considers three models: the individual reliance model, the multilateral bargain model, and the public entitlement model.³⁰

accompanying text, may be a promising means to address retirement challenges that seem beyond the reach of traditional solutions. See *infra* notes 330–334 and accompanying text.

²⁸ See, e.g., *Bondi*, 780 F. Supp. 2d at 1295, 1298, 1305 (holding individual mandate and entire legislation unconstitutional); *Cuccinelli*, 728 F. Supp. 2d at 782, 786–88 (holding ACA's individual mandate unconstitutional); Barnett, *supra* note 3, at A19 (arguing that the ACA is unconstitutional).

²⁹ By “citizen,” I imply no formal or legal meaning. I use it simply as a synonym for the more cumbersome phrase “member of society.”

³⁰ See, e.g., Dilley, *supra* note 14, at 979 (describing Social Security, an example of the entitlement model); Medill, *supra* note 12, at 4 (describing the individual model); Mark V. Pauly, *Making a Case for Employer-Enforced Individual Mandates*, HEALTH AFF., Apr. 1994, at 21, 24 (describing wage and benefit tradeoffs, a form of the multilateral bargain model). There is a fourth model: the charity model, where an unaffiliated third party addresses retirement or health needs out of eleemosynary impulses. See Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 10 (1995) (describing pre-twentieth-century health care as having many “hospitals for the poor” that were funded by charity rather than patient fees). To be clear: charity care is different than care administered by a non-profit organization. The former is a gift; the latter can be a gift, but often is pay-for-service, where the “pay” portion is handled either by personal resources, insurance (a type of bar-

Logically, to satisfy benefit needs, one can rely on oneself, other private players, or the government.³¹ The benefit models a society might adopt correspond, respectively, to those three possibilities.³²

Theorizing benefits in this way is useful. First, it makes intuitive sense to organize benefit theory along the lines of who has responsibility for planning, stewarding, or conveying the benefits.³³ Second, it makes clear the nature and the magnitude of benefit disagreements. Some disputes are arguments over which model is preferable in given circumstances; others are about the ways in which a given model can be improved. Third, and most importantly, it aids in the selection of optimal legal rules. Benefit rules cannot be appropriately imagined, proposed, researched, or assessed absent context.

For example, in using a benefit bargain model, a society is implementing important social policy through benefit arrangements which impose binding obligations on private players. And obligations—the negotiation, performance, and mediating thereof—come with behavior-altering costs. The intricate and uncertain assessment of those costs is often the factor that determines what the optimal legal rules are. To ignore the costs of shared responsibility—that is, to overlook the inherent complication of using bargains to solve allocation problems—is to assume away a significant component of the challenge. Indeed, the difficulty of the task of selecting ideal benefit bargain rules is part of the appeal of opt-in federalism.

gain), or the government. I do not discuss the charity model herein because neither the current nor expected volume of charity benefits is significant compared to the other three models. *See, e.g.*, M. Gregg Boche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 304–11 (1995) (describing, in the context of tax exemption status, the evolution of nonprofit hospitals from primarily offering charity care to offering pay-for-service care with little or no charity care); *cf.* TEX. TAX CODE ANN. § 11.1801 (West 2010) (requiring only a modest percentage of care at tax-exempt hospitals to be “charity care or government sponsored indigent care”).

³¹ *See* Dilley, *supra* note 14, at 979; Medill, *supra* note 12, at 4; Pauly, *supra* note 30, at 24.

³² *See* Dilley, *supra* note 14, at 979; Medill, *supra* note 12, at 4; Pauly, *supra* note 30, at 24.

³³ Scholars have surveyed the policy problems and insufficient financial outcomes that imperil various retirement arrangements. *See, e.g.*, Stephen F. Befort, *The Perfect Storm of Retirement Insecurity: Fixing the Three-Legged Stool of Social Security, Pensions, and Personal Savings*, 91 MINN. L. REV. 938, 962 (2007) (concluding that many American workers have insufficiently saved for retirement). *See generally* Medill, *supra* note 12 (examining the policy implications of employee saving). My focus is on arranging benefit models with reference to both factual and *legal* responsibility; the latter is often overlooked, and thus insufficient attention is paid to the content of the legal rules governing a particular benefit arrangement and how those rules should be chosen. Policy is important, but so is legal optimality. Study by legal academics of the latter is crucial.

This Part considers each of the three models below.

A. *Benefit as Individual Reliance*

The individual model is easy to conceptualize: the resources available to address retirement and health needs are those resources the person in question has personally available to satisfy those needs at the time the need arises.³⁴ Such resources in effect consist of money saved, whether it has been saved for a long time—in other words, what we traditionally think of as savings—or whether it is money recently earned or acquired and then immediately transferred to address retirement or health care needs, e.g., using current income to pay for health needs or using a recent inheritance to provide retirement income. The latter category of personal resources can, for present purposes, be constructively described as savings. After it is earned or otherwise falls within the dominion of the player in question, it is “saved,” i.e., not spent on something else, for some arbitrarily small period of time before being used to satisfy retirement or health needs.

A central attraction of the individual model is that it permits people to live by their preferences, wherever such preferences fall along the continuum bounded on each end by Aesop’s fabled grasshopper and ant.³⁵ Relatedly, the individual model rewards, and thus promotes, careful and efficient thinking by individuals regarding the trade-off between current expenditures and saving resources for future needs; such careful thinking may be appealing for economic or moral reasons, or both, depending on one’s perspective.³⁶ Lastly, the individual model

³⁴ See Medill, *supra* note 12, at 4. I consider the use of family resources to address such needs to be “individual” resources.

³⁵ See Bronsteen et al., *supra* note 17, at 2328 (2008) (noting the theoretical attractiveness of permitting employees to save “according to their risk and consumption preferences”). As for Aesop’s insects, the industrious ant worked diligently and saved up food for lean times; the carefree grasshopper failed to store food and suffered accordingly when winter came. AESOP’S FABLES WITH A LIFE OF AESOP 121 (John E. Keller & L. Clark Keating trans., 1993). The fable has long illustrated the wisdom of planning and saving, and the folly of failing to do so. See *id.*; see also, e.g., Dilley, *supra* note 14, at 976 (invoking Aesop to illustrate opposing views regarding the provision of retirement benefits).

³⁶ See, e.g., Edward J. McCaffery, *Tax Policy Under a Hybrid Income-Consumption Tax*, 70 TEX. L. REV. 1145, 1163 (1992) (collecting different historical authorities, from Aesop to Thomas Hobbes to Benjamin Franklin, who have suggested saving is virtuous); Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451, 522–23 (2004) (expressing economic concerns about self-directed benefit savings but noting that this is consistent with American cultural preferences for “individual ownership and control”); Martin Feldstein, *Rethinking Social Insurance 2* (Nat’l Bureau of Econ. Research, Working Paper No. 11250, 2005) (making the economic observation that pension programs “depress saving”).

does not materially draw other players into the benefit calculus, and thus avoids the nontrivial transaction, strategic, and litigation costs associated with shared responsibility.³⁷

The shortcomings of the individual model are many. Most challenging is that many cannot save enough; that is, some segment of the population simply does not earn enough today to save enough to maintain an acceptable standard of living and have sufficient resources to deal with expected retirement and health needs.³⁸ Other problems fall into the “may not save enough” category. Individuals may lack the resources or training to appropriately plan for future needs, a problem that may be exacerbated by cognitive distortions that affect the way in which people engage in prediction and decision-making.³⁹ Considerable behavioral economic evidence exists that suggests individuals are particularly susceptible to cognitive biases in the benefit setting.⁴⁰ Third, even assuming an expected benefit cost projection that a diligent, rational, and appropriately wealthy individual could save for, the variance around such projections, particularly for health care, is too significant for all but the wealthiest individuals to bear.⁴¹

³⁷ See, e.g., Bronsteen et al., *supra* note 17, at 2299 (describing agency costs). Plans of self-reliance do not give rise to obligations; bargains do. For this reason savings made pursuant to a fiduciary bargain are more usefully categorized under the multilateral model. See *infra* notes 47–75 and accompanying text. It is frequently the transaction and indirect costs associated with the legal rules governing multilateral obligations that explicitly or implicitly *determine* the optimal legal rules.

³⁸ See Medill, *supra* note 12, at 17 (noting that in one study, of those participants who knew the maximum amount they could contribute to their 401(k) plans, less than half contributed the maximum amount, and that inability to save was one of the top three reasons for opting not to contribute).

³⁹ See RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS 17–39 (2008) (discussing various systemic biases in human thinking); see also Medill, *supra* note 12, at 3–4 (noting the difficulties that individuals face in retirement planning).

⁴⁰ See Victor Ricciardi, *The Psychology of Risk: Behavioral Finance Perspective*, in 2 HANDBOOK OF FINANCE 85, 91–105 (Frank J. Fabozzi ed., 2008) (discussing cognitive biases in retirement planning); see also Medill, *supra* note 12, at 14 (noting that “[m]any Americans have a false sense of confidence as it concerns their own retirement”). See generally Jeffrey B. Liebman & Richard J. Zeckhauser, Simple Humans, Complex Insurance, Subtle Subsidies (Nat’l Bureau of Econ. Research, Working Paper No. 14330, 2008) (discussing biases in the health insurance setting).

⁴¹ This is why even health arrangements that are sometimes described as “defined contribution” schemes, such as health savings accounts, are coupled with high deductible health insurance (sometimes called “catastrophic” insurance). See Bronsteen et al., *supra* note 17, at 2329–30; see also Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 389 (2001) (finding that medical debt played a causal role in a significant percentage of bankruptcies); Amy B. Monahan, *The Promise and Peril of Ownership Society*

It is uncontroversial to say that the individual model, standing alone, is not a comprehensive benefit solution in contemporary times. It adequately described American society during a time period when much of society either did not retire,⁴² did not live a significant period beyond retirement, or relied upon extended family for retirement needs;⁴³ a period when health care was overwhelmingly palliative (and thus vastly less costly and variable) rather than curative;⁴⁴ and a period when more complicated benefit arrangements simply did not exist.⁴⁵

Importantly, however, the individual model is neither a historical artifact nor lacking in modern usefulness. Traditional individual saving, in particular, can and is an important and sometimes necessary part of providing desirable answers to benefit questions. But it exists largely as a supplement to, if not contained within, more sophisticated benefit models.⁴⁶ The next Section discusses these models.

B. *Benefit as Multilateral Bargain*

The multilateral model is a bargain model, and by definition more complicated and flexible than the savings model, because it involves at least two players and frequently more. The animating principle behind the multilateral model is that at T_0 , the beneficiary-to-be gives up, directly or indirectly, something of value (most often foregone wages or cash) for the legal right to receive services or resources from another

Health Care Policy, 80 TUL. L. REV. 777, 780–81 (2006) (discussing savings and insurance arrangements in health care). As I explain, such arrangements are better conceived of as multilateral bargains, given the considerable role of the insurer. See *infra* note 64.

⁴² W. ANDREW ACHENBAUM, SOCIAL SECURITY: VISIONS AND REVISIONS 105 (1986) (explaining that “[a]s late as 1900, roughly two-thirds of all men over sixty-five were still gainfully employed”).

⁴³ STEVEN A. SASS, THE PROMISE OF PRIVATE PENSIONS: THE FIRST HUNDRED YEARS 4–6 (1997).

⁴⁴ The primitive nature of medicine prior to the early twentieth century meant by necessity much treatment was for comfort rather than cure. Cf. Joel D. Howell, *Diagnostic Technologies: X-Rays, Electrocardiograms, and CAT Scans*, 65 S. CAL. L. REV. 529, 532–33 (1991) (asserting that improvements in medical technology in the nineteenth and early-twentieth centuries eventually permitted acute and curative intervention, rather than merely long-term care).

⁴⁵ See SASS, *supra* note 43, at 1 (“Prior to 1900, today’s vast and complex pensioning apparatus existed in embryo only, and the elderly derived their livelihood from much simpler sources.”).

⁴⁶ See, e.g., Medill, *supra* note 12, at 11 (discussing the role of individual saving and planning in 401(k) plans); Zelinsky, *supra* note 36, at 454 (noting that today’s defined contribution plans are mostly self-funded by an individual’s contributions to an account); *infra* note 64 (explaining how elements of multilateral plans resemble individual models).

party, to address a later retirement or health need.⁴⁷ Importantly, the term “multilateral” rather than “bilateral” is used because many modern bargains involve players other than the direct parties to the bargain who are both compensated for their work and who, practically speaking, are tied to the core bargain.⁴⁸

Given that involving others in benefit planning and conferral is burdensome, the question arises: why do benefit bargains exist? Although benefit bargains come in wildly different varieties, in each case the beneficiary’s theoretical rationale for the bargain’s appeal is that a bargain is preferable to a self-reliance approach because the other party to the bargain can provide some useful service—usually professional expertise or the ability to bear risk—that the beneficiary cannot sufficiently provide on his own.⁴⁹ A brief look at three bargain types—pension, insurance, and fiduciary bargains—shows the practical appeal of the multilateral model.

1. Traditional Pensions

A classic example of benefit as bargain is the traditional pension, in which workers forego wages for the promise by the employer of retirement income for life, calculated according to a defined formula.⁵⁰ Under the customary pension bargain, a worker trades current income

⁴⁷ See Albert deRoode, *Pensions as Wages*, 3 AM. ECON. REV. 287, 287 (1913) (noting that a “pension system” is paid for by “[foregone] wages”); Pauly, *supra* note 30, at 24 (describing wage and benefit tradeoffs). See generally Sherwin Rosen, *The Theory of Equalizing Differences*, in 1 HANDBOOK OF LABOR ECONOMICS 641 (Orley Ashenfelter & Richard Layard eds., 1986) (observing the “theory of equalizing differences” suggests higher non-wage benefits will result in lower wages).

⁴⁸ See Pauly, *supra* note 30, at 24 (describing wage and benefit tradeoffs). By other players, I mean fiduciaries. See 29 U.S.C. § 1002(21)(A) (2006). The term “fiduciary” is functionally defined to include any party who “has any discretionary authority or discretionary responsibility in the administration” of a plan. See *id.* A “plan” is ERISA’s term for a benefit bargain. See *id.*; *infra* note 91 and accompanying text. The bargain between the employer and the employees in effect sweeps in fiduciaries, on whom ERISA relies heavily to effectuate bargains. See 29 U.S.C. § 1002(21)(A) (defining “fiduciary”); Colleen E. Medill, *The Law of Directed Trustees Under ERISA: A Proposed Blueprint for the Federal Courts*, 61 MO. L. REV. 825, 828–35 (1996) (discussing the importance of fiduciaries in ERISA benefit arrangements); see also *infra* note 60 (discussing fiduciary duties).

⁴⁹ See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 30 (2001) (noting that employers have superior bargaining power than employees).

⁵⁰ See deRoode, *supra* note 47, at 287 (noting that a “pension system” is paid for by “[foregone] wages”).

for (1) clarity regarding the level of his future retirement income,⁵¹ (2) fiduciary care and investment expertise in the handling of the underlying assets supporting the promised income,⁵² and (3) reduced risk and variance in connection with receiving the expected retirement income.⁵³ Today such arrangements are called “defined benefit” pensions and are heavily regulated under ERISA.⁵⁴

2. Fiduciary Bargains

Fiduciary bargains occur when the beneficiary party seeks to engage another party with comparatively superior capabilities to act with heightened care in protecting or advancing the first party’s retirement and health interests.⁵⁵ More specifically, the deployment of the fiduciary’s skill and the fiduciary’s assumption of more exacting duties to the beneficiary are intended to increase the likelihood that when the bene-

⁵¹ See Maher & Stris, *supra* note 9, at 452–55 (explaining that the aim of a “defined benefit” pension is to provide precision as to the level of benefit to be received). A defined benefit plan’s tax qualification depends on the provision of “definitely determinable benefits.” 26 C.F.R. § 1.401-1(b)(1)(i) (2010); see also Rev. Rul. 74-385, 1974-2 C.B. 130 (stating that benefits are “definitely determinable” when calculated via a fixed formula and “not within the discretion of the employer”); cf. Kathryn J. Kennedy, Conkright: *A Conundrum for Future Courts, an Opportunity for Congress*, in 2 NEW YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION 16-1, 16-65 to -68 (Alvin D. Lurie ed., 2011) (discussing the statutory importance that pension benefits be determinable and not subject to discretion of the plan administrator).

⁵² See, e.g. Daniel Fischel & John H. Langbein, *ERISA’s Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1112–20 (1988) (describing fiduciary duties in benefit plans).

⁵³ Cf. Jacob S. Hacker, *The New Economic Insecurity—And What Can Be Done About It*, 1 HARV. L. & POL’Y REV. 111, 113 (2007) (concluding that Americans face increased economic insecurity in part because of the move away from traditional pensions toward individual savings-oriented retirement plans); Zelinsky, *supra* note 36, at 455–70 (discussing several reasons why traditional pensions are less risky for employees than individual investment accounts). Professor Hacker recently achieved renown as the originator of the “public option” for health insurance. See generally JACOB S. HACKER, CTR. FOR HEALTH, ECON. & FAMILY SEC., U.C. BERKELEY SCH. OF LAW, *THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM* (2007), available at http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf?# (arguing for the creation of public health insurance to compete with private health insurance providers).

⁵⁴ See 29 U.S.C. § 1002(35) (2006) (defining “defined benefit plan”). ERISA’s regulation of certain aspects of defined benefit pensions has been accurately described as “mind-boggling” in its detail. See, e.g., Catherine L. Fisk, *Lochner Redux: The Renaissance of Laissez-Faire Contract in the Federal Common Law of Employee Benefits*, 56 OHIO ST. L.J. 153, 167 (1995).

⁵⁵ See Hyman & Hall, *supra* note 49, at 30. That the bargain is with the employer and not directly with the fiduciary is not here relevant. The whole arrangement is best conceived of as a multilateral bargain.

fiary has a need for retirement or health resources, they will be available and timely conveyed to the beneficiary.⁵⁶

As mentioned above, a fiduciary bargain accompanies the traditional “defined benefit” pension arrangement.⁵⁷ In that setting, among other things, the imposition of fiduciary duties on parties involved in the pension bargain serves to promote responsible handling of the assets underlying the pension promise and to insure fair conveyance of the benefits when due.⁵⁸

In addition, a fiduciary bargain is a crucial part of, and in many circumstances arguably envelops, what are known today as “defined contribution” pension arrangements.⁵⁹ In a defined contribution retirement arrangement, an employer promises to contribute some amount of money (whether deducted from the employee’s wages or in the form of a company “match” that is the functional equivalent of foregone wages) to an individual investment account administered by a fiduciary on the beneficiary’s behalf.⁶⁰

⁵⁶ See Bronsteen et al., *supra* note 17, at 2307–09 (describing “asset risk” and “benefit risk”). Asset risk is the possibility that available assets will be insufficient to satisfy the benefit promise. *Id.* at 2307–08. Benefit risk is the possibility that the promise will not be performed for some other reason. *Id.* at 2308–09. As I have in past work, I use the terms “benefit promise” and “benefit bargain” interchangeably.

⁵⁷ See 29 U.S.C. § 1104 (2006 & Supp. II 2008) (fiduciary duties); Fisk, *supra* note 54, at 167.

⁵⁸ See *supra* note 48; see also Bronsteen et al., *supra* note 17, at 2307–09 (describing the expectation that fiduciaries will properly manage funds and fairly confer benefits); Fischel & Langbein, *supra* note 52, at 1113–19 (discussing fiduciary duties under trust law and under ERISA).

⁵⁹ 29 U.S.C. § 1002(34) (2006) (defining a “defined contribution” plan). A defined contribution plan effectively provides a participant with a “tax-preferred savings account[.]” Richard A. Ippolito, *A Study of the Regulatory Effect of the Employee Retirement Income Security Act*, 31 J.L. & ECON. 85, 87 (1988). But these accounts are accompanied by significant duties on the part of plan fiduciaries. See 29 U.S.C. § 1104(a).

⁶⁰ See Ippolito, *supra* note 59, at 87. Defined contribution accounts are subject to varying degrees of control by the beneficiary, depending on the plan. See 29 U.S.C. § 1002(34) (defining defined contribution plan); 29 U.S.C. § 1104(c) (relaxing fiduciary duties where the beneficiary exercises greater control over the plan); Susan J. Stabile, *The Behavior of Defined Contribution Plan Participants*, 77 N.Y.U. L. REV. 71, 72 (2002) (noting that choices by participants in defined contribution plans are shaped by choices employers make regarding the plan structure and operation and by legal requirements). Fiduciaries must satisfy duties of loyalty, prudence, and investment diversification, and they must adhere to plan terms to the extent such terms are consistent with ERISA. 29 U.S.C. § 1104(a); cf. Maher & Stris, *supra* note 9, at 458 n.124 (“For defined contribution plans that do not offer the option of investment self-direction, the promisor’s fiduciary role is obvious and enormous: the fiduciary is actively deciding how to invest assets beneficially owned by the plan participant.”).

ERISA does provide an option for defined contribution plans to be structured to permit various levels of beneficiary control of investments and concomitantly to reduce the fiduciary duties owed by plan fiduciaries regarding investment losses. See 29 U.S.C. § 1104(c) (provid-

Defined contribution plans are sometimes conceived of as pure savings vehicles—and thus may seem more properly described as instances of the “individual” benefit model. In fact such accounts, under ERISA, include as the default rule significant fiduciary promise(s) by the plan fiduciaries with regard to investing and/or administering the assets in the beneficiary’s account.⁶¹ There is little doubt that the cost of securing the fiduciary bargain is nontrivial and reflects a material role the fiduciary plays in the arrangement.⁶²

3. Insurance

Private insurance is obviously a bargain.⁶³ Consider health insurance: the insured pays premiums in exchange for the right to demand transfer payments equivalent in value to “medically necessary” treatment.⁶⁴ The premium reflects the expected cost of payments to the in-

ing a “safe harbor” provision which relaxes fiduciary duties of prudence and diversification in cases where participant exercises investment “control”); 29 C.F.R. § 2550.404c-1 (2010) (implementing regulations). Debates over the amount of residual fiduciary duties that remain in such circumstances are ongoing. See *Hecker v. Deere & Co.*, 556 F.3d 575, 589–90 (7th Cir. 2009) (discussing scope of fiduciary duties under section 1104(c) and disagreeing with the view of the Department of Labor); *DiFelice v. U.S. Airways, Inc.*, 497 F.3d 410, 418 n.3 (4th Cir. 2007) (“[The] safe harbor provision does not apply to a fiduciary’s decisions to select and maintain certain investment options within a participant-driven 401(k) plan.”); *DOL Opinion Letters, PWBA Declined to Issue Advisory Opinion Regarding Whether Nonqualified Plan Was Pension Plan in Effect*, Pens. Plan Guide (CCH) ¶ 19,987, at n.1 (Mar. 6, 1998) (opining that the selection of an investment menu by the plan administrator is beyond beneficiary control); see also *infra* note 334. Plan structuring that truly renders de minimis the duty and liability of the fiduciary approaches a self-reliance benefit approach. See *supra* notes 34–46 and accompanying text (describing the individual model).

⁶¹ See 29 U.S.C. § 1104; *supra* note 60 and accompanying text.

⁶² Although the benefit bargain is in some sense “struck” between the employer and the employee, the bargain is only in practice possible to the extent some players agree to serve as fiduciaries and be compensated accordingly. Fiduciary willingness thus serves as a driver of bargain terms.

⁶³ Insurance obtained through an employer is financed by compensation reduction, although most workers probably do not recognize this fact. See Alan B. Krueger & Uwe E. Reinhardt, *The Economics of Employer Versus Individual Mandates*, HEALTH AFF., Apr. 1994, at 34, 40 (suggesting that workers are less aware of health insurance financed by “gradual reductions in pay raises” than by direct individual payment).

⁶⁴ In practice, insurance always includes a small self-reliance element: insurance policies include deductibles and co-insurance requirements, which are to be funded by the insured’s savings (“savings” including, as I have explained, current income transfer), rather than by the insurer. See Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 535–37 (1968) (offering the classic explanation of the utility of deductibles and coinsurance). These payments by the individual are intended to reduce “moral hazard,” or the tendency of lowered costs of medical care to the insured to increase the insured’s use of medical services. *Id.* at 535. But essentially this use of savings is part of the bargain struck between the insurer and the insured, and still falls within the bounds of the

sured during the coverage period and a “loading cost” (the amount the insurance company charges for running the insurance company and writing policies).⁶⁵ The traditional explanation as to why insurance is attractive is that individuals are risk averse; they prefer certain outcomes to outcomes with equivalent expected value but higher variance.⁶⁶ In the health insurance context, few people are willing to bear the risk that an unlikely-to-be-needed but extraordinarily expensive treatment could exhaust or exceed their savings, even if the expected value of that risk is small.⁶⁷ Accordingly, risk-averse individuals are willing to pay the insurance company’s loading cost (and more) to the extent that such cost is less than the amount they are willing to pay to avoid great variance in their expected costs.⁶⁸ An additional financial justification for insurance is that, even for risk-neutral insureds, the insurance company has superior buying and negotiating power with medical services providers.⁶⁹

The multilateral model shares a problem with the individual model: some people simply do not have enough income today to save or

multilateral model, because the insurer has a significant portion, indeed the majority, of the responsibility for overall health needs.

⁶⁵ REXFORD E. SANTERRE & STEPHEN P. NEUN, *HEALTH ECONOMICS: THEORIES, INSIGHTS, AND INDUSTRY STUDIES* 149 (2009) (explaining the loading fee). The expected cost portion of the insurance premium can be thought of as the “actuarially fair” or “pure” premium and the remaining premium as the price of insurance. *Id.*

⁶⁶ See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *AM. ECON. REV.* 941, 959 (1963) (describing individuals as “normally risk-aversers” in his discussion of the theory of ideal insurance, and noting that “[t]his assumption may reasonably be taken to hold for most of the significant affairs of life for a majority of people . . .”).

⁶⁷ Arrow, *supra* note 66, at 959–61 (explaining the theoretical health insurance calculus). Professor Arrow’s paper is widely considered to be a foundational work in the field of health economics.

⁶⁸ See Pauly, *supra* note 64, at 531–32 (explaining that individuals prefer health insurance up to a certain premium that is not actuarially fair, over self-insurance); Mark V. Pauly, *Competition in Health Insurance Markets*, *LAW & CONTEMP. PROBS.*, Spring 1988, at 237, 239 (explaining that insureds, when buying health insurance, are in part buying the “traditional risk-spreading function of insurance”). Professor Pauly is credited with effectively describing, in the early 1990s, the individual mandate as a means to permit the use of market solutions—i.e., bargains—rather than entitlements to solve the health insurance coverage problem. See Julie Rovner, *Republicans Spurn Once-Favored Health Mandate*, *NPR*, (Feb. 15, 2010), <http://www.npr.org/templates/story/story.php?storyId=123670612>; see also Pauly, *supra* note 30, at 21 (describing the appeal of the individual mandate in ensuring insurance coverage).

⁶⁹ See Pauly, *supra* note 68, at 254–55 (explaining that group insurance, by having a larger market share, can be used to extract discounts from medical service providers); see also Hyman & Hall, *supra* note 49, at 30 (noting that employers have superior bargaining power than individual employees).

bargain for enough to satisfy tomorrow's needs.⁷⁰ That aside, the multi-lateral model is theoretically attractive because it combines the appeal of individual action with comparative advantage. The result is that benefit outcomes the individual could not or would not have achieved on his own can be achieved through the involvement of other parties. A central difficulty with the bargain model is that real-life bargains suffer from bargaining differentials, motive problems, and strategic play.⁷¹ Deals struck between parties of different bargaining strength may not reflect truly fair exchanges; employment and insurance bargains have long attracted particular scrutiny in this regard.⁷² Finally, the party to the arrangement that agrees to provide something—for example, the risk-sharer, the fiduciary, or the investment expert—is motivated by personal gain.⁷³ This is not a moral criticism, merely recognition that the profit motivation may result in the striking of certain bargains—whether they are per se “unfair” or not—that insufficiently serve the nation's retirement and health care goals.⁷⁴

The shortcomings of the multilateral model present a strong case for government regulation of benefit bargains, whether in the form of statutory, judicial, or administrative rules.⁷⁵ In the two landmark benefit statutes of the past half-century, ERISA and the ACA, that is precisely

⁷⁰ See Medill, *supra* note 12, at 17; *supra* notes 38–41 and accompanying text (discussing the fact that many people cannot save enough money in the individual model of benefits).

⁷¹ See, e.g., Maher & Stris, *supra* note 9, at 472–73 n.201. This observation is, to put it mildly, not new. But it enjoys distinguished company. See Roscoe Pound, *Liberty of Contract*, 18 YALE L.J. 454, 454 (1909) (declaring that “actual industrial conditions” undermine the appeal of “freedom of contract” theories).

⁷² See, e.g., Roscoe Pound, *Do We Need a Philosophy of Law?*, 5 COLUM. L. REV. 339, 344–46 (1905) (decrying the failure of common law principles to appreciate bargaining differentials in employment and criticizing “freedom of contract” justifications to void protective statutes). The first use of the term “contract of adhesion” to appear in a legal academic journal appeared in an article discussing life insurance. See Edwin W. Patterson, *The Delivery of a Life-Insurance Policy*, 33 HARV. L. REV. 198, 222 (1919) (internal quotation marks omitted).

⁷³ See Bronsteen et al., *supra* note 17, at 2306 (noting that ERISA permits an employer to employ or control a fiduciary); cf. Peter Diamond, *Organizing the Health Insurance Market*, 60 ECONOMETRICA 1233, 1234 (1992) (noting that in the health care setting, a doctor serves as both a provider of health care advice and a provider of health care services).

⁷⁴ See Maher & Stris, *supra* note 9, at 472–73 n.201.

⁷⁵ Cf. Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 629 (1943) (describing the rise of standard commercial contracts and the need for legal rules to appropriately police their use). Professor Kessler's article focused on contracts of adhesion, but the insights translate to an argument for context-variant protective legal rules in a variety of settings. *Id.* at 642 (“[F]reedom of contract must mean different things for different types of contracts.”). A contract, of course, is simply a form of bargain. See *id.* at 630.

what happened. To that this Article will return. But first, the following Section briefly considers the third benefit model.

C. *Benefit as Public Entitlement*

Benefit as entitlement is a model that allocates resources for retirement and health pursuant to direct political promises made by the sovereign and paid for via the public treasury.⁷⁶ The benefit-entitlement model differs from the individual and multilateral models in that benefit-entitlement approaches do not aim to “promote” adequate savings and bargains to address retirement and health needs.⁷⁷ Instead, they aim to have the sovereign itself pay the bills.⁷⁸ Social Security and Medicare are classic examples of benefit-entitlement approaches in retirement and health care, respectively.⁷⁹ In my model, the defining feature of an entitlement is that the arrangement is fundamentally a political act.⁸⁰

The appeal of a benefit-entitlement model is a particularly complicated inquiry. The sovereign is an utterly different actor than either individuals making savings decisions or parties striking a commercial

⁷⁶ See, e.g., Dilley, *supra* note 14, at 979 (describing Social Security as a “public entitlement”).

⁷⁷ See *id.*

⁷⁸ I consider government financial support, i.e., tax expenditures, of a particular individual or multilateral benefit arrangement to be analytically distinct from entitlement models; you cannot push a rope. In that way tax expenditures to support voluntary arrangements are very different than direct government provision of benefits. Tax expenditures to promote certain benefit arrangements are enormously important, but beyond the scope of this paper. As a simplifying assumption, unless I note otherwise, I assume throughout—a patently false assumption—that all benefit arrangements are tax-neutral, not because that is realistic, but because it allows clear conceptual thinking before considering the effects of tax distortions.

⁷⁹ See Dilley, *supra* note 14, at 979 (referring to Social Security as a “public entitlement” to future income).

⁸⁰ Certainly, one can imagine “entitlement” as meaning many different things. For example, one view may be that an entitlement is an unconditional moral right; under that definition, Social Security is not an entitlement, because it has conditions. For my purposes, however, the defining feature of an entitlement is that the government, as sovereign, is making a promise. That act is motivated by political considerations, not economic self-interest, and thus implicates an entirely different host of considerations than those implicated by private actors making what are essentially self-interested financial decisions. To the extent the government is acting more like a private actor than a sovereign, such as when it acts as an employer, then the benefit arrangement is more accurately conceived of as a bargain. Public employee benefit arrangements, however, involve a host of unique considerations that are beyond the scope of this Article. See, e.g., Paul M. Secunda, *Constitutional Contracts Clause Challenges in Public Pension Litigation*, 28 HOFSTRA LAB. & EMP. L.J. 263 (2011).

benefit bargain.⁸¹ The sovereign has unique power to tax, borrow, spend, punish, and make law; is motivated by something other than profit; and, in purely economic terms, has more risk-tolerance and purchasing power than any private player or collection of private players.⁸² This presents both advantages and disadvantages, depending on the specific context in which an entitlement model is used and one's foundational assumptions about the "correct" level of sovereign involvement in society (in either specific or broad terms).⁸³

The modern political consensus (although that is today being challenged in some quarters) is that the entitlement model is, at least, the appropriate way to provide retirement and health care for those unable to have saved or bargained their way there.⁸⁴ Beyond that, the appeal and appropriateness of an entitlement model inspires heated, sometimes febrile, debate. For example, a sovereign's enormous resources and risk-tolerance have long been invoked to justify public health insurance;⁸⁵ conversely, a sovereign's susceptibility to cronyism and unresponsiveness to market pressures have long been cited as countervailing reasons to disfavor public health insurance.⁸⁶ That debate has been resolved differently in other countries.⁸⁷

In America, the current political environment suggests no epic expansion of the benefit as entitlement approach is in the foreseeable future. Quite the opposite: proposals to reform Social Security seek to

⁸¹ See generally Dilley, *supra* note 14 (comparing private and public retirement plans in discussing the debate over the privatization of Social Security).

⁸² *Cf. id.* at 981–82, 1035 (arguing that public entitlement is more likely to satisfy retirement needs than private savings and noting that it is designed to "protect the public interest in social stability").

⁸³ See, e.g., Gruber, *supra* note 5, at 572 (noting the debate over whether more or less government involvement is the proper response to improving health care access). See generally Dilley, *supra* note 14 (discussing the debate over whether to privatize Social Security and the reasoning on each side of the debate).

⁸⁴ *But see* Jeremy Binckes, *Tea Party Leader: We Should Abolish Social Security*, HUFF POST POL. (Mar. 31, 2010, 11:50 AM), http://www.huffingtonpost.com/2010/03/31/tea-party-leader-we-shoul_n_519970.html (suggesting the elimination of Social Security).

⁸⁵ See, e.g., F.A. HAYEK, *THE ROAD TO SERFDOM: TEXT AND DOCUMENTS* 148 (Bruce Caldwell ed., 2007) (noting the appeal of a "comprehensive system of social insurance" to deal with "sickness"). I do not offer an exhaustive recitation or endorsement of the arguments in favor of entitlement, of course. There are many and they vary in quality.

⁸⁶ See, e.g., Blumstein & Zubkoff, *supra* note 6, at 398–99 (discussing advantages of nongovernmental approaches to cost-containment in the health care context). I do not offer an exhaustive recitation or endorsement of the arguments against the entitlement model, of course. There are many and they vary in quality.

⁸⁷ See Gruber, *supra* note 5, at 571 (noting that the United States has a high number of uninsured citizens, in contrast to other countries that guarantee universal health care).

reduce, rather than expand, the breadth and depth of the program.⁸⁸ And Congress, in passing the ACA, rejected both the creation of a “Medicare for All” health program and multiple versions of a “public option,” where the government would have offered need-subsidized health insurance to those who chose to acquire insurance directly from the government.⁸⁹

Instead, health care reform took a different tact: through use of a mandate to obtain insurance, the federal government has essentially compelled people to make bargains.⁹⁰ The result of this hotly-contested compulsion, as this Article discusses later, is to create a legal meta-structure in which individuals and states could in some (but not all) respects have more effective say in shaping the legal rules that affect the health insurance bargain than they did prior to the ACA’s enactment. To understand this increase in the power of individuals and states, we must look at the primary pre-ACA hurdle to individual and state power in the benefit context: ERISA.

II. ERISA AND THE RISE OF THE BARGAIN MODEL

ERISA contains multitudes. There is no need here to plumb most of its specifics. Any thoughtful discussion of benefit law and policy, however, must necessarily recognize and understand two of the statute’s central characteristics.

First, ERISA federally regulates bargains—more specifically, employment-based benefit bargains⁹¹—at a level that markedly limits state

⁸⁸ See generally Dilley, *supra* note 14 (discussing the recent interest in privatizing Social Security). President Obama recently appointed a bipartisan commission to propose solutions to the nation’s budget woes. A portion of the commission’s final proposal was to reduce Social Security expenditures and increase reliance on “personal retirement savings.” NAT’L COMM’N ON FISCAL RESPONSIBILITY & REFORM, *THE MOMENT OF TRUTH* 48–56 (2010), available at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf (proposing Social Security reform).

⁸⁹ See Ezra Klein, *Death of the Public Option*, WASH. POST (Dec. 15, 2009, 12:14 AM), http://voices.washingtonpost.com/ezra-klein/2009/12/the_death_of_the_public_option.html (discussing death of the public option as a political possibility). Single-payer proposals, such as Representative John Conyers’s proposed bill, got even less political traction than the public option. See United States National Health Care Act, H.R. 676, 111th Cong. § 205 (2009) (single payer scheme).

⁹⁰ See 26 U.S.C.A. § 5000A (West 2011) (effective Jan. 1, 2014) (requiring individuals to maintain minimal essential coverage to avoid payment of tax penalty); *infra* notes 228–252 and accompanying text.

⁹¹ ERISA regulates “any employee benefit plan” established by an employer or employee organization. See 29 U.S.C. § 1003(a) (2006). A benefit plan is defined as “an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.” *Id.* § 1002(3).

regulation. Indeed, to a considerably higher degree than most federal statutes, it reposes exclusive rulemaking authority in the federal government.⁹² Second, ERISA heavily relies upon the federal judiciary to fill in statutorily unresolved matters of law and policy.⁹³ In this regard, the bench's efforts have received sparse praise.⁹⁴ ERISA's ultimate result has been a set of legal rules of vast reach that please few.⁹⁵ The statute's shortcomings shed light on more attractive alternatives.

A. Federalizing the Bargain Model

ERISA was enacted by the ninety-third Congress and signed into law on Labor Day 1974.⁹⁶ It was conceived and enacted in an era that favored centralized solutions.⁹⁷ Business conglomerates were still in vogue,⁹⁸ and even leading Republican politicians were unafraid to invoke federal power to address social challenges. Consider President Richard M. Nixon, for example. By the time of ERISA's passage, he had already resigned in disgrace over Watergate.⁹⁹ Prior to his fall, however,

The pension plan definition encompasses both "defined benefit" and "defined contribution" retirement arrangements. *Id.* § 1002(2). The welfare plan definition encompasses health insurance. *Id.* § 1002(1). That ERISA is conceived of in terms of regulating "plans" is not important for this Article's purposes; one can think of an ERISA plan as an ERISA bargain or promise, and vice versa. In practical effect, ERISA governs all health and retirement bargains struck at the workplace. See Peter J. Wiedenbeck, *ERISA's Curious Coverage*, 76 WASH. U. L.Q. 311, 311-12 (1998). Exceptions to ERISA's coverage are limited in scope. See, e.g., 29 U.S.C. § 1003(b)(1)-(5) (specifying enumerated and narrow exceptions).

⁹² See 29 U.S.C. § 1144(a) (ERISA preemption provision).

⁹³ See Norman Stein, *ERISA and the Limits of Equity*, LAW & CONTEMP. PROBS., Winter 1993, at 71, 110.

⁹⁴ See *infra* notes 130-222 and accompanying text.

⁹⁵ See, e.g., Donald T. Bogan, *Protecting Patient Rights Despite ERISA: Will the Supreme Court Allow States to Regulate Managed Care?*, 74 TUL. L. REV. 951, 953 (2000) (arguing that "ERISA has failed . . . miserably to serve as a beneficial consumer protection statute for ERISA welfare plan participants"); Bronsteen et al., *supra* note 17, at 2315-16 (criticizing ERISA's role in generating increased agency costs in the health care setting); Fischel & Langbein, *supra* note 52, at 1105-07 (noting various criticisms of ERISA and arguing that ERISA fiduciary law belongs "on the list of ERISA's major blunders").

⁹⁶ See WOOTEN, *supra* note 18, at 1.

⁹⁷ See, e.g., Lewis B. Kaden, *Politics, Money, and State Sovereignty: The Judicial Role*, 79 COLUM. L. REV. 847, 847 (1979) (noting that the period from 1936 to 1976 reflected an appetite for national solutions to social problems).

⁹⁸ See, e.g., Brian Cheffins & John Armour, *The Eclipse of Private Equity*, 33 DEL. J. CORP. L. 1, 26 (2008) (observing that conglomerates were a "familiar" part of the landscape in the 1970s).

⁹⁹ See Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (enacted on Sept. 2, 1974). Nixon resigned in August 1974. See JOAN HOFF, NIXON RECONSIDERED 338 (1994).

he (and other leading Republicans) either implemented or favored federal solutions to many national problems, including wage and price controls, a reduction of the speed limit, and the creation of the U.S. Environmental Protection Agency and the Occupational Safety and Health Administration.¹⁰⁰ Indeed, Jacob Javits, a Republican Senator from New York, was the primary force behind ERISA's enactment.¹⁰¹

Prior to 1935, the United States did not have a broad-based public retirement system.¹⁰² By the late-nineteenth century, however, various private industry players had concluded that offering pensions—what today we would call “defined benefit” pensions¹⁰³—were attractive for business reasons, and even moral ones.¹⁰⁴ Accordingly, different companies offered retirement arrangements that varied in their substantive terms, depending upon business- and market-specific factors.

¹⁰⁰ See HOFF, *supra* note 99, at 1–144 (discussing Nixon's domestic policies); see also Bruce Ackerman, *Interpreting the Women's Movement*, 94 CALIF. L. REV. 1421, 1428 n.15 (2006) (“Nixon supported the Civil Rights Act of 1964 and other Great Society legislation . . .”). Of course, whatever the possible wisdom of Nixon's policies, history will have other good reasons to judge him harshly.

¹⁰¹ See generally WOOTEN, *supra* note 18 (offering a detailed political history of ERISA and explaining Senator Javits's pivotal role in drafting and passing ERISA).

¹⁰² Social Security was enacted in 1935. ANN SHOLA ORLOFF, *THE POLITICS OF PENSIONS: A COMPARATIVE ANALYSIS OF BRITAIN, CANADA, AND THE UNITED STATES, 1880–1940*, at 13 (1993). In Europe, Germany had the first broad public pension system, established by Otto von Bismarck in 1889. See Axel Börsch-Supan, Anette Reil-Held & Reinhold Schnabel, *Pension Provision in Germany*, in *PENSION SYSTEMS AND RETIREMENT INCOMES ACROSS OECD COUNTRIES* 160, 162 (Richard Disney & Paul Johnson eds., 2001). Other European countries followed. See ORLOFF, *supra*, at 14 tbl.1.1 (listing the years in which various European countries, Britain, and the United States first adopted old age insurance laws). In contrast, “the United States and Canada . . . were ‘laggards’ in the institution of modern [pension] programs relative to the European countries . . .” *Id.* at 13.

¹⁰³ See *supra* note 54.

¹⁰⁴ See SASS, *supra* note 43, at 1–2. Private pensions, although not common, began to arise in the late-nineteenth century. ALICIA H. MUNNELL, *THE ECONOMICS OF PRIVATE PENSIONS* 8 (1982) (describing early private pension arrangements, such as the one offered by American Express in the 1870s); see also DAN MCGILL ET AL., *FUNDAMENTALS OF PRIVATE PENSIONS* 16–20 (9th ed. 2010) (discussing early private sector pensions). By the 1930s, approximately “[ten] percent of the nonagricultural labor force . . . were employed by corporations offering pension plans, although not all employees were eligible for plan membership.” MUNNELL, *supra*, at 8 (citing MURRAY W. LATIMER, *INDUSTRIAL PENSION SYSTEMS IN THE UNITED STATES AND CANADA* 42–48 (1932)).

For a discussion of the economic appeal of pensions, see Maher & Stris, *supra* note 9, at 447 (explaining the economic attraction of pensions). Some believed pensions for elderly workers—after long careers of hard work—were morally appropriate. See, e.g., MCGILL ET AL., *supra*, at 6, 20 (explaining that many employers were “not willing to discard long-tenured faithful employees” without pensions and that “[a]t first, private pension benefits were universally regarded as gratuities from a grateful employer in recognition of long and faithful service”).

Troubles arose. Whatever the merit of leaving private actors to negotiate pension terms, in many instances workers' pension expectations were frustrated; companies made unfair, unclear, or insecure pension promises with unacceptable frequency.¹⁰⁵ These problems with traditional pensions impelled ERISA's enactment.¹⁰⁶ Importantly, at the time of ERISA's conception, pension bargains were by far the dominant employment benefit bargain in the United States: the value of assets committed to pension promises dwarfed the assets attributable to defined contribution or health insurance employment bargains.¹⁰⁷ Thus many of ERISA's legal rules—actuarially sound funding requirements, vesting limitations, government guarantees—were aimed directly at pension bargains and applied only to them.¹⁰⁸ In short, the ninety-third Congress, in enacting ERISA, was trained on solving a pension problem, not a benefits one.

ERISA, however, covers much more than pensions.¹⁰⁹ With narrow exceptions, it regulates all workplace benefit bargains.¹¹⁰ That includes employment-based health insurance, which in the early 1970s was considered a modest “fringe benefit” of employment rather than the costly bugbear it is in 2011.¹¹¹ Employment health insurance had taken hold during World War II as a response to wage controls that limited employers' ability to compete for workers using wage increases.¹¹² In the post-

¹⁰⁵ See, e.g., WOOTEN, *supra* note 18, at 51 (noting that when Studebaker Corporation closed its auto production plant in 1963, its pension plan did not contain enough funds to meet its obligations, and that some commentators believe the Studebaker fund failed because “company officials misused plan funds”). For example, reformers were troubled by harsh forfeiture rules. See, e.g., *Menke v. Thompson*, 140 F.2d 786, 790 (8th Cir. 1944) (dealing with an employee with a 45-year tenure who was denied his pension because he participated in a strike years before). Another problem was performance risk: that an employer would fail to properly manage or preserve the assets underlying the promise. See WOOTEN, *supra* note 18, at 51. Employees expecting pensions after years of work were told that there was no money to pay them. See *id.* at 51–79.

¹⁰⁶ Medill, *supra* note 12, at 4.

¹⁰⁷ See, e.g., Stabile, *supra* note 60, at 74 (discussing the dominance of traditional defined benefit pension as retirement income in 1974, when ERISA was enacted).

¹⁰⁸ See Medill, *supra* note 12, at 4. See generally Wiedenbeck, *supra* note 91 (discussing the differing categories of ERISA rules).

¹⁰⁹ See Medill, *supra* note 12, at 4.

¹¹⁰ See *supra* note 91 and accompanying text.

¹¹¹ See Maher & Stris, *supra* note 9, at 437 (defining “fringe benefit” as “any nonwage item of value provided by an employer to an employee”); *supra* note 91 and accompanying text.

¹¹² See Clark C. Havighurst, *American Health Care and the Law*, in *THE PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES* 1, 3 (M. Gregg Bloche ed., 2003). Prior to World War II, “[t]he vast majority of care was purchased directly by consumers out-of-pocket on a fee-for-service basis in the private market place.” William D.

war period, health insurance became an increasingly popular benefit.¹¹³ At the time of ERISA's passage, the content and cost of employment-based health insurance was not a primary concern for Congress, because "there was no crisis in health plans in 1974."¹¹⁴ Nonetheless, it was an employment-based benefit, and there were scattered reports of abusive practices.¹¹⁵ In the general spirit of reformist enthusiasm, but with far less careful thought than had gone into the specifics of pension regulation, Congress subjected workplace health insurance to ERISA's dominion.¹¹⁶

Unlike the many precise rules governing pension arrangements, ERISA offered very few specific rules governing health promises.¹¹⁷ Instead, the primary federal rules governing health bargains were rules of general applicability to all benefit bargains: rules of obligation, of duty, of notice, and of remedy.¹¹⁸ Many of these rules took the form of "standards," as opposed to classic legal rules, and thus left to the judiciary capacious authority and responsibility.¹¹⁹

White, *Market Forces, Competitive Strategies, and Health Care Regulation*, 2004 U. ILL. L. REV. 137, 141 (citing I.S. FALK ET AL., *THE COSTS OF MEDICAL CARE* 8–9 (1933)). World War II wage controls encouraged employers to offer health insurance, which they increasingly did in the post-war period. See Havighurst, *supra*, at 3–4.

¹¹³ See Havighurst, *supra* note 112, at 3.

¹¹⁴ Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century* of EMPLOYEE BENEFITS LAW, at lxiii, lxvii–lxix (Steven J. Sacher et al. eds., 2d ed. 2000). Some commentators and policymakers were expressing concern about rising health expenditures in general, but 1970s legislative proposals for national health insurance reform failed in Congress. See generally Flint J. Wainess, *The Ways and Means of National Health Care Reform, 1974 and Beyond*, 24 J. HEALTH POL. POL'Y & L. 305 (1999) (discussing failed 1970s health reform efforts).

¹¹⁵ See Gordon, *supra* note 114, at lxix.

¹¹⁶ See 29 U.S.C. § 1002(1) (2006) (extending ERISA coverage to welfare plans); cf. Fisk, *supra* note 54, at 165–66 (explaining that Congress gave "relatively little thought" to welfare benefits); Hyman & Hall, *supra* note 49, at 29 ("Health benefits were included in ERISA as an afterthought . . .").

¹¹⁷ See Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829.

¹¹⁸ See *infra* notes 130–179 and accompanying text.

¹¹⁹ See, e.g., 29 U.S.C. § 1104(a)(1)(B) (2006) (describing the general standard of care as that of a prudent person familiar with the benefit plan matters at issue). "[C]lassic 'rules' are legal directives that, in objectively discernable circumstances, impose determinate results. Classic 'standards' are legal directives that, in circumstances possessing a certain character, authorize a range of consequences sensitive to situational facts." Maher & Stris, *supra* note 9, at 441–42 (collecting authorities regarding the rule versus standard distinction); see also *infra* notes 130–179 and accompanying text. In this Article, when discussing legal rules, I mean both classic rules and classic standards, unless context suggests otherwise.

In contrast to the significant authority conferred upon the federal judiciary, ERISA sharply preempted the authority of states to regulate employee benefit bargains.¹²⁰ ERISA explicitly preempts, by statutory provision, the ability of states to make law that “relates to” benefit plans.¹²¹ Whatever the boundary of that vast provision, ERISA then “saves” to the states the authority to pass general laws of insurance.¹²² Finally, ERISA “deems” any employee benefit plan not to be an insurance company, and thus forbids states from regulating any employee benefit plan that is self-insured.¹²³ Self-insured plans cannot be regulated even by means of “saved” laws.¹²⁴

¹²⁰ See 29 U.S.C. § 1144(a). ERISA preemption case law and commentary is labyrinthine at best and incoherent at worst. A coherent and readable recent treatment is that of Professor Wiedenbeck. See PETER J. WIEDENBECK, *ERISA: PRINCIPLES OF EMPLOYEE BENEFIT LAW* 245–49 (2010).

¹²¹ 29 U.S.C. § 1144(a) (“[ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan [governed by ERISA]”). In 1995, the Court backed away from its earlier, expansive interpretation of this clause. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654–55 (1995) (noting a rebuttable presumption against preemption in its interpretation of section 1144(a)’s “relate to” language).

¹²² 29 U.S.C. § 1144(b)(2)(A) (saving from preemption state laws that regulate insurance). This provision is called the “savings” clause, for obvious reasons. See *id.*

¹²³ *Id.* § 1144(b)(2)(B) (stating that employee benefit plans shall not be “deemed” insurance companies subject to state regulation). This provision is called the “deemer” clause. See *id.* A self-insured plan is one where the plan itself, rather than any insurer, is directly obligated to pay benefits to the beneficiaries. See Paul O’Neil, *Protecting ERISA Health Care Claimants: Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L.J. 724, 735 (1994).

¹²⁴ See 29 U.S.C. § 1144(b)(2)(A). Thus, insured and self-insured plans are treated differently. Compare *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (holding that the regulation of a self-insured plan is preempted because it does not qualify under ERISA savings clause), with *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 758 (1985) (holding that state regulation of benefit plan’s insurer is not preempted because it qualifies as a “law which regulates insurance” under the ERISA savings clause). Neither type of plan can be directly regulated by states. 29 U.S.C. § 1144(a). However, “insurance companies selling health care insurance policies (and, thus, indirectly the policy benefits to plan participants) are subject to regulation by state insurance laws.” Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 492 (1998). Conversely, the deemer clause bars states from using general insurance law to regulate self-insured plans. See 29 U.S.C. § 1144(b)(2)(B). The distinction matters “because most employers self-insure their welfare plans, which means that state efforts to regulate and reform health care are largely ineffective.” Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 243 (1997). But see *infra* note 127 (discussing the regulation of stop-loss insurers that many self-insured plans use).

In addition to explicit preemption, the courts have also read ERISA to preempt certain state laws implicitly.¹²⁵ Thus, even if a state law were outside the reach of ERISA's enumerated preemption provisions, under this line of preemption reasoning, state laws that sufficiently frustrate or conflict with ERISA's purpose would be preempted.¹²⁶

The result is a regulatory scheme in which the effective level of federal displacement of state authority varies from "very significant" to "absolute," depending on the plan structure and the state law at issue.¹²⁷ In any event, the combination of ERISA's explicit and implicit

¹²⁵ See 29 U.S.C. § 1144(a); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 217–18 (2004) ("Under ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.")

¹²⁶ See 29 U.S.C. § 1144(a); *Aetna*, 542 U.S. at 217–18.

¹²⁷ An interesting wrinkle is that most self-insured plans actually rely on outside insurance called "stop-loss" insurance to offload risk. See Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1372–73 (describing stop-loss insurance). Payments above a certain amount are covered by the stop-loss insurer; easily triggered stop-loss policies are functionally little different from a traditionally insured plan. See *id.* "ERISA fails to clearly define the scope of federal preemption of states' attempts to regulate self-insured plans with stop-loss coverage." Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615, 616 (1995). The circuit courts of appeals are split over the degree to which ERISA preempts stop-loss plan regulation, although the majority view is that state regulation is preempted. Paredes, *supra* note 124, at 251–60 (discussing the circuit split). Compare *Tri-State Mach., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994) (holding that a plan covered by stop-loss insurance is self-insured for ERISA preemption purposes and thus is exempt from indirect state insurance regulation), with *Mich. United Food & Commercial Unions v. Baerwaldt*, 767 F.2d 308, 311–13 (6th Cir. 1985) (holding that a plan covered by stop-loss insurance is "insured," and the stop-loss provider is thus subject to state insurance regulation). The Supreme Court has not resolved the question. Cf. Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 110–12 (2005) (arguing that state regulators can use the "savings clause" to directly regulate stop-loss insurance companies).

To summarize: States cannot regulate self-funded plans. See *supra* note 124. Some but not all circuit courts have held that states cannot regulate nominally self-funded plans that use stop-loss insurance. Many plans are either purely self-funded or self-funded and use stop-loss insurance. As a result, a significant number of employment-based health insurance is provided in such a way to be beyond the reach of state regulatory power. Thus, many employers have been in effect able to opt out of state authority.

Of course, employers are not individuals and have different reasons to choose law. Society will get different legal rules, and serve different values, if law is being driven by employer choice rather than individual choice. A notable feature that the meta-structure the ACA contemplates, and a significant part of its theoretical appeal, is vertical regime choice by *individuals*. In addition, when individuals choose state law under the ACA, they do not drag employers with them, as employers essentially do to employees when they choose federal law under ERISA. In other words, to the degree the ACA empowers individuals to

preemptive power has severely constrained states from engaging in additional or supplemental state regulation of benefit bargains.¹²⁸ Commentators have extensively criticized both ERISA's preemptive scheme and the judicial interpretation of it.¹²⁹

B. *Judicializing the Bargain Model*

Congress left considerable work to the judiciary in giving content to ERISA's flexible statutory standards.¹³⁰ Key judicial tasks include fleshing out rules of obligation, interpretation, review, and remedy.¹³¹ These issues have drawn the attention of the Supreme Court on a regular basis.¹³² They are very important because they define the particulars of private enforcement, on which ERISA relies significantly to shape

make choices about law, it also partners them with a player who *ex ante* agrees with that choice. *See infra* notes 223–329 and accompanying text.

¹²⁸ *See* 29 U.S.C. § 1144(a). “ERISA preemption has thwarted [health] reform efforts in a large number of states.” Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 36 (1996); *see also* Bogan, *supra* note 95, at 996 (“ERISA super-preemption . . . harms millions of workers by nullifying a myriad of state health care consumer protections.”); Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 252 (1997) (describing a regulatory void where states cannot regulate and the federal government has not regulated). *But compare* Retail Indus. Leaders Ass’n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007) (holding that the Maryland “pay or play” health insurance scheme preempted), *with* Golden Gate Rest. Ass’n v. City of San Francisco, 546 F.3d 639, 642 (9th Cir. 2008) (holding that the San Francisco “pay or play” law not preempted).

¹²⁹ *See, e.g.*, O’Neil, *supra* note 123, at 727–38 (criticizing ERISA preemption). *See generally* Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619 (1994) (same).

¹³⁰ *See, e.g.*, 29 U.S.C. § 1104(a)(1) (2006) (the “exclusive benefit rule”); Fischel & Langbein, *supra* note 52, at 1110 (criticizing the exclusive benefit rule for sweeping too broadly); Stein, *supra* note 93, at 110 (explaining that ERISA left open questions for the courts to answer).

¹³¹ *See* Stein, *supra* note 93, at 110.

¹³² *See generally, e.g.*, *Hardt v. Reliance Standard Life Ins. Co.*, 130 S. Ct. 2149 (2010) (reviewing whether, under ERISA, a claimant for attorney’s fees and costs must first be a “prevailing party”); *Conkright v. Frommert*, 130 S. Ct. 1640 (2010) (reviewing whether a plan administrator’s error in interpreting a plan justifies denying the administrator deference for later interpretations of the plan); *Kennedy v. Plan Adm’r for DuPont Sav. & Inv. Plan*, 555 U.S. 285 (2009) (reviewing an ERISA plan administrator’s interpretation of the documents governing the plan); *Metro. Life Ins. v. Glenn*, 554 U.S. 105 (2008) (reviewing what considerations a reviewing court should consider in determining whether a plan administrator abused its discretion in denying benefits under an ERISA plan); *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248 (2008) (reviewing a plan participant’s rights to remedy under ERISA for fiduciary breaches that impaired the value of plan assets in a participant’s individual account).

conduct in the first instance and provide relief in the case of wrongdoing.¹³³

Before considering the Court's decisions, recall the stage. ERISA does not require any employer to provide benefits; it only regulates promises voluntarily made.¹³⁴ Of course, legal rules that make benefit arrangements clearer or more secure come with an expected price (and some level of uncertainty around that expected price). Increased cost and uncertainty associated with understanding, complying with, or litigating a particular rule has a potentially chilling effect: it may deter employers from offering benefits in the first place, or it may result in less generous offers being made.¹³⁵ ERISA's regulatory approach inherently involves a tradeoff between benefit security, clarity, and cost.¹³⁶

There is no doubt that Congress, in enacting ERISA, was well aware that it was increasing the cost of striking benefit bargains.¹³⁷ The challenge is resolving precisely *how much* security and clarity are to be prioritized over cost.¹³⁸ To the extent the statute does not plainly answer that question in a given setting, how should statutory ambiguity or silence be resolved? In important areas—fiduciary status, plan interpretation, judicial review, and remedy—the Court has tended to choose legal rules that prioritize cost and volatility reduction over benefit security.¹³⁹ It has done so either by raising the threshold requirement for court intervention or limiting the relief available.¹⁴⁰

¹³³ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (“The civil enforcement scheme of § 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA.”).

¹³⁴ *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (“Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.”).

¹³⁵ See Brendan S. Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 WIS. L. REV. 657, 659.

¹³⁶ See Maher, *supra* note 135, at 659 (discussing the policy tradeoff inherent in ERISA); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 133 (2009) (arguing that the Court has prioritized cost reduction over protecting beneficiaries, contrary to congressional wishes).

¹³⁷ See Maher & Stris, *supra* note 9, at 435 (explaining that rules that provide security and clarity increase cost).

¹³⁸ See, e.g., *Conkright*, 130 S. Ct. at 1648–49 (“We have therefore recognized that ERISA represents a careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.”) (citation omitted) (internal quotation marks omitted); Dana M. Muir, *The Plan Amendment Trilogy: Settling the Scope of the Settlor Doctrine*, 15 LAB. LAW. 205, 213 (1999) (noting the “inherent tension” between protecting participants and encouraging plan sponsorship).

¹³⁹ See, e.g., *LaRue*, 552 U.S. at 250–51 (limiting fiduciary remedy); *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443–45 (1999) (narrowing the definition of “fiduciary” through the settlor doctrine); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108–15 (1989)

1. Obligations

Many of ERISA's protections hinge upon the status of the alleged bad actor as a fiduciary.¹⁴¹ In a series of cases in the 1990s, the Court narrowed the functional definition of "fiduciary" by announcing what is known as the "settlor doctrine."¹⁴² Where an actor is designing, amending, or terminating a plan, those actions are not fiduciary actions, but rather "settlor" actions that do not trigger ERISA's fiduciary provisions.¹⁴³ The rationale was that employers who created or amended plans were acting akin to the settlor of a trust, who historically could act freely in fashioning the trust.¹⁴⁴ The word "settlor" does not appear in ERISA;¹⁴⁵ the settlor doctrine is a judge-made concept that reflects the conclusion that key aspects of the benefit bargain are matters of business discretion in which neither ERISA nor the courts should interfere.¹⁴⁶

(holding that a court should use an arbitrary and capricious standard to review a fiduciary's decision of when a plan awards the fiduciary discretion).

¹⁴⁰ See *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15.

¹⁴¹ See 29 U.S.C. § 1002(21) (2006) (defining "fiduciary"); *id.* § 1104(a)(1)(A)(i) (imposing traditional trust law duty of loyalty on fiduciaries); *supra* note 48 (identifying and describing fiduciary definitions in ERISA); see also John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1325 (2003) ("ERISA subjects all significant aspects of plan administration to fiduciary duties and remedies derived from trust law . . .").

¹⁴² See, e.g., *Hughes*, 525 U.S. at 443–45; *Lockheed*, 517 U.S. at 890–91; *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 81–82 (1995).

¹⁴³ See *Hughes*, 525 U.S. at 443–45; *Lockheed*, 517 U.S. at 890–91; *Curtiss-Wright*, 514 U.S. at 81–82. The decisions in *Hughes*, 525 U.S. at 443–45, *Lockheed*, 517 U.S. at 890–91, and *Curtiss-Wright*, 514 U.S. at 81–82, all address the scope of the settlor doctrine. There are modest limits in ERISA regarding plan formation or amendment. See, e.g., 29 U.S.C. § 1102(b)(3) (2006) (requiring the establishment of procedure for amending a plan).

¹⁴⁴ See *Hughes*, 525 U.S. at 443–45; *Lockheed*, 517 U.S. at 890–91; *Curtiss-Wright*, 514 U.S. at 81–82.

¹⁴⁵ See Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829.

¹⁴⁶ See *Hughes*, 525 U.S. at 443–45; *Lockheed*, 517 U.S. at 890–91; *Curtiss-Wright*, 514 U.S. at 81–82. The settlor doctrine is not clearly foreclosed by the statute's text, has policy appeal, and may very well express congressional intent. Although the doctrine has merit, influential commentators have criticized the Court's reasoning. 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, 425–26 (2000) (describing and criticizing the settlor doctrine); Marilyn J. Ward Ford, *Broken Promises: Implementation of Financial Accounting Standards Board Rule 106, ERISA, and Legal Challenges to Modification and Termination of Postretirement Health Care Benefit Plans*, 68 ST. JOHN'S L. REV. 427, 446–50 (1994) (arguing, in advance of the settlor doctrine cases, that "postretirement health care benefit plans" were intended to be protected by ERISA). The point, however, is merely that the Court's creation of the doctrine has reduced the reach of ERISA's fiduciary provisions. See, e.g., *Pegram v. Herdrich*, 530 U.S.

2. Deference

Fiduciaries administer all benefit plans pursuant to written instruments.¹⁴⁷ In 1989, in *Firestone Tire & Rubber Co. v. Bruch*, the U.S. Supreme Court held that if a plan by its terms awards a fiduciary discretion in administering the plan, then when reviewing the fiduciary's conduct, the Court will use an "arbitrary and capricious" standard.¹⁴⁸ Unless the fiduciary acted unreasonably, the court will defer to its judgment.¹⁴⁹ Predictably, plan drafters thereafter included such discretionary provisions as a matter of course.¹⁵⁰

The Court's lenient standard worried commentators because ERISA does not prohibit the use of fiduciaries who are employed or controlled by the employer (to the contrary, it is commonplace).¹⁵¹ Many if not most fiduciaries who enjoy judicial deference labor under some level of conflict, and various scholars have expressed concern about biased plan administration.¹⁵² The Court remains enthusiastic about its deferential mode of review and has declined opportunities to change course.¹⁵³ In two recent decisions, the Court held that the arbitrary and capricious standard is appropriate notwithstanding either (1) the presence of a stark conflict—for example, where the fiduciary construing the terms of the bargain is the same insurance company paying out claims—or (2) an instance of prior unreasonable conduct by the administrator—for example, where earlier in the benefit dispute, the adminis-

211, 226–30 (2000) (holding that choosing to structure a plan as a health maintenance organization is not a fiduciary act, nor is a mixed eligibility and treatment decision). *But see Aetna*, 542 U.S. at 218 (holding that a benefit determination is "generally a fiduciary act").

¹⁴⁷ See *supra* note 48 and accompanying text (explaining that fiduciaries administer plans); *supra* note 91 and accompanying text (explaining that plans are benefit bargains).

¹⁴⁸ See 489 U.S. at 108–15 (articulating the standard of review in benefit determination cases).

¹⁴⁹ *Id.* at 111–14.

¹⁵⁰ See, e.g., MICHAEL J. CANAN & WILLIAM D. MITCHELL, *EMPLOYEE FRINGE AND WELFARE BENEFIT PLANS* 591 (1997) (discretionary clause in model welfare plan); John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 220 (predicting insertion of discretionary clauses in plans); 2 Pens. Plan Guide (CCH) ¶ 30,047 (illustrating a model defined benefit plan with a discretionary clause).

¹⁵¹ See 29 U.S.C. § 1108(c)(3) (2006); Fischel & Langbein, *supra* note 52, at 1126 (noting that plan sponsors "routinely" select fiduciaries from the "ranks of management").

¹⁵² See Bronsteen et al., *supra* note 17, at 2304–19 (arguing that conflicted fiduciaries threaten fair delivery of health care); John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. REV. 1315, 1316 (2007) ("Most ERISA plan benefit denials are the work of conflicted decisionmakers.").

¹⁵³ See, e.g., *Conkright*, 130 S. Ct. at 1644; *Glenn*, 544 U.S. at 110–19.

trator behaved unreasonably.¹⁵⁴ In each opinion, the Court stressed the appeal of resolving benefit disputes without judicial intervention.¹⁵⁵

3. Remedies

ERISA provides multiple remedies to beneficiaries wronged under the statute or the governing plan. Three cover the overwhelming majority of ERISA disputes.¹⁵⁶ The first is a “benefits” remedy designed to allow beneficiaries to obtain benefits that were promised but not paid;¹⁵⁷ the second is a “fiduciary” remedy designed to police inappropriate fiduciary behavior;¹⁵⁸ and the third is a “catch-all” remedy designed to afford “appropriate equitable relief” in case of a violation of ERISA or the terms of the governing plan.¹⁵⁹ Each remedy bears significant Court-imposed limitations.¹⁶⁰

The benefits remedy has been interpreted to include only the value of the benefit that was not properly conferred.¹⁶¹ For example, in the case of a medical treatment held to have been wrongfully denied under the terms of the plan, the plaintiff’s recovery would be limited to the value of the benefit withheld; consequential damages to make the plaintiff whole for physical or financial injuries suffered as a result of

¹⁵⁴ See *Conkright*, 130 S. Ct. at 1644 (holding that a deferential review can survive mistake); *Glenn*, 554 U.S. at 110–19 (confirming application of the arbitrary and capricious standard in cases of conflict, but noting that a review should consider the “circumstances” of the conflict).

¹⁵⁵ *Conkright*, 130 S. Ct. at 1650; *Glenn*, 554 U.S. at 116.

¹⁵⁶ See 29 U.S.C. § 1132(a)(1)(B) (2006) (benefits remedy); *id.* § 1132(a)(2) (fiduciary remedy); *id.* § 1132(a)(3)(B) (catch-all remedy).

¹⁵⁷ See *id.* § 1132(a)(1)(B).

¹⁵⁸ See *id.* § 1132(a)(2).

¹⁵⁹ See *id.* § 1132(a)(3)(B); see also Maher & Stris, *supra* note 9, at 465 (noting that the Supreme Court has “exploited textual ambiguity” in ERISA by “developing several restrictive ‘judicial glosses’”).

¹⁶⁰ See, e.g., *LaRue*, 552 U.S. at 250–51 (limiting the fiduciary remedy); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 361–62 (2006) (limiting the catch-all remedy); *Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002) (same); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256–61 (1993) (same); *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (limiting the benefits remedy).

¹⁶¹ See 29 U.S.C. § 1132(a)(1)(B); *Russell*, 473 U.S. at 148.

[T]he relevant text of ERISA, the structure of the entire statute, and its legislative history all support the conclusion that in § 409(a) Congress did not intend to provide, and did not intend the judiciary to imply, a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims.

the wrongful denial are not available.¹⁶² Nor are punitive damages available.¹⁶³

The fiduciary remedy—which polices fiduciary breaches, the core malfeasance ERISA was conceived to deter—has been interpreted to apply only in limited situations: when a fiduciary’s misconduct has resulted in a loss to the plan or a gain to the fiduciary.¹⁶⁴ Yet fiduciary misconduct can occur, and cause injury, when neither the plan is hurt nor the fiduciary advantaged.¹⁶⁵ Indeed, the text of the fiduciary provision seemingly contemplates circumstances other than plan injury or fiduciary gain in which a court might provide relief.¹⁶⁶ As a result of the

¹⁶² *Russell*, 473 U.S. at 148. The 1985 Supreme Court case of *Mass. Mutual Life Ins. Co. v. Russell* in fact involved a section 1132(a)(2) claim, but its limit on “extracontractual” damages has widely been interpreted by courts and commentators to apply to section 1132(a)(1)(B) benefit claims. *See id.*; *see, e.g.*, Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625, 632 (2001) (observing that “consequential damages are not allowed”). This has been passionately criticized. *See, e.g.*, George Lee Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 647 (1994) (referring to consequential damage limits as “pure fiction—caused either by vicious judicial and legal subterfuge or, more likely, gross judicial and legal malpractice on the part of [the] Supreme Court”).

¹⁶³ Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMP. L.J. 387, 394–95 (2009) (noting the absence of consequential and punitive damages under ERISA).

¹⁶⁴ *See* 29 U.S.C. § 1132(a)(2); *LaRue*, 552 U.S. at 254 (noting that the fiduciary remedy was intended to protect a plan’s financial integrity and that a plaintiff who receives all benefits to which she was entitled under a plan, although late, is not eligible for relief under ERISA’s section 1132(a)(2)). In the 2008 Supreme Court case of *LaRue v. DeWolff, Boberg, & Associates, Inc.*, the beneficiary allegedly lost money as a result of plan administrators failing to follow his investment instructions. 552 U.S. at 250–51. At issue was whether the fiduciary remedy was triggered. *Id.* at 250. The Court’s decision assumed there was a fiduciary breach and held relief available, but only because it held there was a loss to the plan. *See id.* at 252–53. Were the fiduciary remedy not constricted, it would have applied regardless of whether the plan suffered a loss. *See id.*; *see also Russell*, 473 U.S. at 142 (“A fair contextual reading of the statute makes it abundantly clear that its draftsmen were primarily concerned . . . with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary.”).

¹⁶⁵ *See, e.g.*, *Farr v. U.S. W. Commc’ns, Inc.*, 151 F.3d 908, 911 (9th Cir. 1998) (finding that misrepresentation in the form of bad tax advice hurt the beneficiary, but was not remediable because the misrepresentation neither injured the plan nor benefitted the fiduciary).

¹⁶⁶ *See* 29 U.S.C. § 1132(a)(2). Any fiduciary who breaches any of the fiduciary duties imposed by ERISA

shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

narrow interpretation of the fiduciary remedy, however, lower courts have struggled to handle situations in which a clear fiduciary breach has occurred but the “plan loss” or “fiduciary gain” triggering conditions are not present.¹⁶⁷

Limitations on the first two remedies might be of little consequence if the third remedy, the “catch-all” remedy, was interpreted expansively.¹⁶⁸ The opposite is true.¹⁶⁹ In a series of decisions, the Supreme Court has held that the catch-all remedy is burdened by a significant constraint.¹⁷⁰ The relief available under the catch-all remedy is limited to the relief “typically available” in *historical* equity, that is, in the days of the divided bench.¹⁷¹ Roughly, a plaintiff in the twenty-first century seeking relief under the catch-all remedy is limited to the equitable relief of the nineteenth.¹⁷² What the latter entails precisely is disputed, but according to the Court it only very rarely, if ever, includes relief resembling traditional consequential damages.¹⁷³

The aggregate effect of the Court’s work has been to use narrower obligations, lenient interpretative and review standards, and highly circumscribed remedies to reduce the judiciary’s role in policing employment benefit bargains.¹⁷⁴ Commentators, unable to square the Court’s decisions with notions of ERISA as a protective statute, with the doctrinal skeleton of trust law, or with traditional interpretative-methodological frames, have criticized the Court’s jurisprudence.¹⁷⁵

29 U.S.C. § 1109(a).

¹⁶⁷ See, e.g., *Farr*, 151 F.3d at 911 (holding that bad tax advice is not remediable under ERISA, notwithstanding the existence of a fiduciary breach).

¹⁶⁸ See 29 U.S.C. § 1132(a)(1)(B), (a)(2), (a)(3)(B).

¹⁶⁹ See *id.* § 1132(a)(3)(B).

¹⁷⁰ See, e.g., *Sereboff*, 547 U.S. at 361–62; *Knudson*, 534 U.S. at 210; *Mertens*, 508 U.S. at 256–61.

¹⁷¹ See *Sereboff*, 547 U.S. at 361; *Knudson*, 534 U.S. at 210; *Mertens*, 508 U.S. at 256–61; see also Langbein, *supra* note 141, at 1348–63 (discussing *Mertens* and *Knudson*).

¹⁷² See *Sereboff*, 547 U.S. at 361; *Knudson*, 534 U.S. at 210; *Mertens*, 508 U.S. at 256–61.

¹⁷³ *Mertens*, 508 U.S. at 256 (holding that equitable relief refers to “those categories of relief that were typically available in equity [and] not compensatory damages”); see also Langbein, *supra* note 141, at 1318–19 (explaining that the Court wrongly held for equitable relief to exclude monetary relief); cf. Judith Resnik, *Constricting Remedies: The Rehnquist Judiciary, Congress, and Federal Power*, 78 IND. L.J. 223, 231–71 (2003) (discussing at length the Court’s interpretation of “equitable relief” and the difficulties with the Court’s position). Happily, the Court’s view may be changing. In the recently decided *Cigna Corp. v. Amara*, the Court concluded that historical equity, and thus ERISA, permitted remedies, such as “surcharge,” which are functionally similar (though not identical) to claims for consequential damages. See 131 S. Ct. 1866, 1880 (2011).

¹⁷⁴ See *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15; *supra* notes 130–179 and accompanying text.

¹⁷⁵ See *supra* notes 35, 48, 52, 128, 129, 136, 146, 150 and accompanying text.

Many of those criticisms, certainly, have merit. Yet, in terms of offering a persuasive account of why the Court has done what it has done—as well as laying bare fundamental problems with the current way modern benefit law is conceived—a realist approach offers the most promise.

As I have explained elsewhere, the Court's decisions evidence acute fear of legal rules that could undermine the frequency and generosity of bargains, not only because Legal Rule A will have a significant expected cost, but also because there will be significant variance around the expected cost of Legal Rule A.¹⁷⁶ More bluntly, what the Court has done with respect to ERISA bargains—which govern the delivery of trillions of dollars of retirement income and health care in this country—is to have largely succumbed to a particular policy judgment.¹⁷⁷ It has decided that the cost and volatility associated with the traditional level of judicial involvement in private disputes is unacceptably high and would undermine the ERISA benefit model.¹⁷⁸ Instead, the Court has articulated constrictive legal rules that—by sharply limiting the role of courts in defining and policing ERISA bargains—reduce the cost and uncertainty associated with making benefit promises.¹⁷⁹

C. *Criticizing the ERISA Bargain Model*

The ways in which ERISA allocates power regarding the law of benefit bargains—to the federal government and, then, in significant measure, to federal judges—are structurally unappealing. ERISA, in effect, lashes much of the country's benefit rules to a single federal mast in a ship captained by judges.¹⁸⁰ It is a classic piece of anti-federalism.¹⁸¹ The appeal of an alternative approach, opt-in federalism, is discussed below.¹⁸² But before considering the alternative, it is necessary to consider in some detail why ERISA is in many respects a failure.¹⁸³

¹⁷⁶ See Maher & Stris, *supra* note 9, at 464–73.

¹⁷⁷ See, e.g., *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15.

¹⁷⁸ See, e.g., *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15.

¹⁷⁹ See, e.g., *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15; see also Maher & Stris, *supra* note 9, at 435 (noting the tradeoff in legal rules).

¹⁸⁰ See Stein, *supra* note 93, at 110 (noting that ERISA left open questions for the courts to resolve).

¹⁸¹ See Richard B. Stewart, *Federalism and Rights*, 19 GA. L. REV. 917, 917 (1985) (noting that “[f]ederalism seeks to maintain political decentralization”).

¹⁸² See *infra* notes 253–293 and accompanying text.

¹⁸³ See Bogan, *supra* note 95, at 953 (noting that “ERISA has failed . . . miserably”).

Consider first the Supreme Court's work.¹⁸⁴ Many observers, including dissenting members of the Court, believe the Court has been materially unfaithful to Congress's protective intent.¹⁸⁵ Congress clearly prioritized benefit security and clarity over minimizing costs; that is why it enacted ERISA.¹⁸⁶ To be sure, legal rules that are extraordinarily costly or extremely volatile (such as punitive damages), might have been outside of Congress's protective intent because they come at too high of a price.¹⁸⁷ Under this thinking, the most intuitively sensible framework to adopt, given the statute's history and expressed "security" purpose, is that when balancing concerns of security and cost, courts should use a rebuttable presumption favoring security.¹⁸⁸ Such runs squarely counter to the Court's pattern of decisions.¹⁸⁹

I am sympathetic to this line of reasoning and believe it to be largely correct.¹⁹⁰ But the true question is more difficult than the binary one of whether the Court has been faithful or not, with the only possible answers being "yes" or "no." The reality is that Congress, in expressing itself, fell short of perfection. In several crucial respects, the federal legislature had only the vaguest of intents, conflicting intent, no specific intent at all, or an intent that judges address certain matters through the development of common law.¹⁹¹ The consequence is that courts, including the Supreme Court, have been forced into a policy-making role in which they face numerous institutional disadvantages.¹⁹²

¹⁸⁴ See, e.g., *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15.

¹⁸⁵ See *Knudson*, 534 U.S. at 224–34 (Ginsburg, J., dissenting) (concluding that Congress did not intend the "catch-all" provision to be limited by the Court's historical equity test); *Secunda*, *supra* note 136, at 133. See generally Langbein, *supra* note 152 (arguing that the Supreme Court failed to implement congressional intent).

¹⁸⁶ See 29 U.S.C. § 1001(b) (2006) ("It is hereby declared to be the policy of [the Act] to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries . . ."). The statute, after all, has the word "security" in its title.

¹⁸⁷ See *Mertens*, 508 U.S. at 270 (White, J., dissenting) (concluding that Congress did not intend for punitive damages to be recoverable under the "catch-all" remedy).

¹⁸⁸ See 29 U.S.C. § 1001(b).

¹⁸⁹ See, e.g., *LaRue*, 552 U.S. at 250–51; *Hughes*, 525 U.S. at 443–45; *Firestone*, 489 U.S. at 108–15.

¹⁹⁰ See Bronsteen et al., *supra* note 17, at 2304–19; Maher, *supra* note 135, at 669–82; Maher & Stris, *supra* note 9, at 464–73.

¹⁹¹ See Stein, *supra* note 93, at 110.

¹⁹² See *Patsy v. Bd. of Regents*, 457 U.S. 496, 513 (1982) (observing that when "the relevant policy considerations do not invariably point in one direction, and there is vehement disagreement over the validity of the [relevant] assumptions . . . [t]he very difficulty of these policy considerations, and Congress' superior institutional competence to pursue this debate, suggest that legislative not judicial solutions are preferable"). And scholars have recently begun to explore the degree to which judicial "cognitive illiberalism" may

That they may have done a poor job does not change the fact that they were dealt a very challenging hand.

To understand the difficult position courts have been put in, consider the proposition that a proposed legal rule is unattractive because its imposition could reduce the frequency or generosity of benefit bargains. Whether that is actually true for a particular legal rule is a complicated matter of policy and empirics. Put another way: if using Less Protective Legal Rule A will result in more bargains, it will also likely result in more breaches. Is the marginal increase in bargains, on balance, “worth more” than the marginal increase in breaches? When the answers to such questions, as here, directly implicate the contour and equities of the nation’s retirement and health policy, such answers should flow from legislative or agency officials, not Article III judges.¹⁹³ They are neither trained for nor enthusiastic about such a role.¹⁹⁴

More troublingly, the epistemological near-impossibility of correctly ascertaining Proposed Protective Rule A’s marginal value and cost in the course of a behind-the-bench balancing test obscures a very important fact. It obscures the fact that the ontological answer to the question of marginal value and cost will *vary* with the subject matter of the benefit bargain to be governed by Proposed Protective Rule A. For example, there is little independent reason to believe, *ex ante*, that legal rules governing obligations, judicial review, and remedy for defined benefit promises and health insurance promises should be “one-size-fits-all.”¹⁹⁵

manifest itself in workplace (including benefit) disputes. Paul M. Secunda, *Cognitive Illiberalism and Institutional Debiasing Strategies*, 49 SAN DIEGO L. REV. (forthcoming 2012), available at http://papers.ssrn.com/sol3/paper.cfm?abstract_id=1777104.

¹⁹³ See *Patsy*, 457 U.S. at 513.

¹⁹⁴ The Court’s frequent taking of ERISA cases may be motivated more by a sense of judicial duty than intellectual interest. Justice David Souter, upon retirement, cited as one motivation for his departure a lack of interest in “numbingly technical cases involving applications of pension or benefits law.” Jess Bravin & Evan Perez, *Justice Souter to Retire from Court*, WALL ST. J., May 1, 2009, at A1. There was much to recommend about Justice Souter, but there is no accounting for taste.

¹⁹⁵ See Blumstein & Zubkoff, *supra* note 6, at 401 (“[T]here is a strong argument that ‘no single standard and style of health care can be appropriate for all Americans, given their widely varied attitudes, tastes, and religious convictions, their other needs, and the necessarily limited resources at their disposal’” (quoting C.C. Havighurst, *Controlling Health Care Costs*, 1 J. HEALTH POL., POL’Y & L., 471, 491 (1977))). Imagine evaluating whether or not a particular legal rule is an attractive legal rule for a benefit bargain. A defined benefit pension promise is very different than a health insurance promise. The substantive ways in which the parties may fail to understand the terms differ; the promise length differs; the opportunities for incompetent, strategic, or malicious behavior differ; the interpretive ambiguity of the core bargain term differs, e.g., a precise mathematical

The Supreme Court, however, has interpreted ERISA this way, and thus done exactly the wrong thing when it comes to making benefit rules: it has been largely indifferent to context.¹⁹⁶ That is unlikely to result in ideal legal rules. Instead it virtually guarantees square pegs for round holes.¹⁹⁷

The problem is made more complicated in that the selection of an optimal legal rule in a benefit setting need not only consider the effect of alternate rules, but also the possibility of alternate benefit settings entirely. That last part requires some explanation. Let us assume that, in fact, a particular legal rule will be so costly or volatile that it *will* reduce the frequency or generosity of *employment-based* benefit bargains of a particular type. So what? Employment-based benefit bargains are not an end in and of themselves; they are a means to provide for retirement and health care. The ultimate cost associated with fewer or less generous employment benefit bargains is measured by looking at the extent to which workers not receiving employee benefits will not obtain health insurance or retirement income as cheaply, or at all, *some other way*. Health insurance provides a useful practical illustration of this point. It

formula compared to a broad promise to provide “medically necessary care”; the fitness of a judge to resolve disputes differs; and the nature and magnitude of the consequences to the beneficiary in the case of breach differ. There is little if any reason to believe the optimal legal rules across those circumstances will or should be the same. *See* Maher & Stris, *supra* note 9, at 467–73. Even within the category of health bargains, rule optimality would need to consider heterogeneity of substantive preference. *Cf.* Blumstein & Zubkoff, *supra* note 6, at 401.

¹⁹⁶ *See, e.g., Lockheed*, 517 U.S. at 890–91 (applying the settler doctrine in the pension setting without serious explanation of its reasoning); *Curtiss-Wright*, 514 U.S. at 81–82 (same, in the welfare setting). The Court has also ignored context in determining the rules of review and remedy. *See, e.g., Glenn*, 554 U.S. at 105, 113 (ignoring the rules of review). No statutory provision speaks to the settlor doctrines or the standard of review, so the Court was and is free to make law as it sees fit. Regarding remedies, the “benefits” remedy refers to “rights,” 29 U.S.C. § 1132(a)(1)(B) (2006); the “fiduciary” remedy to “remedial” and “appropriate” relief, *id.* §§ 1109, 1132(a)(2); and the “catch-all” remedy refers to “appropriate equitable relief,” *id.* § 1132(a)(3). An extended textual analysis is not necessary to see that the provisions are nearly as pliable as a context-sensitive Court might want them to be. In any event, were the Court in fact confined by text, the objection would still have force against Congress. Ultimately it does not matter. The problem is that the rules are difficult to pick, and the right rules are too likely to be different for different players. The answer is not that Congress should have given clearer instruction to the courts. The answer is that Congress should reduce the importance of both its and the courts’ judgments.

¹⁹⁷ The point is that ERISA, reposing as it does so much authority in federal rule-makers, does not provide an opportunity for any natural corrective. Thus, when federal judges develop square-peg-for-round-hole rules, effectively no force other than Congress can address that mistake. Opt-in federalism, in contrast, provides competitive pressure, as well as an exit option if competitive pressure fails to improve a given rule.

is difficult for many individuals to obtain health insurance outside the workplace.¹⁹⁸

In any insurance promise, the expected cost is a function of the likelihood a given insured will experience a loss event and the size of the expected loss.¹⁹⁹ The higher this expected cost, the higher the actuarially fair premium an insurer must charge to be profitable.²⁰⁰ But if the insurer offers too high a premium, many potential insureds will be dissuaded from purchasing policies.²⁰¹ Health insurance is attractive to insureds to the extent it reflects an actuarially fair premium plus some cost increment reflecting the insured's level of risk-aversion.²⁰²

One method for an insurer to charge the appropriate premium is to "rate" insureds correctly.²⁰³ Insureds that are higher rated for risk are either (1) not offered insurance at all or (2) offered insurance with an increased premium, relative to the average-rated insured.²⁰⁴ The effect is that some people will be not offered insurance at any price in an unregulated market, whereas others will be offered insurance at a price they cannot afford.²⁰⁵ Precise rating is difficult.²⁰⁶ Information asymmetries can result in adverse selection, where an insurer knows less about the true riskiness of the potential insured than does the insured, and a premium not reflective of the true expected cost of the insured is offered and accepted.²⁰⁷ The result is that in the next round of premium calculation, the premiums increase, and for healthier people, the insurance deal becomes financially unattractive.²⁰⁸ When healthy people leave the pool, this departure increases the expected payout per person, which results in higher premiums, which exacerbates the prob-

¹⁹⁸ See Diamond, *supra* note 73, at 1236–37 (explaining that in the small group and individual markets, individuals considered high risk may either be rejected for coverage or may only obtain coverage at premiums they cannot afford).

¹⁹⁹ SANTERRE & NEUN, *supra* note 65, at 148–54 (discussing the insurance calculus).

²⁰⁰ See *id.* at 149.

²⁰¹ See *id.*

²⁰² See Arrow, *supra* note 66, at 959–61.

²⁰³ In the individual insurance market, this is achievable through the underwriting process, which occurs at the inception and renewal of the insurance contract. See Diamond, *supra* note 73, at 1237. Underwriting is where the insurer gathers information regarding the risk profile of the potential insured and rates the insured accordingly. See Hyman & Hall, *supra* note 49, at 32.

²⁰⁴ See Diamond, *supra* note 73, at 1237.

²⁰⁵ See *id.*

²⁰⁶ See JONATHAN GRUBER, PUBLIC FINANCE AND PUBLIC POLICY 311–13 (2005).

²⁰⁷ *Id.* (explaining adverse selection). See generally Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECONOMICS 629 (1976) (offering the theory of adverse selection).

²⁰⁸ See Hyman & Hall, *supra* note 49, at 32.

lem, and so on.²⁰⁹ Severe adverse selection problems can destroy or wildly distort insurance markets, and require government intervention.²¹⁰

Adverse selection risks decline to the extent an insurer can insure a group bound together by some commonality other than an interest in obtaining health insurance—for example, the same employer, the same geographical region, or the same church.²¹¹ Thus employment-based health insurance is useful because, by aggregating people for reasons unrelated to health status, it ameliorates the problem of adverse selection, which imperils the functioning of the individual health insurance market.²¹²

Accordingly, in selecting optimal legal rules in the employment benefit context, one must consider alternative benefit possibilities. To the extent the individual market is afflicted by adverse selection distortions, imposing legal rules that discourage employers from offering insurance can potentially have a very steep downside.²¹³ If an employer chooses to not offer health insurance because of costly or uncertain legal rules, the consequence could be that some of the people who would have been beneficiaries of such unmade promises will not obtain insurance at all on the individual market.²¹⁴

Besides adverse selection,²¹⁵ other obstacles to securing benefits outside of employment bargains exist. There are several reasons—many identified in behavioral economic literature—why workers who do not receive retirement or health benefits at work may be unlikely to secure

²⁰⁹ See GRUBER, *supra* note 206, at 312 (noting that less risky individuals are more likely to seek lower insurance coverage than risky individuals).

²¹⁰ The degree to which adverse selection manifests itself in practice is contested. See, e.g., Gruber, *supra* note 5, at 577 (noting there is “mixed” evidence on the degree to which those who choose to be insured are “adversely selected”). For a clear treatment of the topic, see generally Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004).

²¹¹ See Hyman & Hall, *supra* note 49, at 32.

²¹² See Allison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 28 (2010) (“Insurers have little concern of adverse selection with respect to large, employer-sponsored group insurance.”).

²¹³ See *id.* (discussing adverse selection).

²¹⁴ See Diamond, *supra* note 73, at 1237. *But cf.* Siegelman *supra* note 210, at 1231 & n.26 (challenging the strength of the argument that adverse selection concerns support narrowing liability standards).

²¹⁵ See, e.g., Gruber, *supra* note 5, at 574, 577 (noting that the nongroup insurance market “has not provided a very hospitable environment” and that the high cost of health insurance is a large reason for uninsurance). A milder form of adverse selection is thought to exist in the pension context. See Feldstein, *supra* note 36, at 8 (discussing adverse selection in individual annuity markets).

such benefits through alternate arrangements.²¹⁶ These complications make even more difficult the appropriate weighing of considerations when selecting benefit rules in different contexts.

Given the complexities of the marginal costs and advantages of various legal rules, the difference in those valuations across contexts, and the comparative difficulties associated with securing benefits through other means, it is likely, if not certain, that federal judges are not best suited to this task.²¹⁷

I do not mean to suggest that choosing optimal legal rules is easy. To the contrary, it is quite difficult for any actor. It involves complicated judgments regarding what data to collect and rely on, what assumptions should govern in the absence of data, and which subjects of the rules are best suited to bear what levels of risk. Optimal benefit rules are not easily determined. Confidence regarding the rightness of a particular rule selection is modest at best.²¹⁸ In addition, different rules might be optimal given the preferences of different individuals or groups. Preferences for cost and security vary; preference for legal rules will vary accordingly.²¹⁹

Selecting optimal legal rules regarding retirement and health care bargains necessarily implicates textured, varying, and challenging policy questions.²²⁰ Divergent preferences increase the challenge, diminishing the appeal of a centralized mechanism for answering those ques-

²¹⁶ See *supra* note 41 and accompanying text. See generally Edward J. McCaffery, Comments on Liebman and Zeckhauser, Simple Humans, Complex Insurance, Subtle Subsidies (U.S.C. Law & Econ. Working Paper No. 81, 2008), available at <http://law.bepress.com/cgi/viewcontent.cgi?article=1085&context=usclwps> (discussing cognitive biases in the health insurance context).

²¹⁷ Cf. Stein, *supra* note 93, at 110 (arguing that courts are “poorly suited” to answer questions ERISA left unanswered).

²¹⁸ The more uncertain and challenging rule selection is, vesting authority in a single decision-maker becomes less appealing. Additional trials, e.g., other rule-makers, become more appealing. Cf. Cass R. Sunstein, *Due Process Traditionalism*, 106 MICH. L. REV. 1543, 1546 (2008) (noting that “the persistence of a practice across many minds . . . makes it more likely to be correct, wise, or good”). More generally, in many settings, aggregative reasoning can be helpful to an observer attempting to determine the “right” answer, although it has limits. Cf. *id.* at 1550–52 (discussing aggregative approaches in assessing the wisdom of legal rules).

²¹⁹ Nor is the claim of varying preference inconsistent with the observation that considerable uncertainty plagues the task of identifying an optimal rule. Uncertainty around optimality does not mean that for Group A the cloud of uncertainty does not hover in a different place than it does for Group B. Imagine there are ten possible rules: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. If the average uncertainty surrounding a preference is one, then if Group A prefers Rule 2 and Group B prefers Rule 9, even though uncertainty clouds each group’s preferences, it is clear the Groups prefer different rules.

²²⁰ See Maher & Stris, *supra* note 9, at 435.

tions. Such perfectly describes ERISA.²²¹ The conclusion, then, is not simply that the Court has gotten the answers wrong, although it likely has. The conclusion is that ERISA, a rigidly centralized statute, has structural infirmities that one would expect to, and in fact do, frustrate the search for optimal benefit law. This is true not only regarding the law ERISA affirmatively produced, but also regarding the law it blocked—state law.²²² The following Part considers a more promising approach.

III. IMPROVING BARGAIN LAW WITH “OPT-IN FEDERALISM”

Law can specify not only substantive rules, but also who chooses them. The Patient Protection and Affordable Care Act (“ACA”) offers a novel and conceptually fascinating approach regarding who makes and chooses law: “opt-in federalism.” Fusing individual autonomy with decentralization, it is truly twenty-first-century federalism, and has far reaching implications.

Using a federalist lens, the ACA can be thought of as exercising federal power in two distinct ways. The first way is a classic (if constitutionally challenged) exercise of federal power—direct federal rulemaking:²²³ the ACA specifies that all or certain health insurance bargains in the country satisfy particular federal requirements.²²⁴ The best examples of this are the ACA’s commands that certain policies provide specified minimum coverage.²²⁵ Minimum coverage requirements may be complicated or unwise, but theoretically, they are akin to the federal

²²¹ Nor does it bear the usual advantage of centralized action: the guarantee of a minimum to everyone. ERISA does not guarantee any promises get made.

²²² See 29 U.S.C. § 1144(a) (2006).

²²³ See, e.g., 42 U.S.C.A. § 18022 (West Supp. 2011) (establishing minimum coverage requirements); 42 U.S.C.A. § 300gg-11(a) (West 2003 & Supp. 2011) (prohibiting limits on lifetime or annual coverage). How one categorizes this direct rulemaking—whether as an instance of “preemptive” or “cooperative” federalism, or something else, see *infra* note 256—is an interesting question that deserves attention, but that is not my aim here. The opt-in federalism element of the statute is more novel. I focus on that and the unexplored potential it poses for resolving difficult and divisive questions of law and policy regarding health care and retirement. Cf. generally Kenneth Scott, *The Dual Banking System: A Model of Competition in Regulation*, 30 STAN. L. REV. 1 (1977) (discussing the choice made by banks with respect to federal or state charters). But see Daniel Schwarcz, *Regulating Insurance Sales or Selling Insurance Regulation?: Against Regulatory Competition in Insurance*, 94 MINN. L. REV. 1707, 1721 (2010) (discussing and criticizing reform proposals calling for increased regulatory choice by insurers in life, property, and casualty markets).

²²⁴ See, e.g., 42 U.S.C.A. § 18022.

²²⁵ *Id.* (specifying what package of services need be covered by the policy). Another example of direct rulemaking is the prohibition on lifetime or annual coverage limits for all policies sold. See *id.* 42 U.S.C.A. § 300gg-11(a).

government stepping into the shoes of every state government and announcing the rules.

The other way in which the ACA exercises federal power is quite different. It is not direct rulemaking. The ACA uses federal power to create a legal meta-structure in which *individuals* can plausibly “opt-in” to either federal (specifically ERISA) or state law governing their health bargains.²²⁶ In exercising federal power to create this choice-of-law structure, the federal government is explicitly *not* making substantive law.

In theoretical terms, a legal structure of “opt-in federalism” presents considerable appeal. Because of the way in which it melds individual, state, and federal roles, it seems more likely than any other to optimize benefit law. Put another way, it is most likely to maximize the chance that the nation collectively, and citizens individually, will have access to the most desirable body of law regarding the private provision of health insurance (and perhaps retirement income). The chief irony, perhaps, is that although the ACA forces people to make bargains,²²⁷ it bespeaks a legal structure that can accommodate more individual choice in governing law—as well as more effective say from the states—than was the case before the ACA.

A. *ACA and Opt-in Federalism*

One of the ACA’s many aims was to make health insurance available to all.²²⁸ It does so in part by using federal power to address problems in individual health insurance markets. Specifically, the ACA limits the permissible scope of underwriting, abolishes the preexisting condition exclusion, and imposes an individual mandate requiring all individuals to have health insurance or pay a penalty.²²⁹

²²⁶ See *infra* notes 228–252 and accompanying text. It bears emphasizing that this applies to only the parts of bargains that are not governed directly by ACA. See *infra* notes 228–252 and accompanying text.

²²⁷ One can conceive of an opt-in system without a federal mandate that individuals buy insurance; a mandate is one mechanism that opens up individual markets.

²²⁸ See 42 U.S.C.A. § 18091 (West Supp. 2011).

²²⁹ 42 U.S.C.A. § 300gg (West 2003 & Supp. 2011) (specifying rating factors); 42 U.S.C. § 300gg-1 (2006 & Supp. II 2008) (guaranteed availability); 42 U.S.C.A. § 300gg-2 (West 2003 & Supp. 2011) (effective Jan. 1, 2014) (guaranteed renewability); 42 U.S.C.A. § 300gg-3 (West 2003 & Supp. 2011) (effective Jan. 1, 2014, except effective immediately for enrollees under 19) (prohibition against preexisting condition exclusion); 26 U.S.C.A. § 5000A (West 2011) (mandate) (effective Jan. 1, 2014).

These three reforms are targeted at ameliorating the adverse selection problem that can destroy or severely hamper individual markets.²³⁰ From this perspective, the ACA is a hyper-form of the benefit as bargain model.²³¹ It aims to achieve universal coverage by using federal power to make bargains realistically possible for those outside the group market. Importantly, however, the ACA does not limit participation in the individual market it functionally creates to only those who do not have or cannot get health insurance through their employer.²³² Individuals who wish to obtain insurance *other* than group insurance offered by their employer may do so.²³³ The consequences of this bear examination.

Recall that there are effectively two markets for health insurance—the group market and the individual market.²³⁴ They were (and are) governed by different legal regimes. As I have emphasized, employment-based insurance dominates the group market.²³⁵ The legal rules governing employment-based health insurance are in the main federal rules, with state regulatory discretion limited under ERISA’s preemptive scope.²³⁶ Much of the relevant federal rules are judge-made and have attracted considerable criticism.²³⁷ In contrast, in the individual

²³⁰ If every person is required to obtain insurance, the peril of adverse selection is vastly diminished; there is little need for risk underwriting or preexisting condition exclusions. See *supra* notes 203–210 and accompanying text. Congress specifically found that the mandate “is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold.” 42 U.S.C.A. § 18091(a)(2)(I) (West Supp. 2011); cf. Amitabh Chandra, Jonathan Gruber & Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 NEW ENG. J. MEDICINE 293, 293–95 (2011) (explaining reduction in premiums in Massachusetts after instantiation of the mandate).

²³¹ See *supra* notes 47–75 and accompanying text (discussing benefits as bargains).

²³² See 42 U.S.C.A. § 18032(a)(1); see also Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care by Dumping Sick Employees?*, 97 VA. L. REV. 125, 154–55 (2011).

²³³ See 42 U.S.C.A. § 18032(a)(1).

²³⁴ See, e.g., Diamond, *supra* note 73, at 1237–38 (discussing the large and small group markets, and noting that the small group market is much like the individual market); see also Hyman & Hall, *supra* note 49, at 30–35 (discussing the comparative advantages of employer-based insurance, or group insurance, compared to individual employee insurance). This is a bit of an oversimplification, given the peculiarities of small-group markets. For my purposes, it does not matter.

²³⁵ See *supra* notes 91–222 and accompanying text.

²³⁶ See *supra* notes 91–222 and accompanying text. State regulation exists, of course. See, e.g., 29 U.S.C. § 1144(b)(2)(A) (2006) (allowing states to regulate insurance). But its application is limited by ERISA and the small nature of the individual market. See Gruber, *supra* note 5, at 573 (explaining that employer-based insurance dominates the private insurance market).

²³⁷ See *supra* notes 47–75 and accompanying text.

market, regulation in the main is state-based.²³⁸ Because of problems of adverse selection, however, as well as other obstacles, the individual market is not accessible to many people.²³⁹

Employment-based group insurance is largely governed by the federal law of ERISA.²⁴⁰ In contrast, individual ACA policies will be health insurance policies that are in significant part governed by state law.²⁴¹ The effect of the ACA can thus be summarized as follows: it enacts rules that provide a federal core for health insurance policies sold in the country;²⁴² it enacts rules that revitalize the moribund individual insurance market;²⁴³ and in determining the legal rules governing

²³⁸ See Amy B. Monahan, *Initial Thoughts on Essential Health Benefits*, in 1 NEW YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION, *supra* note 57, at 1B-1, 1B-2.

²³⁹ See Gruber, *supra* note 5, at 575 (observing that for less healthy people, it is almost impossible to obtain complete coverage); Hyman & Hall, *supra* note 49, at 32 (observing that adverse selection could destroy the insurance market altogether, when unalleviated by things such as employment-based insurance).

²⁴⁰ See Monahan, *supra* note 238, at 1B-3; see also *supra* notes 121–127.

²⁴¹ See *id.*

²⁴² The scope of ACA's "federal core" is not straightforward. Different core federal requirements govern individual policies as opposed to those that govern group policies. Compare 42 U.S.C.A. § 300gg-11 (West 2003 & Supp. 2011) (both group and individual policies may not impose lifetime or annual caps), with 42 U.S.C.A. § 18021(b)(1)(B) (West Supp. 2011) (providing that the minimum coverage requirements for "qualified health plans" do *not* cover "a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under [ERISA]"). An excellent initial analysis of the fluctuating nature of the applicable "core" federal coverage was done by Professors Monahan and Schwarcz. See Monahan & Schwarcz, *supra* note 232, at 146–51.

My task is entirely different. Certainly, determining the size of the "direct" rulemaking aspect of a federal statute—which in ACA I am calling the federal "core," or cores, to the extent the core varies across contexts—is necessary to assess the *degree* to which an opt-in federalist structure exists in a given statute. The idea of this Article is that foundational analysis needs to be done as to *why* opt-in federalism might be desirable at all, and to pose questions regarding what categories of rule or policies opt-in federalism might be appropriate for. The answer to that can be used to evaluate whether ACA has struck the right balance in its actual division of authority.

²⁴³ See *supra* note 230 and accompanying text. ACA also establishes "exchanges." See 42 U.S.C.A. §§ 18031–18033, 18041–18044 (West Supp. 2011). Exchanges "will provide a point of access for people to comparison shop among individual and small group health insurance offerings." Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform and Rural Economics*, 113 W. VA. L. REV. 1, 24 (2010). Millions of people are expected to use the exchanges. See, e.g., CONGRESSIONAL BUDGET OFFICE, *supra* note 19, at 23 tbl.4 (projecting 24 million people will obtain coverage through exchanges); RICHARD S. FOSTER, DEP'T OF HEALTH & HUMAN SERVS., ESTIMATED FINANCIAL EFFECTS OF THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT," AS AMENDED 4 (2010), available at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (estimating that 16 million individuals will be covered through exchanges). Insurance can be purchased outside of the exchanges. 42 U.S.C.A. § 18071 (West Supp. 2011).

health insurance (other than the federal core regulations), the ACA uses ERISA for group policies and state law for individual policies.²⁴⁴

This legal structure creates the possibility for opt-in federalism.²⁴⁵ Although all health insurance bargains now have a federal core component, the ACA's creation of an alternative individual health market reasonably accessible to individuals allows individuals to choose between striking bargains governed by the ACA and ERISA or, alternatively, by the ACA and state law.²⁴⁶

The most salient example is the law of remedy under the ACA. Individuals, in short, can opt-out of ERISA and its passel of constrictive

²⁴⁴ 42 U.S.C.A. § 300gg-23 (West 2003 & Supp. 2011) (preserving state authority to regulate insurance to the extent such does not "prevent" the application of an ACA requirement); 42 U.S.C.A. § 18041(d) (West Supp. 2011) ("Nothing in this chapter shall be construed to preempt any State law that does not prevent the application of the provisions of this chapter."). ACA provides no remedies, and thus the remedies available to a purchaser of individual insurance in the case of wrongfully denied coverage would be those of state law.

²⁴⁵ There are certainly practical obstacles to choice, in the form of lost employer contributions or different tax treatment, that are not trivial. See, e.g., Monahan & Schwarcz, *supra* note 242, at 155, 170–71. That is a fact of practical rather than theoretical importance. If opt-in federalism is conceptually appealing, then that justifies making policy changes to truly level the options. Additional legislation, for example, could require employers' contributions to be portable and/or level tax treatment regarding individual insurance purchases. Moreover, worker preferences may result in employers, in response to labor pressures, constructing benefit regimes that enable insurance choice through health reimbursement arrangements. See, e.g., *id.* at 160-61 (discussing means by which employers can enable choice but expressing concern over the consequences).

I note again a more general point: the aim of this Article is to consider whether "opt-in federalism" is an appealing theoretical mechanism to make and choose benefit law, not whether ACA does a particularly good job of instantiating an opt-in federalist approach. ACA admits of opt-in federalism, but may botch the specifics, and I do not pretend otherwise. Of course, specifics matter. What legal rules should come directly from the federal government in the form of "direct rulemaking" and what legal rules should be in the "opt-in space" is no small issue; whether ACA struck the right balance there is a matter unto itself. Ensuring that individuals have true options regarding whatever categories of legal rules are in the opt-in space is yet another issue that requires separate treatment. Moreover, permitting choice regarding some legal rules may present risk-classification problems (because of employer gaming or otherwise) or face cognitive hurdles. The answer to such thorny practical issues will depend on the content of the legal rules being chosen and will inform the means by which we might address the foregoing concerns.

²⁴⁶ The statute is neither a model of clarity in its particulars or simplicity in the interlocking nature of its scheme. It may be that different interpretations of portions of the statute, or of collective portions, threaten the reality of opt-in federalism in ACA. That is not my view, but it is not impossible; no one, for example, would have predicted how the Supreme Court construed ERISA. See *supra* notes 130–179 and accompanying text. Such does little to undermine my point, however: ACA admits the possibility of opt-in federalism, and it is that possibility we should keep in mind both when assessing (or even adjudging) ACA and imagining future reforms moving forward.

judge-made rules.²⁴⁷ A citizen living in State *X* who receives group insurance through his employer will be party to a bargain that is governed by the ACA in terms of its core requirements and by the federal law of ERISA for remedy.²⁴⁸ If that same citizen chooses to purchase a policy on the ACA individual market, that person will be subject to the ACA's core rules but state rules of remedy.²⁴⁹ The ACA permits individuals to opt for the source of legal rules—federal or state—governing bargains they strike. If they choose employment insurance, they are choosing federal rules.²⁵⁰ If they choose individual insurance, they are choosing state rules²⁵¹—hence the term “opt-in federalism.”²⁵²

B. *The Appeal of Opt-in Federalism*

Some legal rules directly govern everyday conduct, such as rules of negligence. Other legal rules do not directly regulate conduct, but instead regulate *who* has the power to make legal rules. A convenient if imperfect shorthand might be to label the former “rules of law” and the latter “rules of power.” Rules of power specify who can make rules of law.²⁵³

Rules of power can train themselves along different divisions of authority. Federalism, for example, is rule of power theory that seeks to desirably allocate power between national and local governments, i.e., a

²⁴⁷ See 42 U.S.C.A. § 18032(a) (West Supp. 2011).

²⁴⁸ See *id.* § 18032(a); 29 U.S.C. § 1132(a)(1)(B), (a)(2), (a)(3)(B) (2006).

²⁴⁹ See 42 U.S.C.A. § 18032(a).

²⁵⁰ See 29 § 1132(a)(1)(B), (a)(2), (a)(3)(B) (2006); *supra* note 244 and accompanying text. I have presumed here that in the case where an employer purchases a policy from a state “exchange” and offers it to employees, the remedies available to an employee are ERISA remedies, not state law remedies. See 29 U.S.C. § 1132(a)(1)(B), (a)(2), (a)(3)(B). See generally Monahan, *supra* note 238, at 1B-2 to -3 (discussing the triggered sources of law in different employment scenarios). Were that not the case, it would simply lessen the number of people with an option.

²⁵¹ See 42 U.S.C.A. § 18032(a); Monahan, *supra* note 238, at 1B-2.

²⁵² See *id.* Nor obviously is opt-in federalism, as a theoretical approach, limited to rules of remedy. It can apply to all types of legal rules—notice, procedure, duty, construction, presumption, and so on.

²⁵³ One immediately thinks of H.L.A. Hart’s distinction between “primary” obligation-imposing rules and “secondary” rules of power. See H.L.A. HART, *THE CONCEPT OF LAW* 77–96 (1961); see also NEIL MACCORMICK, H.L.A. HART 35 (1981) (discussing Hart’s “rules of obligation” and “power-conferring” rules). I use my informal “rule of law” and “rule of power” distinction not as a commentary on what law *is*, but merely as an argumentative device to help explain the work the opt-in federalism part of ACA does, namely, increasing the roles individuals and states play in making and choosing law.

power allocation between sovereigns.²⁵⁴ Separation of powers is a rule of power theory that seeks to allocate power among different departments within a government, i.e., power allocation within a sovereign.²⁵⁵

Rules of power need not be mutually exclusive.²⁵⁶ The functional sharing of lawmaking or enforcement authority between sovereigns or within sovereigns is obviously a form of power allocation.²⁵⁷ In modern arrangements, frequently power is shared, with the background formal rules of power specifying (with varying degrees of clarity) that one lawmaker must defer to the other when there is conflict in a specified area, but with cooperation sought and conflict avoided as much as pos-

²⁵⁴ This is true whether one conceives of the power of the inferior sovereign to be rooted in de jure or de facto autonomy. Cf. Heather K. Gerken, *Foreword: Federalism All the Way Down*, 124 HARV. L. REV. 4, 7 (2010) (discussing the conflict between courts and scholars). There is a nearly endless amount of literature describing, attacking, or defining what “federalism” does or should mean in modern times. Cf. DAVIS, *supra* note 5, at 216 (noting that “[i]f there are now ten ways of looking at the subject [of federalism], how many more will there be by the year 4000 A.D.?”). Of course “federalism” can conceivably cover, and historically has described, many very different arrangements. See, e.g., *id.* at 2 (“If we wish to come to terms with this political concept, we must come to terms with its history . . .”). See generally ALISON L. LACROIX, *THE IDEOLOGICAL ORIGINS OF AMERICAN FEDERALISM* (2010) (illustrating a recent and engaging treatment of the life and times of American federalism). In any event, I use “federalism” here in the broadest, most functional sense of the term: as a description of a system in which national and subnational governments each play some material policymaking role in a given field.

²⁵⁵ The famous *Erie* doctrine operates along both federalist and separation of power dimensions, attempting to chart out when federal procedural law displaces state law, and calibrating the answer based on whether the federal rules were instantiated by the federal legislature or the federal bench. See *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 78 (1938); Stephen B. Burbank & Tobias Barrington Wolff, *Redeeming the Missed Opportunities of Shady Grove*, 159 U. PA. L. REV. 17, 25–26 (2010) (noting that in the *Erie* context “the allocation of lawmaking power between the federal government and the States depends on the source of federal lawmaking power”).

²⁵⁶ A sensible categorization of federalist approaches, in descending order of federal power, can be thought of as “preemptive federalism,” “cooperative federalism,” and “dual federalism.” See Philip J. Weiser, *Federal Common Law, Cooperative Federalism, and the Enforcement of the Telecom Act*, 76 N.Y.U. L. REV. 1692, 1693 (2001) [hereinafter Weiser, *Federal Common Law*] (discussing variants of federalism). Preemptive federalism is what it sounds like. See *id.* Cooperative federalism envisions federal and state authority working in tandem to design optimal rules, as opposed to “dual federalism,” in which separate spheres of authority exist. See Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. REV. 663, 665, 671 (2001) [hereinafter Weiser, *Cooperative Federalism*] (discussing cooperative federalism); see also Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1, 1–2 (1950) (describing dual federalism and its diminished fortunes in the aftermath of the New Deal and World War II); Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and “Dual Sovereignty” Doesn’t*, 96 MICH. L. REV. 813, 815–17 (1998) (discussing cooperative and dual federalism).

²⁵⁷ See, e.g., Weiser, *Federal Common Law*, *supra* note 256, at 1693.

sible.²⁵⁸ Agency deference is a rule of power theory that seeks to cooperatively share power within a sovereign, i.e., between courts and agencies (although it can also happen *across* sovereigns).²⁵⁹

Opt-in federalism is an innovative and intriguing way to allocate power. The core intuition is that, with respect to important particulars of the health insurance bargain, federal and state sovereigns have parallel rulemaking power. Respective sovereigns' bodies of law are triggered to the extent that an individual opts-in to that body of law; choice and federalism are fused. The theoretical appeal of such an arrangement—as framed but certainly not perfectly embodied by the ACA—is manifold, as the following Sections examine below.²⁶⁰

1. Preferences

First, opt-in federalism increases the likelihood that individual preferences regarding rules of law will be realized.²⁶¹ To the extent an individual can freely choose from various policies available on the ACA individual market, rather than accept the ERISA insurance policy offered by his employer, the chances for preference maximization increase.²⁶² Unlike traditional federalism, where the individual must move between states to take advantage of different rules,²⁶³ opt-in fed-

²⁵⁸ See, e.g., Weiser, *Cooperative Federalism*, *supra* note 256, at 665.

²⁵⁹ Cf. Weiser, *Federal Common Law*, *supra* note 256, at 1768 (describing modern federalism as using “federal courts as advisors to and watchdogs over federal regulatory agencies, state agencies, and Congress, more than as direct lawmaking authorities”).

²⁶⁰ The following caveat bears considerable emphasis. For theoretical and expository clarity, I use an “idealized” ACA as a frame to present the idea, and potential appeal, of opt-in federalism. That is, I imagine ACA as setting up a legal structure where individuals can tax-neutrally, see *supra* note 78, obtain insurance through their employer or via the individual market; where certain aspects of the insurance promise are governed by ACA, whether obtained through the employer or via the individual market; and where other, significant aspects of the insurance bargain are governed either by ERISA or state law. See 42 U.S.C.A. § 18032(a) (1) (West Supp. 2011); Monahan, *supra* note 238, at 1B-2 to -3. That ACA is not a platonic form of opt-in federalism (particularly in terms of tax; it is not tax-neutral) is conceded but of minor theoretical concern. See *supra* note 245 and accompanying text. This Article, in short, is about opt-in federalism, not the extent to which ACA obstructs the innovative structure it contemplates.

²⁶¹ It also, obviously, allows insureds to comparison shop along other metrics, although such is limited by federal requirements. I focus on choice of law.

²⁶² Such is obviously not so to the extent state law exactly mirrors ERISA law. No state's law does.

²⁶³ See Charles M. Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416, 418–23 (1956) (evaluating the possibility of exiting a jurisdiction which has an undesirable rule and the consequences on rule evolution); see also PAUL E. PETERSON, *THE PRICE OF FEDERALISM* 18 (1995) (noting that local governments must be responsive to the needs of local businesses and residents, or residents will relocate); Robert P. Inman & Daniel L.

eralism permits a far less costly manner of expressing one's preference.²⁶⁴ Admittedly, the choice is only between the law of State X and ERISA,²⁶⁵ but the expression of such choice does not require relocation, which no doubt poses a considerable obstacle to choice.²⁶⁶

"Traditional" federalism, of course, theoretically gave any potential insured the horizontal "vote with the feet" choice between the law of State X and State Y.²⁶⁷ But the ACA in principle increases the traditional federalist option because it creates in every state an individual market that is by law open to any of that state's residents.²⁶⁸ In the past, individual underwriting and pre-existing exclusions effectively destroyed the possibility of horizontal choice among certain insureds.²⁶⁹ Some people, even if they had moved to a particular state, simply could not bargain

Rubinfeld, *The Political Economy of Federalism*, in PERSPECTIVES ON PUBLIC CHOICE: A HANDBOOK 73, 83–85 (Dennis C. Mueller ed., 1997) (discussing, in economic terms, that overall market and social efficiency in a federalist model relies on the ability of citizens to relocate without cost); Wallace E. Oates, *On Local Finance and the Tiebout Model*, 71 AM. ECON. REV. 93, 95–97 (1981) (discussing the work of Charles Tiebout).

²⁶⁴ Cf. Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 919–20 (1994) (favoring options within "a national, decentralized program"). In that same article, Professors Rubin and Feeley attempted to distinguish the virtues of "federalism" from mere "decentralization." See generally *id.* To oversimplify, their argument was that "federalism" is undesirable to the extent it means anything more than "decentralization," an organizational concept that they argued was, on balance, attractive. See *id.* at 908–09. Their argument has been criticized in various ways. See, e.g., Vicki C. Jackson, *Federalism and the Uses and Limits of Law: Printz and Principle?*, 111 HARV. L. REV. 2180, 2183 (1998) (offering multiple criticisms). Although this distinction may be quite important elsewhere—particularly regarding the appropriate judicial posture towards "federalism"—I think for my purposes, labels matter less than does a functional assessment of the legal choice structure ACA arguably creates.

²⁶⁵ Because the individual states regulate insurance, consumers cannot purchase insurance "across state lines" to avail themselves of the rules of another state. See Walter W. Heiser, *Due Process Limitations on Pre-Answer Security Requirements for Nonresident Unlicensed Issuers*, 88 NEB. L. REV. 494, 496 (2010) ("Each state has the power to regulate insurance companies who conduct business within the state's boundaries.").

²⁶⁶ See, e.g., James M. Buchanan & Charles J. Goetz, *Efficiency Limits of Fiscal Mobility: An Assessment of the Tiebout Model*, 1 J. PUB. ECON. 25, 26–39 (1972) (examining cost and likelihood of movement); Brian Galle & Joseph Leahy, *Laboratories of Democracy? Policy Innovation in Decentralized Governments*, 58 EMORY L.J. 1333, 1366 (2009) (questioning whether, in a federalism analysis, the costs of relocation are worth the purported efficiency gains); Brian D. Galle, *The Role of Charity in a Federal System* 49–69 (FSU College of Law, Public Law Research Paper No. 394, 2011), available at <http://ssrn.com/abstract=1473107> (discussing, in Part IV, how relocation costs are significant and can undermine notions of competitive federalism).

²⁶⁷ See *supra* note 264 and accompanying text.

²⁶⁸ See 42 U.S.C.A. § 18032(a)(1) (West Supp. 2011).

²⁶⁹ Cf. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154–61 (2010) (to be codified at 42 U.S.C. § 300gg-1 to -7) (promoting nondiscrimination in health care coverage).

their way into the markets in which that state's law (as opposed to ERISA) governed, and thus did not have true horizontal choice.²⁷⁰ The ACA improves horizontal as well as vertical choice, and in both ways increases the likelihood that individual preferences will be satisfied.²⁷¹

Moreover, those who remain subject to ERISA's constrictive rules—to the extent their state offers a different regime—have agreed to be governed by ERISA rules.²⁷² There is a marked difference between a world where there is no realistic choice other than to live under a federal regime where judges assumed policymaking roles outside their institutional competence²⁷³ and a world where one can, if one so *chooses*, opt-in to such a regime because the content of those judge-made rules are nonetheless appealing. ERISA supplies us the former;²⁷⁴ the ACA makes possible the latter.²⁷⁵

In the broadest terms, the refuge of an alternative is deeply satisfying. Although we all accept that we must be governed by law, we are continually troubled that the law might be “wrong,” in two senses. The first is that the law does not actually reflect the preference of the majority (or the command of some constitutional document that supersedes the majority will), but is instead the law of a legislature unduly influenced by special interests or made by rogue judges.²⁷⁶ The second is that the law very well might reflect the majority preference or some constitutional command, but it does not reflect our personal preference. In either case the solace of another sovereign is appealing, and being able to opt-in at little cost is more appealing still. It is vastly easier than attempting to change the original sovereign's rule (either by democratic or judicial means, or by insurrection) or to escape the rule by physically leaving the sovereign's dominion. The last two are quite difficult, and thus in reality people faced with undesirable rules simply accept them; we all intuitively know this, and thus all intuitively appreciate the power of an easily exercisable option.

²⁷⁰ See Gruber, *supra* note 5, at 574 (noting the difficulty of obtaining coverage in the nongroup market).

²⁷¹ See 42 U.S.C.A. § 18032(a)(1) (West Supp. 2011).

²⁷² See *id.*

²⁷³ See *supra* notes 130–179 and accompanying text.

²⁷⁴ See *supra* notes 130–179 and accompanying text.

²⁷⁵ See 42 U.S.C.A. § 18032(a)(1).

²⁷⁶ See, e.g., *supra* notes 180–189 and accompanying text (discussing criticisms of the U.S. Supreme Court's interpretations of ERISA for running counter to Congress's intent). *But see* note 245 (discussing hurdles to choice under the ACA).

2. States

The ACA restores to the states a significant measure of regulatory power that vanished during ERISA's reign.²⁷⁷ ERISA's preemptive power, by definition, emanates from the regulation of employee benefit plans.²⁷⁸ In practice, ERISA granted an outsized role to federal regulation of health insurance because the majority of private health insurance in the United States was delivered through employee benefit plans.²⁷⁹ The ACA sidesteps the issue by in effect setting up a plausible alternative system of insurance that exists outside of employee benefit plans.²⁸⁰ To be sure, while ACA insurance is subject to core federal requirements, important law governing the bargain is a matter of state law. Remedies are the clearest example.²⁸¹

Such power is wisely vested in state authorities, on the classic rationale that they are more aware of and responsive to local preferences of constituents.²⁸² In other words, they are more likely to discern the preferences of citizens than a national government that is literally and proverbially farther away.²⁸³ In addition, local rule is more accommodating to regional diversity of preference; some states' citizens may, as a body, simply prefer one set of legal rules over another.²⁸⁴ Both Californians and Texans are likely to prefer a regime where their state governments get to craft significant portions of law in a way consistent with

²⁷⁷ See 42 U.S.C.A. § 18032(a)(1); *supra* notes 130–222 and accompanying text.

²⁷⁸ See 29 U.S.C. § 1144(a) (2006).

²⁷⁹ See *id.*; *supra* notes 96–129 and accompanying text (discussing the predominant role of the federal government under ERISA).

²⁸⁰ See 42 U.S.C.A. § 18032(a)(1).

²⁸¹ See *supra* notes 228–252 and accompanying text.

²⁸² See, e.g., Gerken, *supra* note 254, at 7 (describing the asserted virtues of federalism as “choice, competition, experimentation, and the diffusion of power”); Stewart, *supra* note 181, at 917–18 (describing various rationales in favor of federalism). In American law “the basic assumption is that states have authority to regulate their own citizens and territory.” Cass R. Sunstein, *Interpreting Statutes in the Regulatory State*, 103 HARV. L. REV. 405, 469 (1989).

There are constitutional arguments in favor of federalism “even if one could prove that federalism secured no advantages to anyone.” *New York v. United States*, 505 U.S. 144, 157 (1992); see also John C. Yoo, *The Judicial Safeguards of Federalism*, 70 S. CAL. L. REV. 1311, 1357–91 (1997) (arguing that the Constitution envisions the judiciary policing the power allocations of federalism). It is not necessary to consider the merit of such constitutional arguments here.

²⁸³ See FELIX FRANKFURTER, MR. JUSTICE HOLMES AND THE SUPREME COURT 67 (1938) (“[F]ederalism is a response to size.”).

²⁸⁴ See Michael W. McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1484, 1493 (1987) (reviewing RAOUL BERGER, *FEDERALISM: THE FOUNDERS' DESIGN* (1987)) (noting the argument that local government better reflects local preferences).

local preferences, rather than being subject to a uniform federal regime that presumably represents a national preference.²⁸⁵ Moreover, the susceptibility of state authority to grassroots or local activism may increase the odds of civic participation and promote active democracy, which has value independent of whether participation leads to the actual adoption of a particular rule.²⁸⁶

State preferences are not set in stone. They can change or be uncertain. To the extent a state needs to “discover” its preferences—as perhaps something different than the traditional remedial and insurance law of the state, or as a confirmation of the wisdom of such tradition—the creation of a parallel health insurance market in which the states play a more significant role increases the likelihood that legal innovation and evolution will occur at the state level.²⁸⁷ A state has a greater incentive to confirm the preferences of its own citizens or serve as a “laboratory of benefits” if its regulatory decisions will not be reduced into nothingness by ERISA preemption or by the lack of an audience of people to regulate.²⁸⁸

The iterative appeal of federalism as an organizational system for producing “better” rules rests on the notion that states will see what has worked or not worked in other states and make their own adjustments

²⁸⁵ See, e.g., McConnell, *supra* note 284, at 1493 (“So long as preferences for government policies are unevenly distributed among the various localities, more people can be satisfied by decentralized decision making than by a single national authority.”).

²⁸⁶ See S. Candice Hoke, *Preemption Pathologies and Civic Republican Values*, 71 B.U. L. REV. 685, 712 (1991) (“[V]igorous republican federalism would repose substantial political authority in subnational governments because of their greater access to ordinary citizens and their participatory efforts.”); see also Jackson, *supra* note 264, at 2220–23 (describing the appeal of states as “loci” of political participation). Some have suggested this argument is no longer persuasive given the size of many states, or for other reasons. See, e.g., Rubin & Feeley, *supra* note 264, at 916 (questioning the assumption that federalism “fosters participation”); Robert A. Schapiro, *Justice Stevens’s Theory of Interactive Federalism*, 74 FORDHAM L. REV. 2133, 2140 (2006) (discussing that state size limits participation possibilities). Presumably the answer depends on the size of the state and the size of the issue. One imagines that health care is an issue on which people have a strong impulse to be heard—unlike, for example, the undoubtedly important but narrow in application question of prison reform—and that impulse is more easily satisfied (and considered by decision makers) when the relevant powers are reasonably close. See McConnell, *supra* note 284, at 1493.

²⁸⁷ See Gerken, *supra* note 254, at 7 (noting that federalism engenders experimentation). But see generally Galle & Leahy, *supra* note 266 (examining the difficulties with the theory that state governments will innovate).

²⁸⁸ State experimentation in health regulation has been proposed as attractive for some time. See, e.g., Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J. L. REFORM 899, 935–36 (1999) (suggesting the benefits of providing a federal ERISA waiver to states, and noting the desirable effect of granting Hawaii a waiver).

accordingly.²⁸⁹ In many cases there is a credible counter-argument that states pay little attention to what other states do on various local matters. That is unlikely to be the case in connection with rules governing health bargains. Such law affects everyone, and successful innovation could greatly advance the careers of responsible policymakers.²⁹⁰

In addition, restoration of the states' roles in selecting legal rules for health insurance promises reduces the impact of the policymaking role forced onto the federal judiciary by ERISA's failure to provide useful guidance on the appropriate tradeoff between security and cost.²⁹¹ Almost certainly, an allocation of rulemaking authority that relies less on judicial prerogative will be more likely to reach optimal legal rules for a given state. The larger the non-ERISA market for health insurance, the less the aggregate effect federal judge-made rules will have. States can, according to their views on how power within the state should be allocated, assign different levels of authority to a variety of decision makers, along multiple dimensions.

3. Clarity

Finally, opt-in federalism is an appealingly bright-line version of federalism. In many contexts, the line between federal and state authority is difficult to draw, and thus it is difficult for private actors to appropriately plan for where that line will be drawn.²⁹² Pure opt-in federalism is predictable. An individual decides at the bargain's inception

²⁸⁹ Justice Louis Brandeis offered the most famous formulation of this principle: "It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). As with all elements of federalism, the innovation rationale has been challenged. See Larry Kramer, *Understanding Federalism*, 47 VAND. L. REV. 1485, 1494–95 (1994) (explaining that there is literature on every side of every federalism issue). See generally Galle & Leahy, *supra* note 266 (examining difficulties with the theory that state governments will innovate); Susan Rose-Ackerman, *Risk Taking and Relection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593 (1980) (critiquing the idea that the state governments are innovative lawmakers).

²⁹⁰ Mitt Romney might be the exception that proves the rule. See James Hohmann, *Voters: 'Romneycare' Not Fatal*, POLITICO (Mar. 6, 2011, 3:23 PM), <http://www.politico.com/news/stories/0311/50741.html> (discussing the effect of Massachusetts health reform on Mitt Romney's presidential aspirations).

²⁹¹ See 42 U.S.C.A. § 18032(a)(1) (West Supp. 2011). Recall that ERISA's failure to provide useful guidance on the appropriate tradeoff between security and cost created this judicial policymaking role. See *supra* notes 117–119 and accompanying text.

²⁹² Cf. Robert A. Schapiro, *Toward a Theory of Interactive Federalism*, 91 IOWA L. REV. 243, 278–317 (2005) (describing the difficulties of drawing lines between state and federal authority).

whether the bargain (or specific parts thereof) will be governed by federal or state law and expresses that choice in a way readily discernable to outsiders. Judges need not wade into the murky waters of line drawing; the governing law is the chosen law.²⁹³ The parties on the other side of the bargain know in advance what law governs and can agree to strike the bargain under such terms or not.

C. *Objections to Opt-in Federalism*

One can imagine a series of objections to opt-in federalism. A useful way to group them is as concerns about (1) the content of the law created by opt-in federalism, (2) the undesirable systemic effects opt-in federalism could lead to, and (3) the utility of choice.²⁹⁴

1. Content of Law

A central objection to classic federalism is that if power is reposed in the states to make law, they might use that power poorly—for example, to create bad law. One variant of this argument is that the collective law of the states will overall be worse than federal law. The classic formulation of this argument is the “race to the bottom” argument.²⁹⁵ States, when “competing” to make law, may favor rules that are competitively advantageous but socially undesirable.²⁹⁶ Race to the bottom arguments assume both that the law will develop in a certain direction

²⁹³ *Id.*

²⁹⁴ I group them in this way for ease of consideration, not because alternative organizational schemes are necessarily flawed.

²⁹⁵ See, e.g., Richard B. Stewart, *Pyramids of Sacrifice? Problems of Federalism in Mandating State Implementation of National Environmental Policy*, 86 *YALE L.J.* 1196, 1212 (1977) (describing the race to the bottom argument in context of environmental standards).

²⁹⁶ Environmental standards are a classic example. See, e.g., *id.*

Given the mobility of industry and commerce, any individual state or community may rationally decline unilaterally to adopt high environmental standards that entail substantial costs for industry and obstacles to economic development for fear that the resulting environmental gains will be more than offset by movement of capital to other areas with lower standards.

Id. Businesses will use the threat of exit to deter a state’s instantiation of burdensome environmental regulation. See *id.* The race to the bottom argument can in theory be reason to justify federal over state regulation in any case where the regulation “imposes costs on mobile capital.” Richard L. Revesz, *Rehabilitating Interstate Competition: Rethinking the “Race-to-the-Bottom” Rationale for Federal Environmental Regulation*, 67 *N.Y.U. L. REV.* 1210, 1211 (1992). Dean Revesz has argued, however, that in the environmental context competition among states does not lead to an undesirable race to the bottom. *Id.* at 1211–12.

and that that direction will be unappealing.²⁹⁷ It is unlikely both will occur in an opt-in federalism system.

It is fairly clear that states (and presumably their populations) have different preferences for law.²⁹⁸ Those preferences reflect some value judgment about competing costs and benefits.²⁹⁹ An easy example is tort law. Expanded liability rules may have heightened the cost of doing business in a state, but by how much, and whether such is worth it to secure additional protection for those protected by the rule, is a matter on which individual states differ.³⁰⁰ One can construct theoretical arguments as to why states may uniformly prefer protective rules that favor citizens or lenient rules that favor business.³⁰¹ But the proof is in the pudding. Tort law varies considerably—many states have enacted tort reform, others have not—and so the argument that federalization is needed to prevent a race to the bottom is unpersuasive.³⁰² As for the law governing insurance bargains: it is unlikely that every state will adopt weakly protective rules to attract business or strongly protective rules to assure citizens. That is not how it works currently; insurance law varies

²⁹⁷ If the former is not true, then we are dealing with simple legal diversity; if the latter is not true, we have either a race to the middle or a race to the top. Consider corporate law. Professor Cary famously claimed forty years ago that state competition led to a race to the bottom so undesirable that it should “arrest the conscience of the American bar.” William L. Cary, *Federalism and Corporate Law: Reflections upon Delaware*, 83 YALE L.J. 663, 705 (1974). Other scholars have contended that competition has led to efficient law. See Bruce H. Kobayashi & Larry E. Ribstein, *Delaware for Small Fry: Jurisdictional Competition for Limited Liability Companies*, 2011 U. ILL. L. REV. 91, 95 n.14 (identifying prominent works advancing a race to the top view of corporate law).

²⁹⁸ Cf. Thomas A. Eaton & Susette M. Talarico, Symposium, *Testing Two Assumptions About Federalism and Tort Reform*, 14 YALE L. & POL’Y REV. 371, 372–73 (1996) (noting that local governments are more in tune to local needs, which differ).

²⁹⁹ See Maher & Stris, *supra* note 9, at 435 (noting competing values in determinations of legal rules).

³⁰⁰ See, e.g., Eaton & Talarico, *supra* note 298, at 373 (arguing that local government is more in tune to local needs).

³⁰¹ See, e.g., *id.* (describing but empirically rejecting the argument that tort law results in a race to the bottom that favors resident plaintiffs).

³⁰² There are *other* arguments in favor of federalizing tort law, but they arise from different concerns, namely externality concerns, see, for example, Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 861–88 (2009) (considering malpractice federalization as a solution to “snowball” externalities); uniformity concerns, i.e., whatever the standards are, they should be the same everywhere; or, lastly, a simple desire to substitute the judgment of plaintiff-friendly states with a national judgment that would make the country friendlier to industry, see, for example, Michael A. Coccia, *Uniform Product Liability Legislation: A Proposed Federal Solution*, 51 INS. COUNS. J. 104, 104 (1984).

from state to state.³⁰³ That the potential market for state law is bigger post-ACA does not appreciably adjust our expectations for diversity.³⁰⁴

Another concern over quality of the law generated by federalism mechanisms is slightly different. The worry is not that states overall will be poor lawmakers, but that *particular* states could select unjust or otherwise objectionable rules.³⁰⁵ That is, even if no race to the bottom occurs, one may worry that a handful of states will maliciously or irresponsibly pick rules that, for example, inappropriately protect the disadvantaged (or, conversely, unduly harm businesses). Jim Crow laws are the most potent historical example.³⁰⁶

The response is contextual. Certainly, worries that a particular state might poorly discharge its lawmaking responsibilities can be a very acute concern when dealing with rules that largely govern the fortunes of a marginalized group that lacks democratic voice within the state. Health insurance rules, on the other hand, are of direct interest to essentially everybody. And even if one concedes that some states may get it wrong, the downside of error is smaller than in a national system. For example, ERISA is widely criticized not only because many disagree with the implicit judgments made by the Court, but because there is little opportunity to escape the Court's rules.³⁰⁷ Opt-in federalism supplies most individuals with an out in either direction: federal or state.³⁰⁸

³⁰³ See, e.g., Donald T. Bogan, *ERISA: State Regulation of Insured Plans After Davila*, 38 J. MARSHALL L. REV. 693, 719–21 (2005) (describing differing state rules regarding bad faith). Obviously state insurance law differs in many ways. Insurance companies presumably price their premiums accordingly. An insurance company can make money in a high-liability state or a low-liability state. It depends on the premium. ACA permits pricing based on “rating area,” which should include a state’s legal rules. See 42 U.S.C.A. § 300gg (West 2003 & Supp. 2011).

³⁰⁴ See 42 U.S.C.A. § 18032(a)(1) (West Supp. 2011).

³⁰⁵ See, e.g., Lynn A. Baker, *Should Liberals Fear Federalism?*, 70 U. CIN. L. REV. 433, 445 (2002) (explaining that federalism has been attacked for historically permitting states to pursue racist policies).

³⁰⁶ Gerken, *supra* note 254, at 44 (“Pointing to federalism’s ugly role in preserving slavery and Jim Crow, . . . critics insist that states should not be allowed to depart from strongly held national norms.”).

³⁰⁷ See 29 U.S.C. § 1144(a) (2006).

³⁰⁸ See, e.g., 42 U.S.C.A. § 18032(a)(1). What if there is no daylight between federal and state law, i.e., if State *X* simply adopts wholesale as its rules federal rules? That is unlikely to happen, given the robust presence of insurance rulemaking apparatus in the states. But assume it does. That is no worse than having an exclusively federal system that gets it wrong. More likely there will be daylight between federal and state rules (and between states) and thus individuals will have more choice than they do today, whether through an opt-in mechanism or traditional means of exit.

2. Systemic Concerns

Systemic concerns emanate less from the fear that states will pick undesirable rules in and of themselves than that they will chose rules which threaten the efficient discharge of national policy or the proper functioning of a federal system.

Often these arguments are phrased in externality terms.³⁰⁹ An externality exists when a player does not fully internalize the cost (or benefit) of his conduct. The concern here would be that a state might externalize the cost of legal rules if the federal government is subsidizing the purchase of insurance. In other words, states might choose more costly rules because they know the rest of the country is going to help finance them.³¹⁰ The strength of this argument obviously depends upon the rule in question and its incremental cost. More importantly, it is difficult to see how the federal subsidy in the ACA's case (with respect to bargains, as opposed to entitlements) will result in a material adverse change in an individual state's lawmaking calculus.³¹¹ Only a minority of individuals will receive a subsidy.³¹² Most individuals in a state will not receive a federal subsidy and thus will not be indifferent to more costly rules. They will have no worse incentive than before to ensure elected officials make appropriate judgments regarding the best mix of legal rules.³¹³

Another systemic concern might be related to adverse selection.³¹⁴ Individuals will be able to opt-in to different legal rules, depending on

³⁰⁹ See, e.g., Moncrieff, *supra* note 302, at 861–88 (proposing malpractice federalization as a solution to “snowball” externalities).

³¹⁰ Cf. *id.* at 879–90 (noting that federal financing of entitlement programs whose cost is largely shaped by state action poses a theoretical case for federalization of medical malpractice reform).

³¹¹ See 26 U.S.C.A. § 36B (West 2010 & Supp. 2011) (effective Jan. 1, 2014), *amended by* Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Pub. L. No. 112-9, 125 Stat. 36; Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10, 125 Stat. 38.

³¹² See *id.* (specifying coverage subsidies).

³¹³ 42 U.S.C.A. § 18031(B)(i) (West Supp. 2011) provides that states may require “a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title” but that States must assume the cost of doing so. See *id.* § 18031(B)(ii) (“(ii). . . A State shall make payments—(I) to an individual enrolled in a qualified health plan offered in such State; or (II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled; to defray the cost of any additional benefits described in clause (i).”) The degree to which a state’s *legal rules* are held to be “additional benefits”—and thus need to be paid for directly by the state—will, of course, affect the state’s rulemaking calculus.

³¹⁴ See *supra* note 207 and accompanying text (explaining adverse selection).

their preferences. Because such choices will be made in connection with insurance promises, one might fear that insurance companies cannot accurately ascertain and price risk. This is possible but less likely than feared. While the analysis ultimately depends on the exact legal rules chosen, in general, adverse selection regarding insurance rules should be much less acute than adverse selection regarding health conditions.

With health conditions, the biggest fear is that individuals will not purchase insurance until they are actually sick (and the actually sick are the set of people who pose the largest payout risk to the insurance company). If that were the case—if insurance were only or mostly purchased by sick people—premiums would be astronomical, to protect against the expected payout of the self-selecting pool. Legal rules are different. Imagine a state insurance regime with more protective remedial rules than ERISA.³¹⁵ The highest risk players to insurers in that regime are those who have suffered an event which has or will immediately lead to litigation. Yet the litigation-causing event has *already* occurred and is thus governed by the (less protective) legal rule of the regime under which it occurred.³¹⁶ Certainly some degree of adverse selection is still possible, but the most worrisome instance will rarely happen. Residual concerns, to the extent they exist, can be addressed with measures such as enrollment periods.

I do not mean to dismiss adverse selection concerns; the aim is merely to point out that badgers can grow into bears in the telling. That is, while adverse selection is possible regarding any risk-sorting that insurance companies cannot appropriately price, assuming that permitting choice with regard to most legal rules (which, obviously, is a much larger set than rules of remedy) will have an adverse selection effect that requires as a solution that individual choice be eliminated seems a speculative overbid. Legal rules are a different matter than health conditions. Adverse selection concerns seem more potent regarding the latter than the former, and vary considerably depending on the specific legal rules at issue. And states, of course, can change the opt-in legal rules they conclude are leading to intolerable adverse selection.

³¹⁵ A more protective legal regime should, in theory, mean higher premiums. How much higher is a matter of considerable dispute, as is whether such incremental higher cost is worth it. Such a dispute should be left up to the states.

³¹⁶ I am assuming legal rules do not apply retroactively, and that the governing legal rule corresponds to when the claim arose, rather than when the claim was filed. There are nontrivial administrative difficulties in such a case, of course, that need be considered.

A final commonly made systemic argument against federalist approaches is one of administrative inefficiency.³¹⁷ A single regime is less costly for private players to comply with (and for taxpayers to fund).³¹⁸ The Supreme Court has frequently stressed this point when interpreting ERISA, by identifying the perils of disuniformity.³¹⁹ The argument was that a lack of uniformity regarding health insurance rules increases the likelihood that the nation's primary suppliers of health insurance—employers—will offer less generous (or no) health benefits to deal with the cost of complying with different state regulations.³²⁰ The objection carries comparatively little weight in an opt-in system. People choose between employer-provided insurance governed by federal standards and individual insurance sold by state insurers governed by state standards.³²¹ There is no multi-compliance burden for either the employer or the insurer to bear; they live in different regulatory worlds and need not worry about traveling in-between.³²²

3. Choice Difficulties

Much scholarship and literature over the past two decades has challenged long-held notions that choice is an unalloyed good.³²³ Choice might worsen outcomes if individuals are not particularly good at mak-

³¹⁷ See, e.g., Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2374 (2010) (discussing high compliance costs in federalist arrangements).

³¹⁸ See *id.*

³¹⁹ See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983) (explaining that obligating employers to differing state laws would increase administrative costs and effect a reduction of offered benefits); see also Monahan, *supra* note 127, at 1375–76 (describing primary burden of state regulation as forcing employers to comply with two regimes); Moncrieff, *supra* note 317, at 2374 (discussing high compliance costs in federalist arrangements). Opt-in federalism is, of course, more administratively expensive than the alternative of having a single national policy regarding every aspect of health insurance, but such savings are only appealing to the extent one is utterly unmoved by the merits of federalism.

³²⁰ See *Shaw*, 463 U.S. at 105; Monahan, *supra* note 127, at 1375–76.

³²¹ See, e.g., 42 U.S.C.A. § 18032(a)(1) (West Supp. 2011).

³²² Nor is there a reason to believe states will be administratively worse at promulgating and enforcing rules regarding health insurance bargains struck by in-state insurers than the federal government would be in regulating such insurers; states traditionally exercise authority in this area. This point should not be misconstrued. It is *not* that the state lawmaking and administration regarding insurance is a picture of efficiency. It is that there is no particular reason to think that as a result of ACA permitting people to opt into state law, that state lawmaking will be comparatively inefficient.

³²³ Cf. Ricciardi, *supra* note 40, at 85–111 (discussing cognitive biases that affect decision making).

ing choices.³²⁴ Information costs and a host of cognitive biases can diminish the appeal of relying on choice-driven mechanisms to order our individual and collective affairs.³²⁵ If in fact someone other than an individual “is likely to be the best decision-maker, or, better put, decision-framer,”³²⁶ there may be a significant loss of utility when individuals opt out of the employment benefit bargain world into state insurance regimes.

There are several responses. First, *some* individuals will make the right (or mostly right) choices. Opt-in regimes benefit them, and that positive should not be disregarded. Second, much choice criticism can be addressed through use of defaults, rather than abolition of choice.³²⁷ Nonetheless, I think the choice criticism has particular merit in the health insurance context because the most sensible default is probably a set of legal rules that are more, rather than less, protective. That is, as a policy matter, I would prefer if an opt-in system was set up in a way such that the default option is more protective of insureds, given their cognitive and bargaining limitations. ERISA, which is the default option under the ACA’s version of opt-in federalism, is on balance less protective of individuals than most state regulation. Nonetheless, indictments of default settings, in my view, should not obscure the appeal of opt-in federalism in general. They simply mean the defaults should be adjusted.³²⁸

Most importantly, we must consider the appeal of realistic alternatives. That choices are imperfect does not mean no-choice centralized rulemaking is better. ERISA is the perfect illustration. Virtually no credible observer applauds its health content, yet no politically viable discussion of comprehensive reform of the statute has ever taken place. Choice infirmities, on the other hand, can be addressed, either at the federal level or at the state level through educational or informational mechanisms designed with cognitive limitations in mind.³²⁹ Indeed,

³²⁴ See *id.*

³²⁵ See *id.*

³²⁶ McCaffery, *supra* note 216, at 7; see also *supra* note 40.

³²⁷ See Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1201 (2003) (suggesting the use of default rules that acknowledge information and cognitive limitations and encourage socially desirable choices). See generally THALER & SUNSTEIN, *supra* note 39 (same).

³²⁸ Cf. Monahan & Schwarcz, *supra* note 232, at 170–71 (considering the theoretical possibility that strategic behavior by employers could negatively affect choices). The solution to infirmities in the choice mechanism is to fix them, not abolish choice.

³²⁹ See Sunstein & Thaler, *supra* note 327, at 1201.

such is a ripe area for innovation, given the relative newness, but increasing awareness, of such concerns.

CONCLUSION

Age and sickness humble us all; such is the iron bargain of mortality. Whatever our philosophical comfort with life's inevitabilities, pragmatic questions remain: How should society allocate resources to address age and illness? And what law should govern those arrangements?

A society can rely on individual resources, private bargains, or the government to address citizens' retirement and health needs. The ACA is a landmark piece of health legislation that mandates people make insurance bargains. Both the wisdom of the bargain model and the constitutionality of the mandate have prompted intense discussion. In the heated debates over the ACA, however, little attention has been paid to the statute's crucial innovation of law: opt-in federalism. This Article has theorized that, as a means of choosing and making law, opt-in federalism promotes individual autonomy, encourages favorable evolution of rules, accommodates legal uncertainty, recognizes varying preferences, empowers states, and can quietly undo previous legislative mistakes.

Time will tell whether the charm of theory earns the approval of practice. Yet the charm of theory is broad, because opt-in federalism is not limited to the ACA, or even the health context. It offers promise as a means to address the nation's *other* enormous benefit challenge: retirement security. I close by introducing that intriguing possibility.

Retirement is complex, and entitled to a full treatment, but the essentials are this. The United States relies enormously on private arrangements to satisfy retirement needs.³³⁰ In the past, the dominant retirement vehicle was the "defined benefit" pension.³³¹ Today, the dominant vehicle is the "defined contribution" savings account.³³² The implications of the move away from defined benefit to defined contribution arrangements have been increasingly studied by scholars in law, economics, and psychology.³³³

³³⁰ Current estimates of assets held in ERISA retirement plans exceed six *trillion* dollars. COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE 87 (3d ed. 2010).

³³¹ See Zelinsky, *supra* note 36, at 453.

³³² See, e.g., *id.* at 469–71.

³³³ See *supra* note 33 and accompanying text; see also FRANK J. LANDY & JEFFREY M. CONTE, WORK IN THE 21ST CENTURY 504 (3d ed. 2010) (industrial psychologists describing "psychological" effects of defined contribution arrangements on workers). See generally

Because the vast majority of private retirement arrangements implicate some level of fiduciary obligation, no one disputes the enormous importance of optimizing fiduciary law. Currently, the development of fiduciary law in the retirement context is almost entirely federal. This has been much criticized, mostly by scholars or stakeholders who believe federal rulemakers have simply gotten the contours of the law “wrong.”³³⁴ The correct substantive alternative is not clear.

Opt-in federalism represents a potential way to harness the power of aggregative and diversified policymaking while offering a check against races to the bottom and excessive compliance costs. For example, one can imagine a defined contribution system where employers have a single duty: to have as the default choice an investment option that meets fairly conservative federal guidelines and is governed by a congressionally defined set of fiduciary duties. Other (or supplemental, if the federal investment is mandatory) choices for employees could be offered by non-employer investment firms and structured in such a way as to permit embrace of some combination of federal and state rules for fiduciary obligations. The rules for employers would be clear and uniform, but diversity in both investment options and law would be preserved. Obviously the specifics matter, and are complicated, but the notion of a protective federal core with state law options seems a more promising approach than either the status quo or traditional decentralized options.

The ACA may be unwise in its substantive particulars; it may even be unconstitutional. The battles on those fronts are furious. But the legislation suggests an exciting new species of federalism that combines the virtues of choice and decentralization. It would be a shame if that were lost in the crossfire.

ALICIA H. MUNNELL & ANNIKA SUNDÉN, COMING UP SHORT: THE CHALLENGE OF 401(K) PLANS (2004) (pension economists identifying policy challenges of 401(k) arrangements).

³³⁴ See generally, e.g., Fischel & Langbein, *supra* note 52 (criticizing ERISA fiduciary law). Recently, the Department of Labor released proposed regulations regarding fiduciary status in connection with providing investment advice. Definition of the Term “Fiduciary,” 75 Fed. Reg. 65,263–78 (proposed Oct. 22, 2010) (to be codified at 29 C.F.R. pt. 2510). Various stakeholders have expressed concern regarding the regulations. See, e.g., Letter from ERISA Indus. Comm. to Dep’t of Labor, Feb. 2, 2011, available at http://www.eric.org/forms/upload/Files/26E6B0000001D.filename.ERIC_Comments_on_Proposed_Definition_of_Fiduciary_020211.pdf (criticizing and commenting on proposed regulations).

