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Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA

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INTRODUCTION

Last Term, the United States Supreme Court upheld the constitutionality of the Affordable Care Act (ACA).¹ The Court's landmark decision is a forceful reminder that America's oldest question—how power should be shared between state and federal sovereigns—retains powerful political salience. The ACA has been hotly criticized as an affront to state power.² It is now settled that the ACA is constitutional.³ But that is the end of the beginning rather than the beginning of the end.⁴

Insufficient attention has been paid to how, in actuality, healthcare regulatory authority has been and will be divided between federal and state governments. In this Article, we begin to fill that gap. To do so, we apply “federalism-in-fact,” a theory that seeks to measure the real world, as opposed to theoretical, apportionment of power between sovereigns. We examine the ACA's regulation of private health insurance and demonstrate that, while the ACA usurps state authority in some ways, it enhances it in others.⁵ Specifically, when viewed in proper contrast to the previous regulatory regime—dominated by the Employee Retirement Income Security Act of 1974 (ERISA),⁶ which federalized the vast majority of private health insurance—the ACA gives states considerable freedom to enact laws governing health insurance. Moreover, whereas the pre-ACA population of persons whose in-

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1. Nat'l Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012). The decision addressed two pieces of legislation: the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). We refer to both as the “ACA.”
 2. For example, Professors Jonathan Turley of George Washington University Law School and Richard Peltz-Steele of the University of Massachusetts School of Law describe the Court's decision respectively as “killing” and “dismantling” federalism. Richard Peltz-Steele, Op-Ed., *Dismantling Federalism Is a Shortcut with a Very Steep Price*, FORBES, July 8, 2012, <http://www.forbes.com/sites/realspin/2012/07/08/dismantling-federalism-is-a-shortcut-with-a-very-steep-price/>; Jonathan Turley, *Court's Top Conservative Kills Federalism*, USA TODAY, June 28, 2012, <http://www.usatoday.com/news/opinion/forum/story/2012-06-29/supreme-court-roberts-federalism/55901408/1>.
 3. We do not invoke, propose, criticize, or rely on any constitutional analysis of the ACA. Our thesis assumes that the Court rightly upheld, as a constitutional matter, the ACA's regulation of private health insurance. We focus entirely on how this constitutionally permissible regulatory authority has been—and will be—deployed.
 4. See Winston S. Churchill, Prime Minister of the U.K., *The End of the Beginning*, Address at The Lord Mayor's Day Luncheon at the Mansion House (Nov. 9, 1942), in WINSTON S. CHURCHILL, *THE END OF THE BEGINNING* 264 (1943).
 5. Noncharitable health care can be provided through a variety of means, see *infra* text accompanying notes 20-27, but this Article focuses only on the ACA's regulation of private health insurance, see *infra* text accompanying note 28.
 6. Pub. L. No. 93-406, 88 Stat. 829.

dividual health insurance was regulated by state law was modest,⁷ the ACA will cause that population to increase by tens of millions.⁸ In other words, the state's "regulatory market"—and its sphere of influence—will be considerably larger in a post-ACA world. As a result, the dominant narrative of the ACA as a federal takeover of health insurance should be replaced with a more nuanced—and accurate—account.

In Part I, we describe the conceptual tools that frame our analysis of the ACA. First, we describe and defend federalism-in-fact as a scholarly tool. As a general matter, federalism-in-fact analysis measures the actual power deployed by identifiable regulatory authorities. As scholars in disparate legal fields are beginning to realize, such analysis is crucial to any meaningful understanding of what federalism actually *is*, beyond ink on a page.⁹ Second, because all private health insurance entails a bargained-for exchange,¹⁰ we suggest that all laws regulating private health insurance can be divided into two categories: (1) sickness rules, which are laws that govern the content of the core insurance promise, and (2) non-sickness rules, which are laws that govern everything else relevant to the contractual relationship, including laws governing enforcement of the promise.¹¹

To fully evaluate the ACA's effect on the actual division of power between the federal and state governments, it is necessary to consider how the authority to regulate private health insurance was allocated before the ACA was enacted. Part II therefore discusses the most important pre-ACA statute governing private health insurance: ERISA. Under ERISA, states are nearly powerless to enact non-sickness

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7. The overwhelming majority of people with private health insurance are covered by employer-sponsored insurance, rather than by individual (nongroup) policies. *See infra* note 24. Employer-sponsored insurance is governed by ERISA and only minimally by state law. *See infra* Part II.
 8. *See infra* note 98 and accompanying text (explaining that approximately twenty-two to twenty-three million people will receive insurance through health care exchanges by the year 2022); *infra* note 101 and accompanying text.
 9. *See, e.g.,* Rick Hills, *Tough Bargaining by States: Why Not Just Federalize Spending for the Poor?*, PRAWFSBLAWG (July 28, 2012, 9:41 AM), <http://prawfsblawg.blogs.com/prawfsblawg/2012/07/tough-bargaining-by-states.html> (“[T]he heavy lifting about how federalism actually works is done by tax guys . . . administrative law profs . . . and health-and-employment law scholars . . . [while . . . c]onstitutional lawyers . . . seem to be the least interested in the reality of federalism . . .”).
 10. Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733, 1746-49 (2011) (explaining how insurance is a bargain between insured and insurer). In contrast, health insurance received through Medicare and Medicaid entails a public entitlement promise made by the government for political reasons, rather than because there is anything resembling the consideration that is present in a bargained-for promise of insurance between two actors motivated by economic self-interest. *Id.* at 1749-51.
 11. Brendan S. Maher & Radha A. Pathak, *Health Insurance and Federalism-in-Fact*, 28 A.B.A. J. LAB. & EMP. L. 73, 73-76 (2012) (explaining our proposed metric of sickness and non-sickness rules to evaluate the ACA's effect on state regulatory power over private health insurance).

rules, and their ability to enact sickness rules is not particularly meaningful. Despite their historic role in the regulation of insurance, states in a pre-ACA world had little *real* power to regulate private health insurance.

Part III explains that states have a surprising amount of regulatory freedom under the ACA. The first reason is simple: there are *many* ways in which sovereigns can and do regulate private health insurance bargains. In attempting to assess the degree to which the ACA alters the federal/state balance of power, one need consider both its infringements on and enhancements of state authority to do so. Certainly, the legislation favors federal regulators in some respects. But it favors state regulators in others—namely, it appears to allow states almost unfettered ability to enact non-sickness rules and a more limited, but not trivial, ability to enact sickness rules.¹² The second reason is comparative: the ACA did not arise from a blank federal slate. The pre-ACA regulatory health insurance landscape—dominated by ERISA—imposed extraordinary constraints on state regulatory power. The ACA provides states with the welcome discretion to unshackle themselves from those constraints because it will increase significantly the population of individuals who have health insurance policies that states have considerable freedom to regulate. Millions of Americans who previously lacked health insurance will now be able to purchase a policy, and these individuals will populate the states' regulatory markets.¹³ States can grow the markets further by encouraging migration from the ERISA-governed regime. They can accomplish this in part by appealing to employer desire to reduce their role in the health insurance business. Commentators have almost totally ignored this potential expansion of state influence.¹⁴

12. The former question—the degree to which the ACA infringes upon state prerogative—has received considerable attention, in both constitutional and nonconstitutional terms. For nonconstitutional analyses, see, for example, Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534 (2011) (arguing that the implementation of the ACA requires several distinct theories of federalism operating simultaneously); and Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 113 (2011) (arguing that state resistance against implementing the ACA will have a positive effect on federal and state relations as well as decisionmaking regarding healthcare in general). For constitutional analyses, see, for example, Randy E. Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate Is Unconstitutional*, 5 N.Y.U. J. L. & LIBERTY 581 (2010); Brian Galle, *The Taxing Power, the Affordable Care Act, and the Limits of Constitutional Compromise*, 120 YALE L.J. ONLINE 407 (2011); Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825 (2011); Andrew Koppelman, *Bad News for Mail Robbers: The Obvious Constitutionality of Health Care Reform*, 121 YALE L.J. ONLINE 1 (2011); Abigail R. Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209 (2011); and David B. Rivkin, Jr., Lee A. Casey & Jack M. Balkin, *Debate, A Health Debate: The Constitutionality of an Individual Mandate*, 158 U. PA. L. REV. PENNUMBRA 93 (2009), <http://www.pennumbra.com/debates/debate.php>.
13. See *infra* note 98 and accompanying text (explaining that approximately twenty-two to twenty-three million people will receive insurance through healthcare exchanges by 2022); *infra* note 101 and accompanying text.
14. Professors Monahan and Schwarcz have insightfully identified and explained the possibility that employers might “dump” some employees onto the exchanges,

We conclude by proposing some implications of our analysis. If the dominant narrative of the ACA as a federal takeover of health insurance remains in place, it may well influence future decisions about the shape of the statute, potentially creating a self-fulfilling prophecy of state powerlessness. If, on the other hand, the ACA is viewed as a statute that accommodates state regulation of health insurance, future interpretations of the statute—for example, in litigation concerning the scope of the statute’s preemptive reach—may continue to create room for states to exercise their authority. A more provocative thought about the future of employment-based health insurance follows: might the ACA, or a modestly reformed variant, allow states to replace employment-based health insurance with something better?

I. CONCEPTUAL TOOLS

A. *Federalism-in-Fact*

Federalism, if not an American invention, is certainly an American obsession. The American polity’s commitment to the division of power between federal and state sovereigns is, as few forget, enshrined in the United States Constitution.¹⁵ But American federalism is more than constitutional. It is politico-cultural, and thus animates disputes about policy choices even when there is no question that an exercise of federal power is constitutionally permissible. It is therefore of critical importance to ask about the degree to which any significant regulatory territory is or will be *actually* populated by federal actors, state actors, or both. When we use the term “federalism-in-fact,” we are referring to the degree of real world power-sharing between federal and state regulators.¹⁶

but their focus was not the regulatory effect of such migration. See Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 133-53 (2011).

15. See U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”). The Tenth Amendment makes explicit the principle of federalism contained in the original document. See *United States v. Sprague*, 282 U.S. 716, 733-34 (1931) (“The Tenth Amendment was intended to confirm the understanding of the people at the time the Constitution was adopted . . .”).
16. We use the terms “functional federalism” and “federalism-in-fact” interchangeably throughout the Article. Both terms have received only modest explicit treatment in the legal literature. The tidiest definition, and one with which we do not disagree, was offered over fifty years ago by Arthur Miller. See Arthur S. Miller, *The Constitutional Law of the “Security State,”* 10 STAN. L. REV. 620, 634 (1958) (using functional federalism as a term to describe analyses aimed at identifying “the wielder of effective control in fact over large parts of the American power system”). Some scholars use the term “functional federalism” as a shorthand to refer to the policy reasons as to *why*, in organizational terms, power should be allocated to states rather than the federal government, or vice versa. See, e.g., Scott L. Greer & Peter D. Jacobson, *Health Care Reform and Federalism*, 35 J. HEALTH POL. POL’Y & L. 203 (2010) (using functional federalism as a means to evaluate which areas are better suited to state rather than federal authority); Michael E. Solimine, *State Amici, Collective Action, and the Development of Federalism Doctrine*, 46 GA. L. REV. 355, 389 (2012) (referring to functional federalism as a means to assess wheth-

This approach significantly expands the utility of federalism scholarship that is devoted to cataloguing different types of federalist power sharing and theorizing about the possible results of particular allocations.¹⁷ Such federalism scholarship recognizes that, when attempting to set up a power system that shares authority between national and subnational governments, there are many ways in which power can be allocated. These observations are not merely academic: different theoretical species of federalism are commonly held to presage different real-world results. Federalism-in-fact analysis allows this hypothesis to be tested because it explores the results of any particular power arrangement that has been or might be adopted and thus allows observers and decisionmakers to evaluate the degree to which a certain species of federalism drove, undermined, or was irrelevant to outcomes. Such analysis makes the ultimate federalism inquiry more transparent, both positively and normatively.

er a particular power allocation is efficient or inefficient). We do not use “functional federalism” and “federalism-in-fact” in that way. The aim of this Article is to examine, from a federalism perspective, the contours of health care regulation before and after the ACA. To be clear, we do not assess the merits of different regulatory approaches. For thoughts on that subject, see Maher, *supra* note 10, which examines the theoretical appeal of “opt-in” federalism in the healthcare context.

17. In 1933, Professor Edward S. Corwin coined the term “dual federalism” to describe a power allocation in which separate spheres of federal and state regulatory authority coexisted. See Barry Friedman & Daniel T. Deacon, *A Course Unbroken: The Constitutional Legitimacy of the Dormant Commerce Clause*, 97 VA. L. REV. 1877, 1919, 1938 (2011) (discussing Corwin’s coinage of the term, but noting that the idea of dual federalism was much older). In 1950, Corwin claimed that “dual federalism” was dead. Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1, 2-4 (1950). Beyond agreeing or disagreeing with Professor Corwin, postwar scholars spent considerable effort attempting to categorize different theoretical types of federalism, of which “cooperative federalism” was and remains a particularly prominent conceptual category. See, e.g., DANIEL J. ELAZAR, *AMERICAN FEDERALISM: A VIEW FROM THE STATES* 84 (2d ed. 1972) (cooperative federalism); MORTON GRODZINS, *THE AMERICAN SYSTEM: A NEW VIEW OF GOVERNMENT IN THE UNITED STATES* 75-80 (1966) (cooperative federalism and the contemporary regulatory system); 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 (1998); Susan Rose-Ackerman, *Cooperative Federalism and Cooptation*, 92 YALE L.J. 1344 (1983) (cooperative federalism); Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. REV. 663 (2001). Cooperative federalism itself has many species, but the general idea is that federal and state interaction, cooperation, and dialogue promote superior outcomes, both generally and specifically. See, e.g., Kirsten H. Engel, *Harnessing the Benefits of Dynamic Federalism in Environmental Law*, 56 EMORY L.J. 159, 160 (2006) (rejecting “static” allocations of authority between state and federal levels of government in favor of “dynamic” allocations); Hari M. Osofsky, *Diagonal Federalism and Climate Change: Implications for the Obama Administration*, 62 ALA. L. REV. 237, 241 (2011) (suggesting a multidimensional approach to federalism that considers scale, axis, hierarchy, and “bottom-up” assessments); Robert A. Schapiro, *Toward a Theory of Interactive Federalism*, 91 IOWA L. REV. 243 (2005) (discussing the theory and appeal of “polyphonic federalism”).

Federalism-in-fact analysis is more than a helpful lens for scholars. It is also a tool to evaluate and inform political actors. Since the New Deal, the federal government has had vast power to regulate,¹⁸ but it leaves considerable regulatory territory to states. Indeed, when national legislators consider action, they often mention and assess the wisdom of sharing power with states, even where Congress could unquestionably have awarded itself exclusive regulatory dominion.¹⁹ Congressional restraint and solicitude for state prerogatives are motivated by several important, and sincere, beliefs. Some of these beliefs are socially ingrained—for example, the American citizenry has some preference for subnational discretion. Others may be described as organizational or structural motivations—for example, power decentralization can accommodate heterogeneous preferences and result in superior rulemaking.

Federalism-in-fact analysis reveals how power is exercised, regardless of how it formally appears to be exercised or how it is described by legislators. If legislators claim that states have power but in actuality they do not, then the subconstitutional intuitions described above will be offended. Federalism-in-fact analysis may help curtail opportunistic invocations of federalism. And for honest brokers of federalism—whether voters, agency officials, judges, or elected representatives—federalism-in-fact analysis will likely influence their participation in disputes alleged to have federalism implications.

The rub is that a federalism-in-fact inquiry is rarely easy. It requires a firm understanding of the formal content of relevant legislation as well as a keen appreciation of the ways in which those affected have reacted or will react. A deductive (and perhaps seductive) application of first principles is rarely, if ever, sufficient. Instead, it is necessary to scrutinize the specifics of the regulatory regime that is being analyzed, in order to see whether and how the regime inhibits the real exercise of state power.

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18. See, e.g., Stephen Gardbaum, *Rethinking Constitutional Federalism*, 74 TEX. L. REV. 795, 807 (1996) (“[T]he New Deal Court [radically expanded] the scope of federal power over commerce.”); Jordan Goldberg, *The Commerce Clause and Federal Abortion Law: Why Progressives Might Be Tempted To Embrace Federalism*, 75 FORDHAM L. REV. 301, 310 (2006) (describing how, after the New Deal, “Congress’s power under the Commerce Clause [increased] until it appeared to be plenary”); Larry Kramer, *Understanding Federalism*, 47 VAND. L. REV. 1485, 1497-98 (1994) (describing, in the wake of the New Deal, the federal government’s nearly limitless potential power to regulate private activity).
 19. See, e.g., Fernando R. Laguarda, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, 187 (1993) (describing senatorial arguments to grant Oregon an administrative ERISA waiver to allow the state to legislate in the area of healthcare); Nina A. Mendelson, *The California Greenhouse Gas Waiver Decision and Agency Interpretation: A Response to Professors Galle and Seidenfeld*, 57 DUKE L.J. 2157, 2168 (2008) (noting that Congress considered “abstract federalism issues,” such as the value of states as “laboratories of democracy” and whether “the EPA [was] stopping states from leading the nation on difficult policy questions,” in analyzing the EPA’s denial of a preemption waiver under the Clean Air Act (internal citations omitted)).

B. *Sickness and Non-Sickness Rules*

Noncharitable healthcare in the United States is funded through one of several legal regimes. For veterans, the government directly provides health care.²⁰ For those over the age of sixty-five or below a certain income level, the government pays for health care pursuant to Medicare and Medicaid.²¹ For those employed with insurance through their jobs, a private insurer pays for care pursuant to ERISA and the ACA.²² For those who have individual private insurance, an insurer pays for care subject to the ACA and state law.²³

Most Americans are covered by the “Medi-” and the employer-sponsored insurance regimes.²⁴ These are, obviously, two very different models for providing

20. See 38 U.S.C. § 1710 (2012).

21. See The Social Security Amendments of 1965, Pub. L. No. 89-97, tit. I, 79 Stat. 286, 290, 343 (codified in scattered sections of 42 U.S.C.).

22. See Maher, *supra* note 10, at 1774-77 (describing the interaction of ERISA, the ACA, and state law); Amy B. Monahan, *Initial Thoughts on Essential Health Benefits*, 2010 N.Y.U. REV. EMP. BENEFITS & EXECUTIVE COMPENSATION 1B (same).

23. Monahan, *supra* note 22.

24. According to Healthcare.gov, “[t]he 133 million Americans with employer-sponsored health insurance through large employers (100 or more workers) . . . make up the vast majority of those with private health insurance today[,]” 43 million people are insured through small businesses, and 17 million people carry individual health insurance policies. U.S. Dep’t of Health & Human Servs., *Keeping the Health Plan You Have: The Affordable Care Act and “Grandfathered” Health Plans*, HEALTHCARE.GOV (June 14, 2010), <http://www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html>. The Kaiser Family Foundation cites similar numbers: “Individual, or non-group, health insurance covers about 14 million nonelderly people in America, making it the least common source of health insurance. In contrast, about 157 million nonelderly people are covered by employer-sponsored insurance.” *Survey of People Who Purchase Their Own Insurance*, HENRY J. KAISER FAMILY FOUND. (June 2010), <http://www.kff.org/kaiserpolls/upload/8077-r.pdf>; see also CONG. BUDGET OFFICE, CBO AND JCT’S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE, at tbl.2 (2012), <http://www.cbo.gov/publication/43082> (indicating over one hundred and fifty million people were covered through employer-based insurance and over thirty million by Medicaid in 2012); *Medicare Spending and Financing*, HENRY J. KAISER FAMILY FOUND. 1 (2012), <http://www.kff.org/medicare/upload/7305-07.pdf> (approximately fifty million people on Medicare); David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14 CONN. INS. L. J. 307, 308 (2008) (“Approximately 61 percent of the non-elderly population . . . receives health coverage through an employer. 5 percent purchase individual coverage. 16 percent receives government-sponsored coverage, and 18 percent are uninsured.”); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 26 (2001) (discussing the large number of Americans receiving insurance through employment or government).

and financing health care. The “Medi-” models can best be conceived of as public entitlement promises that the sovereign *qua* sovereign makes for political reasons, rather than because there is anything resembling the consideration that would be present in a bargained-for promise of insurance between two actors motivated by economic self-interest.²⁵ In contrast, the employer-sponsored insurance regime involves voluntary promises undertaken by actors motivated by economic self-interest.²⁶ Individual insurance similarly involves a bargained-for exchange.²⁷

We focus our attention on the private insurance regimes that govern health insurance for the employed and those in the individual market.²⁸ To evaluate such regimes, which are essentially contract-governing regimes, we recently suggested that it would be helpful to divide all regulation of private health insurance into two categories: rules that regulate sickness and rules that do not.²⁹ The intuition that inspired our categorization is straightforward. Facially, the most salient feature of health insurance is coverage: what conditions and what treatment are paid for by the policy when the policyholder is injured or becomes ill. Coverage, after all, is

25. See Maher, *supra* note 10, at 1749-51.

26. *Id.* at 1746-49 (explaining how insurance is a bargain between the insured and the insurer).

27. *Id.*

28. We do so, in part, because a scholarly focus on such private insurance regimes appropriately locates and acknowledges an important American political belief—one that is not shared in most other industrialized countries. Americans, wisely or not, have long been hesitant to hand over the entirety of healthcare financing to government. *Cf.* Teresa Ghilarducci & Christian E. Weller, *Issues Still Facing Employer-Based Pensions*, in *EMPLOYEE PENSIONS: POLICIES, PROBLEMS, & POSSIBILITIES* 1, 1 (2007) (“The U.S. stands apart from developed market economies in relying heavily on individual employers to achieve the common goal of securing retirement income for American workers.”). Medicare is today a way of life, but, prior to its enactment in 1965, it faced intense opposition motivated by concerns that Medicare would “socialize” medicine. Clearly, suspicion of government primacy in health care financing was overcome with respect to Medicare (and Medicaid, although that constituency has little or no effective political voice). Nonetheless, a significant percentage of the American polity remains uncomfortable with a Medicare-for-all healthcare solution. *See, e.g.*, Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 754-55 (2011) (arguing that despite claims that the ACA will allow for “grandfathered” healthcare plans to remain intact, these plans will in fact face significant changes, and further that the ACA is an example of “regulatory paternalism” which the polity would do well to reject). In other words, Americans appear to prefer that health care is funded by a private contractual arrangement, for example, through private health insurance. Congressional action reflects this preference. In the last fifty years, two pieces of federal legislation have spoken forcefully on the matter of health insurance: ERISA and the ACA. Both rely on private bargain models to pay for health care.

29. Maher & Pathak, *supra* note 11, at 73-76 (defining sickness and non-sickness rules and describing how states necessarily use those rules differently to effectuate policy preferences).

what motivates people to obtain health insurance. Regulations that govern this subject we dubbed “sickness rules.”³⁰ Conversely, we labeled as “non-sickness” rules those regulations that govern matters other than the conditions and treatments the policy covers.³¹

Unsurprisingly, the public attaches great importance to regulation of sickness rules. But non-sickness rules are more important than people realize. Insurance is a complicated bargain. It is not amenable to precise *ex ante* specification. Instead, insurance requires the use of terms of art, such as “medical necessity,” which require *ex post* interpretation to determine actual coverage.³² Questions of health insurance contract interpretation, in turn, depend heavily on rules of construction, proof, and presumption, and the linchpin of whether a promise is ultimately enforceable may be rules of remedy.³³

Accordingly, we may assess any federal statute’s distribution of the authority to regulate health insurance bargains by inquiring whether states have meaningful authority to regulate either sickness or non-sickness rules. Parts II and III of this Article will answer those questions for ERISA and the ACA, respectively.

II. PRE-ACA REGULATORY TERRAIN

Prior to the enactment of the ACA, ERISA was the dominant federal legislation regarding private health insurance. Most private health insurance is employer-sponsored insurance; *far* fewer Americans are covered by nongroup plans.³⁴ ERISA was not primarily intended to govern health insurance, but rather to regulate employee benefits, namely pensions.³⁵ Nonetheless, ERISA’s effect on employer-sponsored health insurance was—and is—tremendous.³⁶

Health insurance—and other employee benefits—are not gratuities; they are nonwage compensation established, in theory, by negotiation between labor and

30. *Id.* at 74.

31. *Id.*

32. See, e.g., William M. Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 599 (2003) (“explor[ing] the concept of medical necessity as it has evolved in the judicial and administrative oversight of managed care”).

33. For an unusually clear and balanced treatment of these issues, see Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA L. & EMP. J. 387, 398 n.56 (2009).

34. See *supra* note 24.

35. See generally JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* (2004) (providing a general history of ERISA).

36. For additional background concerning the regulation of health care under ERISA, 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, 2300-03 (2008) (describing the regulation of health insurance by ERISA); and Brendan S. Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 WIS. L. REV. 657, 661-64 (same).

management.³⁷ Health insurance and other forms of non-wage compensation—usually collectively referred to as benefits—are promised in connection with employment. Wages (or salary) and benefits comprise the total bundle of compensation upon which an employee makes the labor decision. Benefits thus constitute essential terms of the employment bargain. Although ERISA could have fairly easily been limited to only certain benefit promises, such as benefit promises pertaining to retirement, the statute was written to cover both pension benefits and welfare benefits, the latter including, most importantly, health insurance.³⁸

With respect to pension promises, ERISA provides many important protections, particularly funding requirements and government insurance, but it specifically does not mandate very much about the promise content. So, for example, ERISA does not require any particular rate of pension accumulation. A worker with ten years seniority and a salary of \$100,000 is not entitled to a pension of some specified statutory size. A pension promise of any level is protected by various legal rules, including funding, vesting, and anticutback requirements.³⁹ But the fundamental content of the promise—the size of the pension—is left open to labor market negotiation.

ERISA regulates health insurance promises even more lightly than it regulates pensions.⁴⁰ There is, for example, no funding requirement for employer-provided health care; an employer need not set aside monies to fund its expected payouts on

37. See, e.g., Albert deRoode, *Pensions as Wages*, 3 AM. ECON. REV. 287, 287 (1913) (explaining that pensions are funded via foregone wages); Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 437-38 (2010) (noting that employee benefits are simply wage substitutes); Peter J. Wiedenbeck, *Implementing ERISA: Of Policies and “Plans,”* 72 WASH. U. L.Q. 559, 560 (1994) (revealing that “[e]mployer-provided benefits are now a major component of compensation” and noting that “the cost of all employee benefits constituted 38.4% of payroll in 1990”).

38. See, e.g., 29 U.S.C. § 1002(1) (2012) (defining “employee welfare benefit plan”); *id.* § 1002(3) (defining “employee benefit plan” to include “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.* § 1003 (describing scope of ERISA’s coverage and identifying “employee benefit plan[s]” as targets of coverage). At the time of ERISA’s passage, employer-provided health insurance was far less costly and common than it is today, but there were some reports of abuse that persuaded the ninety-third Congress to include within ERISA’s scope health insurance arrangements incident to insurance. Michael S. Gordon, *Introduction to the Second Edition of EMPLOYEE BENEFITS LAW*, at lxix (Steven J. Sacher et al. eds., 2d ed. 2000) (discussing reports of undesirable conduct in connection with employment-provided health arrangements).

39. See, e.g., 29 U.S.C. § 1053 (2012) (minimum vesting standards); *id.* §§ 1082-1085 (articulating various funding rules).

40. Peter J. Wiedenbeck, *ERISA’s Curious Coverage*, 76 WASH. U. L.Q. 311, 311-12 (1998) (explaining that “ERISA establishes four levels of increasingly intense regulation,” with health insurance plans subject to significantly less regulation than defined benefit pension plans).

health insurance promises.⁴¹ More important for purposes of this Article, however, ERISA engages in virtually no content regulation of the health insurance promise.⁴² With a few narrow exceptions, no coverage areas or levels of coverage are mandated.⁴³ In other words, ERISA is characterized by a near absence of sickness rules. As in the pension context, the content of the health insurance promise is determined almost entirely by the parties.

ERISA does have non-sickness rules, but they do not support robust enforcement of the insurance promise. The statute imposes duties in connection with administering a health care insurance promise, as well as remedies for violations of those duties.⁴⁴ The content of those duties and remedies, as well as the procedures for pursuing and enforcing them, were defined in large part by judicial efforts subsequent to ERISA. Specifically, the Supreme Court and lower courts have narrowly interpreted the remedies available under ERISA in the case of benefit denials by limiting damages, court access, and the availability of impartial review.⁴⁵ ERISA remedies notoriously favor defendants—and have been vigorously criticized by scholars for years.⁴⁶ For example, an insured who has been wrongly denied a benefit may recover only the benefit itself; consequential and punitive damages are unavailable.⁴⁷ To even initiate a lawsuit challenging a benefit denial, an insured must ex-

41. 29 U.S.C. § 1081(a)(1) (2012) (exempting employee welfare benefit plans from ERISA's funding requirements).

42. "ERISA generally monitors only the implementation or conduct of privately-constituted welfare plans, it does not control their content." Wiedenbeck, *supra* note 40, at 312. The content of the health insurance promise is coverage: what conditions and treatment will be paid for. ERISA imposes only limited rules in this regard. *See infra* note 43.

43. ERISA includes very limited mandated benefit provisions, *see* 29 U.S.C. §§ 1185, 1185a, 1185b (2012), some limits on preexisting condition exclusions, *see id.* § 1181, a prohibition on health status discrimination, *see id.* § 1182, and limited rules pertaining to continuation of coverage, *see id.* §§ 1183, 1185.

44. *See, e.g.*, 29 U.S.C. §§ 1021-1024, 1102 (2012) (imposing various duties of disclosure and reporting); *id.* § 1104 (imposing a duty of loyalty upon fiduciaries of the plan); *id.* § 1104(a)(1)(B) (imposing a duty of care upon fiduciaries of the plan); *id.* § 1131 (identifying ERISA's criminal penalties); *id.* § 1132 (articulating ERISA's civil enforcement scheme); *id.* § 1133 (prescribing procedural requirements for benefit denials).

45. *See* Maher, *supra* note 36, at 669-82 (discussing ERISA's remedial provisions).

46. *See, e.g.*, John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 228; 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, 1317-21 (2007); 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 (2003); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131 (2009) (discussing how the Court has interpreted ERISA in the years following its enactment, and arguing that the Court has allowed ERISA to become a type of employer's security act).

47. Maher & Pathak, *supra* note 11, at 83.

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haust the plan's internal administrative process, and the insured may be required to file suit within a contractually established period of time that is considerably shorter than otherwise applicable statutes of limitations.⁴⁸ And the value of judicial review is considerably diminished by the likelihood that the court will apply a deferential standard of review, even to decisions by administrators who have previously behaved arbitrarily in denying the precise benefit that is the subject of the lawsuit.⁴⁹

Courts may have been hesitant to construe ERISA in favor of employees and their beneficiaries because employers possess leverage that is a by-product of the differences between group and individual insurance markets. Employment-based health insurance is functionally group health insurance. Thus, while the individual market for insurance is bedeviled by market imperfections that can effectively close off that market to unhealthy or poorer individuals, the employment-based group market is both less naturally susceptible to those market infirmities and the beneficiary of affirmative federal regulation that limits them. A person who cannot obtain insurance in the individual market often can and does obtain insurance in a group market. Group treatment is highly valuable.

The catch is that employees in effect only have access to group treatment if their employer decides to offer employment-based insurance. Judges interpreting ERISA are faced with a difficult policy reality: if they impose overly demanding legal rules regarding health insurance promises, employers will simply stop offering policies. The employees will then either (1) pay more on the individual market for the same benefits or (2) be unable to obtain insurance on the individual market at all.⁵⁰ The restrictive judicial interpretations of ERISA's non-sickness rules are a result of this policy pressure.

Thus ERISA's non-sickness rules are favorable to insurers, while its sickness rules are virtually nonexistent. In addition, ERISA couples its regulatory inaction (on content grounds) and action (on remedial grounds) with a powerful level of preemption.⁵¹ Under ERISA, virtually all state non-sickness rules are preempted, while state sickness rules are preempted for more than half of employee benefit plans.

Any state regulation that "relates to" employee benefit plans is preempted by ERISA,⁵² and the "relates to" language has been fairly broadly defined by the Su-

48. *Id.* at 82-84 & nn.46-47.

49. *Id.* at 83 & nn.48-49.

50. Maher & Stris, *supra* note 37, at 451-63 (detailing the features of the security-cost tradeoff that is of central importance to employers extending a benefit promise).

51. *See, e.g.,* Aetna Health Inc. v. Davila, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) (noting that broad preemption with little affirmative regulation has created a regulatory vacuum); Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443, 443 (2003) ("For many years, ERISA section 514 was interpreted to displace state regulation of medical care provided via employer-sponsored plans. Since ERISA itself supplies no regulation to replace the state regulation ERISA was believed to preempt, there appeared to be a 'regulatory gap.'" (internal citations omitted)).

52. 29 U.S.C. § 1144(a) (2012) (identifying as preempted "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan").

preme Court.⁵³ Generally applicable state common law rules regarding tort or contract, for example, have been held preempted by ERISA.⁵⁴ As an exception to the “relates to” clause, certain laws, notably state insurance laws, are statutorily “saved” from such preemption.⁵⁵

The savings clause, however, is itself subject to an important exception codified in the “deemer” clause of ERISA.⁵⁶ Because of this statutory provision, employee benefit plans that self-insure⁵⁷—as opposed to plans that entirely rely on third-party

53. See, e.g., *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-39 (1990) (stressing that the preemption clause is intended to be read broadly); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (stating that “[t]he pre-emption clause is conspicuous for its breadth”); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (stating that “the express pre-emption provisions of ERISA are deliberately expansive”); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983) (stating that Congress intended the preemption clause to be read broadly); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) (stating that “Congress . . . meant to establish pension plan regulation as exclusively a federal concern”).

54. See, e.g., *FMC Corp.*, 498 U.S. at 60 (holding that a Pennsylvania law denying to insurers the right of subrogation or reimbursement from an insured’s tort recovery was “related to” employee benefit plans because “it prohibits plans from being structured in a [particular] manner”); *Shaw*, 463 U.S. at 96-97 (holding that New York’s Human Rights Law and Disability Benefits Law were “related to” employee benefit plans because they prohibited such plans from being structured in a way that discriminated on the basis of pregnancy and mandated specific employee benefits, respectively).

55. 29 U.S.C. § 1144(b)(2)(A) (“Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”); *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003) (“[F]or a state law to be deemed a law . . . which regulates insurance under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, [it] must substantially affect the risk pooling arrangement between the insurer and the insured.” (internal quotation marks omitted)).

56. 29 U.S.C. § 1144(b)(2)(B).

57. The term “self-insured” is a bit of a misnomer because, although state authority to regulate stop-loss insurers is unsettled, see Russell Korobkin, *The Battle over Self-Insured Health Plans, or “One Good Loophole Deserves Another,”* 5 YALE J. HEALTH POL’Y, L. & ETHICS 89 (2003), the majority rule seems to be that plans may purchase stop-loss insurance and still qualify as self-insured plans. See, e.g., Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 243 (1997). Were a state able to regulate a stop-loss insurer as much as the state could regulate a normal third-party insurer, then only those employee benefit plans that truly self-insured would be outside of state authority. Plans that used stop-loss insurance would be subject to “saved” insurance laws.

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insurers to directly pay claims—cannot be subject to state insurance laws.⁵⁸ Thus, the “saved” power of a state to promulgate insurance rules—for example, a requirement that a certain condition be covered—affects only employee benefit plans that do not self-insure. States have no power to regulate employee benefit plans that do self-insure—and in 2011, 58.5% of employees receiving employer-sponsored insurance were covered by insured plans.⁵⁹

In addition to this express preemption regime, the Supreme Court has developed a robust doctrine of conflict preemption. Specifically, additional causes of action or heads of damages to remedy benefit denials, beyond those provided for in ERISA—even if such would otherwise be saved—are preempted.⁶⁰

Non-Sickness Rules. Some non-sickness rules have survived preemption,⁶¹ but states have no power to determine the remedies available to an insured who suffers a breach of the health insurance promise, when the health insurance is obtained as an employee benefit. This is because the Supreme Court has held that any state law that attempts to supplement the limited remedies available under ERISA is preempted because it “conflicts” with ERISA.⁶² It is not clear whether states are free

58. See, e.g., *FMC Corp.*, 498 U.S. at 61 (stating that “[w]e read the deemer clause to exempt self-funded ERISA plans from state laws that regulat[e] insurance within the meaning of the saving clause” (internal quotation marks omitted)); Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How To Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 467-68 (2003) (“In other words, if an employer acts like an insurance company in the process of providing a set of benefits to its employees—for example, by promising to pay all the medical expenses incurred by its employees in the future—state insurance regulations cannot apply in that circumstance.”).

59. Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, EMP. BENEFIT RES. INST. 2 (Nov. 1, 2012), http://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-12.Slf-Insrd1.pdf; see also Kathryn Linehan, *Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market*, NAT'L HEALTH POL'Y F. 3 (Dec. 2010), http://www.nhpf.org/library/issue-briefs/IB840_PPACASmallGroup_12-21-10.pdf (“Self-insured plans are the most common source of health insurance for American workers. In 2009, 57 percent of covered workers were enrolled in a partially or fully self-insured health plan.”).

60. See, e.g., *Aetna Health Inc. v. Davila*, 542 U.S. 200, 221 (2004) (holding that state-law created causes of action against HMOs were preempted); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990) (holding that a wrongful termination cause of action was preempted); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (holding that a Mississippi law of bad faith denial of insurance benefits was preempted). Supreme Court jurisprudence is not clear as to what, beyond rules that could be categorized as relating to causes of action or damages, would be preempted on conflict grounds.

61. See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (saving from preemption an Illinois law requiring independent physical review of benefit denials); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 363-64 (1999) (saving from preemption a California law that required an insurer to demonstrate prejudice in order to invoke timeliness as a defense to an insured’s benefit denial challenge).

62. See *supra* note 60 and accompanying text.

to enact non-sickness rules that impose a more demanding standard of review than the deferential standard most plans currently enjoy.⁶³ Even when non-sickness rules survive preemption, however, they do not apply to self-insured plans, as is explained below.

Sickness Rules. With respect to sickness rules, ERISA at first glance seems to allow state regulation. Even though sickness rules will undoubtedly fall within ERISA's broad preemption clause,⁶⁴ they will also qualify as insurance regulation, which is saved from ERISA preemption.⁶⁵ State mandated-benefit laws, for example, have been held to relate to employee benefit plans and thus fall within ERISA's preemption clause; but those laws were saved from preemption because they were considered insurance regulation.⁶⁶

This regulatory freedom, however, is illusory. ERISA's savings clause does not permit state insurance regulation to operate on the massive number of policyholders who obtain health insurance coverage from *self-insured* plans.⁶⁷ As a descriptive matter, therefore, it simply is not the case that states have much power to impose sickness rules on employer-provided health insurance: there are millions of employees who receive health insurance pursuant to a plan that is totally outside the reach of state sickness rules.

Moreover, whether an employer's health insurance is subject to state sickness rules is within the power of the employer, not the state. Imagine an employer unhappy with state laws regulating insurance. Perhaps the employer believes those laws make insurance too costly, too unpredictable, or too difficult to administer. One option is for the employer to drop coverage. Although many employers did drop coverage, others maintained coverage to remain an appealing option for talented labor. A second option is to self-insure.⁶⁸ Self-insurance allows an employer

63. See generally Radha A. Pathak, *Discretionary Clause Bans & ERISA Preemption*, 56 S.D. L. REV. 500 (2011) (surveying state efforts to regulate discretionary clauses within insurance policies and evaluating whether such state action is preempted by ERISA). Discretionary clause bans are state laws that indirectly prevent insurance companies from accessing a deferential standard of review in a benefit denial challenge under ERISA. *Id.* at 501-02, 507. These bans should not be considered expressly preempted, but the Supreme Court could conceivably expand conflict preemption to invalidate such state regulation. *Id.* at 508-13.

64. See *supra* notes 52-54 and accompanying text.

65. See *supra* note 55 and accompanying text.

66. See, e.g., *Met. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739, 758 (1985) (stating that a state mandated-benefit law was related to employee benefit plans but holding that it was not preempted because it fell within the savings clause).

67. More than half of employees—58.5% in 2011—who have employer-provided insurance are covered by self-insured plans. See Fronstin, *supra* note 59, at 2. Most of these individuals work for large employers: in 2011, only 10.8% of employees covered by self-insured plans worked for employers with fewer than fifty employees. *Id.*

68. In order to fully self-insure, an employer must be able to assume financial responsibility for its employees' health insurance claims. Linehan, *supra* note 59, at 3. However, an employer who purchases stop-loss insurance may nonetheless be regarded as self-insured and thus within the scope of the deemer clause, see *supra*

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to reap the market benefits of offering coverage without the hassle of complying with invasive state rules.⁶⁹ And multistate employers who self-insure can avoid the hassle of complying with multiple sets of state rules.⁷⁰ Employer strategy thus pushed millions of employees⁷¹ into the federal regulatory market, because all employees who received insurance through self-insured plans were outside a state's regulatory reach.

That the key determinant of state regulatory power is employer choice has a second-order effect. It is possible that state regulatory initiatives have been chilled by the prospect that regulated parties could flee the regulation without having to leave the state for all purposes. When faced with the possibility that regulatory actions could be challenged on preemption grounds, as well as the possibility that employers would respond to certain regulatory moves by removing themselves from the state's regulatory market (and thus lessening the audience of people the regulations were designed to protect), rational state actors may be more constrained in the regulatory actions they will consider. State actors have neither unlimited time nor unlimited resources. Like everyone, they prefer to pick battles that they are likely to win.

III. POST-ACA STATE POWER TO REGULATE HEALTH INSURANCE

An accurate assessment of the ACA and its implications for federalism must be done in context and not ignore ways in which the statute may create or revitalize avenues of state power. Accordingly, we begin this Part by setting forth the basics of the ACA and explaining how the ACA—in contrast to ERISA—gives states genuine power to specify sickness rules and non-sickness rules regarding health insurance arrangements. Indeed, the ability of states to set remedies for wrongful health insurance coverage denials will be greater than it has been since the enactment of ERISA in 1974. From a federalism-in-fact perspective, this power is crucial because the nature of insurance arrangements heightens the importance of background legal rules and because states can promulgate such rules with little additional cost or infrastructure.⁷²

note 57, so self-insurance is more achievable than it may first appear. Linehan, *supra* note 59, at 3, 5. The percentage of individuals covered by self-insured plans has been increasing since 1998. Fronstin, *supra* note 59, at 2.

69. Linehan, *supra* note 59, at 4 (“ERISA pre-emption of state regulation of self-insured employer plans in effect means that such plans are not subject to laws or regulations that states impose, such as benefit mandates, assessments on health insurers, and other requirements for insurers such as reserve requirements.”) Linehan identifies other advantages of self-insurance, *id.*, but the point here is that one advantage is escape from state regulation.
70. *Id.* at 3 (“Because benefit mandates can vary across states and even conflict, self-insurance allows multi-state employers to offer uniform benefits to workers in different locations.”).
71. See *supra* note 59 and accompanying text.
72. Whether such an expansion of state regulatory authority is outweighed by other provisions of the ACA that restrict state discretion is an open question and, of course, depends upon one's individual priorities and values.

Next, we examine an unexplored potential consequence of health care reform: state regulatory growth. The ACA makes it plausible, if not likely, that the state-level regulatory market—the number of people governed by state rules—will grow. It does this in two ways: (1) the ACA expands the size of the market that states previously regulated,⁷³ and (2) the ACA makes it more likely that states will be able to persuade subjects (employers and individuals) of a previously federal regulatory market (the ERISA market) to opt-in to state regulatory markets.⁷⁴ While the latter depends upon exploitation of subtle features of the existing regulatory regime, the potential effects, whether in terms of future reform or as the handiwork of ambitious state actors, are enormous.

Finally, we identify and address some of the limitations of our analysis. Much discussion of the ACA has focused almost exclusively on the ways in which it circumscribes state authority. We do not wish to make a mistake in the other direction.

A. ACA Basics

The ACA represents a significant federal effort to reconfigure the American health system. It contains a multitude of reforms, many of which receive full treatment elsewhere.⁷⁵ At the broadest level, the ACA seeks to provide near-universal

73. See *infra* text accompanying notes 99-102 (describing how the ACA will dramatically increase the number of individuals subject to state regulation of health insurance).

74. See *infra* text accompanying notes 103-119. Regulatory power is thus a function of both size of the market and discretion to enact rules governing that market. If both increase, power increases. If one increases and the other decreases, whether state power has increased is a value judgment.

75. See, e.g., Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1611 (2011) (describing and analyzing the ACA's minimum health benefits feature); Lance Gable, *The Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights*, 39 J.L. MED. & ETHICS 340, 345-47 (2011) (describing the ACA's individual mandate and employer mandate, its subsidies for qualifying individuals and small businesses, the creation of health insurance exchanges, and cost containment features); Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 827-28 (2011) (describing the ACA's prohibition of much medical underwriting and premium pricing based on health status, its minimum health benefits requirement, and cost-sharing features); Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7 (2010) (describing structural problems that may thwart the implementation of the individual mandate and proposing possible legal and nonlegal solutions); Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Healthcare Reform*, 58 UCLA L. REV. 221 (2010) (discussing and analyzing the ACA's essential health benefits requirement); Monahan & Schwarcz, *supra* note 14, at 133-53 (describing the ACA's creation of health insurance markets, its prohibition of risk classification in individual insurance markets, and its antidumping provisions); Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Healthcare Regulation: The Federalism*

health insurance coverage in America. To that end, it expands government-provided health insurance (e.g., Medicare), but it also relies heavily on private insurance. Indeed, what is transformative about the ACA is that it takes steps to dramatically increase the number of Americans who have private health insurance.

The market for insurance is unusual. It does not maintain itself. Therefore, in order for the ACA to expand private health insurance coverage, it was necessary for the statute to address affordability and availability obstacles that afflict private coverage solutions. These obstacles stem from the market reality that the price of a fair insurance policy is a function of the expected payouts the insurer will have to make on the policy. The sicker (or more likely to be sick) one is, the higher the premium an insurance company will demand to offer a policy.

Insurance companies engage in a process known as risk underwriting to appropriately price policies they offer to individuals. Risk underwriting is an imperfect art. Indeed, in some cases, certain classes of people are such bad risks that insurance companies will simply decide not to offer policies to them on any terms. Accordingly, pre-ACA, many Americans were unable to obtain health insurance coverage in private markets because of unfavorable individual insurance-risk characteristics, such as serious preexisting conditions.⁷⁶ The possibility of adverse selection—the likelihood that those seeking insurance in an unregulated market will consume more policy benefits than the insurance company can effectively predict—drives up the cost of individual insurance higher still.⁷⁷ Higher premiums, in turn, discourage reasonably healthy people from purchasing insurance, leaving a sicker pool of people seeking insurance, which drives up premiums further, and so on.

The ACA addresses these problems with several crucial reforms. First, the individual mandate: the statute requires (almost) everyone to purchase insurance.⁷⁸

Failures of the ACA, KAN. J.L. & PUB. POL'Y 266 (2011) (describing the extent to which the ACA's reforms are dependent on state implementation).

76. See, e.g., Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 574-75 (2008) (noting the difficulty of obtaining nongroup insurance); Mark A. Hall, *Of Magic Wands and Kaleidoscopes: Fixing Problems in the Individual Market*, HEALTH AFF. (Oct. 23, 2002), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.353v1>; Mark A. Hall & Carl E. Schneider, *Patients As Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 649 (2008).
77. Of course, cost is a problem apart from adverse selection. Even in insurance markets in which adverse selection is not believed to be a problem—such as large group markets—rapidly rising insurance costs were making private policies unaffordable for a significant portion of the populace. See Timothy Stoltzfus Jost, *Our Broken Health Care System and How To Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 544-45 (2006) (explaining that even group health insurance is expensive and poses an affordability problem); Paul Steinhäuser, *Poll: Health Care Costs Too Expensive, Americans Say*, CNN (Mar. 19, 2009), http://articles.cnn.com/2009-03-19/politics/health.care.poll_1_health-care-americans-coverage.
78. 26 U.S.C. § 5000A (2012) (requiring “applicable” individuals to maintain “minimum essential coverage” in order to avoid specified penalties).

Second, the statute largely bars the use of risk underwriting.⁷⁹ Third, the statute mandates a minimum package of benefits that must include what the statute refers to as “essential health benefits.”⁸⁰ The rationale for these three fundamental reforms—which states cannot eliminate—is that if everyone is required to purchase insurance, if insurers are not allowed to price-discriminate or exclude based on risk, and if the policies sold offer similar benefits, adverse selection will neither destroy the individual market nor distort it so severely that it is effectively closed to a significant percentage of potential insureds.⁸¹

Nonetheless, even a regulated market may still price the average product at a level that is too high for some percentage of the population to afford. Indeed, even for many healthy people—i.e., those without unusually unattractive insurance-risk profiles—the pre-ACA price of insurance, even in group markets, was simply too high to be affordable.⁸² The ACA addresses the affordability issue through use of subsidies for those at low-income levels.⁸³

79. See, e.g., 42 U.S.C. § 300gg (2012) (allowing premiums to vary based only on number of individuals covered, geographic area, age, and tobacco use); *id.* § 300gg-1 (requiring insurers to accept all applicants); *id.* § 300gg-2 (requiring insurers to renew coverage, subject to limited exceptions); *id.* § 300gg-3 (forbidding preexisting condition exclusions); *id.* § 300gg-6 (requiring coverage for “essential health benefits”); *id.* § 300gg-12 (prohibiting rescissions except in instances of fraud or intentional misrepresentation). For a longer discussion of how the “ACA attempts to eliminate both direct and indirect forms of risk classification by insurers,” see Monahan & Schwarcz, *supra* note 14, at 136-42.

80. See 42 U.S.C. § 300gg-6 (requiring coverage for “essential health benefits”); *id.* § 18022 (defining “essential health benefits”). *But see infra* note 118 (explaining how large employers can satisfy the ACA coverage requirements by providing far less than the package of benefits specified in 42 U.S.C. § 300gg-6).

81. See 42 U.S.C. § 18091(2)(I) (2012) (setting forth Congress’s conclusion that the individual mandate and guaranteed issue would “minimize . . . adverse selection”); *cf.* Amitabh Chandra, Jonathan Gruber & Robin McKnight, *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293, 293-95 (2011) (finding reduction in premiums in Massachusetts after instantiation of the mandate).

82. See *supra* note 77.

83. 26 U.S.C. § 36B (2012) (creating tax credits to provide assistance in paying premiums); 42 U.S.C. § 18071 (2012) (creating cost-sharing subsidies, e.g., subsidies to lower an insured’s deductibles, co-pays, and other out-of-pocket expenses); see also Michael Lee, Jr., *Adverse Reactions: Structure, Philosophy, and Outcomes of the Affordable Care Act*, 29 YALE L. & POL’Y REV. 559, 567-69 (2011) (describing the ACA’s subsidies). The ACA also addresses what can be described as the long-term affordability problem—namely, that ever-rising medical costs will eventually make insurance so costly that only massive subsidies that will break the Treasury could make insurance affordable to everyone—through a variety of other mechanisms. Whether the ACA’s efforts to control rising costs—for example, to “bend the cost curve” downward—are or will be adequate is another matter entirely. A full treatment of that concern cannot occur here. *Cf.* Russell Korobkin, *Bounded Rationality, Moral Hazard, and the Case for Relative Value Health Insurance*, <http://ssrn.com/abstract=1984937> (proposal for a government created CE

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The ACA also attempted to empower consumers as decisionmakers and bargain hunters, imposing various duties upon insurers regarding the gathering, submitting, disclosing, and presenting of information for government and consumer use,⁸⁴ and by providing for the creation of government-run exchanges, which are intended to create stable markets and facilitate comprehensible consumer choice.⁸⁵ These exchanges can be conceived of as virtual insurance stores where a consumer can view a list of state-approved insurance products and decide, based on a uniform description of each insurance product, which product to purchase. States must create these exchanges or the federal government will do so.⁸⁶

Ultimately, the ACA's substantive particulars on the question of private health insurance were largely designed to ensure that private markets for health insurance were accessible, affordable, and comprehensible to all. Whatever the imperfections in execution, the legislation's conceptual aims were clear: the mandate and the risk-underwriting prohibition would open individual markets to all, the subsidies would make those markets affordable, and the exchanges would make them comprehensible.

B. Regulatory Freedom

In decrying the ACA's expansion of federal power, critics have focused on the individual mandate. But, as we explain below, the mandate may not be as great an imposition as it appears. First, some states do not oppose the mandate. And even for states that oppose it, the mandate appears a lesser intrusion when viewed in the context of the entire ACA. Considered as a whole, the ACA allows states to exercise greater control over non-sickness and sickness rules than they had under ERISA.

The individual mandate certainly infringes on state power. Prior to the ACA, each state had the freedom to decide whether or not it wished to impose a mandate on its citizens.⁸⁷ The states now lack that authority: no state may exempt its citizens

rating system that could be incorporated explicitly into insurance contracts); Brendan Maher, *Paul Ryan & Friends*, PRAWFSBLAWG (Apr. 5, 2011, 6:58 PM), <http://prawfsblawg.blogs.com/prawfsblawg/2011/04/paul-ryan-friends.html> (discussing merit of incorporating CE metrics into insurance contracts and Korobkin proposal).

84. See, e.g., 42 U.S.C. § 300gg-9 (requiring disclosure of information to consumers); *id.* § 18031(c)-(e) (describing, inter alia, information to be collected and disseminated through the exchanges).

85. *Id.* §§ 18031, 18041, 18051 (enumerating exchange requirements); see also Brendan S. Maher, *Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected*, 44 CONN. L. REV. 1099 (2012) (discussing rationales for exchanges); Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, COMMONWEALTH FUND (2010), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf (discussing various purposes for exchanges).

86. 42 U.S.C. § 18041(c)(1) (stating that "the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State" if the state does not create one); Gluck, *supra* note 12, at 540.

87. There does not appear to be any accepted federal constitutional argument as to why an individual might have a constitutional right to be free of a state mandate

from the federal requirement to purchase health insurance.⁸⁸ We do not deny this obvious truth, but believe it should be put in appropriate perspective.

The ACA formally denies State *X* the power to not have a mandate in State *X*. Some states, however, prefer having a mandate.⁸⁹ The *functional* deprivation of regulatory freedom for mandate-preferring states is vastly smaller—namely, it is limited to operational differences of opinion regarding mandate details—than it is with respect to those states that would never have enacted a mandate.⁹⁰

We accept that there are a significant number of states that would have never adopted a mandate if left with discretion.⁹¹ With respect to those states, the regulatory deprivation associated with the imposition of a federal mandate is significant. Of course, that constraint cannot be analyzed in isolation. Whatever magnitude one wishes to assign to the regulatory infringement a “never-mandate” state suffers under the ACA, that must be balanced by the effects that a mandate (and other features of the ACA) will have on state power in other ways.

Consider, for example, three subject areas of state regulatory power—Subject *A*, Subject *B*, and Subject *C*. If a federal act severely restricts Subject *A*, that is not the end of the story from a federalism-in-fact perspective. We must determine what the act does with respect to Subject *B* and Subject *C*. It is theoretically obvious that a federal act could limit a state’s power with respect to Subject *A* but enhance it with respect to Subject *B* or *C*. Certainly, a Subject *A* reduction may be more “important”—in state power terms—than a Subject *B* enhancement, but no comprehensive evaluation can occur until Subjects *A*, *B*, and *C* are all analyzed.

The individual mandate (Subject *A*) may be an imposition on state authority. But the imposition is not as great as it appears once we consider the ACA as a whole. Indeed, the ACA increases state authority over its population in important ways. As we have explained in other work, the ACA gives states meaningful discre-

should the state have chosen to impose one. Of course, state constitutions might provide individual rights that make state mandates unconstitutional. Our argument is advanced from a state power perspective; we do not consider any infringements on individual liberty.

88. A state law imposing an individual mandate on state citizens might not be preempted, but a state law attempting to void the ACA’s individual mandate would certainly “prevent the application of” a key provision of the ACA and hence be preempted. 42 U.S.C. § 18041(d).
89. There are numerous reasons, of course, why a state might decide not to sue the federal government to seek to invalidate the mandate. But presumably some of the many states that chose not to oppose the ACA in court chose not to do so because those states preferred having a mandate—and perhaps preferred so for some of the reasons we describe herein.
90. We are not attempting to argue that forcing an actor to do *X* is not an infringement of freedom if the actor were going to do *X* anyway. As we made clear, that compulsion *is* an infringement on freedom. We are merely pointing out that, once that baseline (and significant) infringement has been accounted for, states that would not have done *X* suffer a greater infringement than states that would have done *X*.
91. This seems a reasonable assumption, to put it mildly. Whether states are wise to be antimandate is a separate question.

tion to affect both sickness and non-sickness rules.⁹² A comparison to ERISA highlights that grant of authority.

A key sickness rule in the ACA is that individual health insurance policies must include essential health benefits, which are to be defined by the Secretary of Health and Human Services but which must include benefits within the ten categories specified in the statute.⁹³ While this rule may appear to foreclose state regulation of the content of the health insurance promise, in fact it does not, because the Secretary has adopted a cooperative federalism approach, explicitly incorporating state preferences into the package of benefits that the ACA requires to be offered.⁹⁴ The states cannot entirely eliminate the essential health benefits requirement or remove any of the ten categories, but states who wish to impose additional requirements can do so. In other words, states can essentially enact mandated benefit laws for all individual health insurance policies without running afoul of the ACA.⁹⁵

With respect to non-sickness rules—such as rules of interpretation and remedy—the ACA provides very little in the way of preemptive hurdles. In effect, it leaves the majority of background rules to state determination.⁹⁶ Moreover, state influence, in significant respects, is achievable through traditional and cost-effective means, namely, by regulations promulgated through existing insurance apparatuses and by the articulation of state common law (much of which has already been articulated). In our view, the incremental costs associated with these revitalized channels of state power—i.e., background regulation of the health insurance bargains via legal rules—are modest and bearable by all states. From a federalism-in-fact perspective, that is important, because it increases the likelihood that states will actually behave in a way that expands their influence, and not fail to do so because practical or financial difficulties will forestall such efforts.

The ACA thus gives states meaningful authority to influence both sickness and non-sickness rules. We note two important points with respect to this influence. First, the foregoing analysis does not, in large part, apply to traditional employment-based health insurance. The ACA largely reserves the regulation of that type of insurance to ERISA. In the first analysis of its kind, we explain in Section III.C why that is of less consequence than it may first appear. Second, we do not deny that, in important ways, the ACA does limit state authority to promulgate both sickness and non-sickness rules. We discuss those specifics in more detail in Section III.D, and also consider objections that our analysis prioritizes a few trees at the ex-

92. See Maher & Pathak, *supra* note 11, at 76-85.

93. 42 U.S.C. § 18022(b)(1) (2012).

94. Maher & Pathak, *supra* note 11, at 76-77.

95. *Id.*

96. The ACA's preemptive language is explicitly modest and overtly sensitive to state regulatory authority. 42 U.S.C. § 18041(d) (2012) (making clear that Title I of the ACA was not intended to preempt any state law unless such state law "prevent[ed] the application of the provisions" of Title I of the ACA); see also *id.* § 300gg-23 ("[T]his part and part C of this subchapter insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.").

pense of the forest. But first, we explain that, in addition to giving states freedom to enact sickness and non-sickness rules, the ACA will also increase the number of people over whom states have regulatory authority.

C. Regulatory Growth

By imposing a mandate, the ACA opens up and expands the individual insurance market in each state. Before the ACA, most uninsured people could not obtain insurance because they could not purchase it on the individual market (because of a preexisting condition) or because they could not afford the high prices of individual policies (in part because adverse selection problems had driven up prices).⁹⁷ More affordable individual insurance will now be available to all, so large numbers of individuals who did not have health insurance before will purchase it. One estimate from the Congressional Budget Office suggests that 8 million people will receive insurance through the exchanges in 2014, and the number increases to 12 million in 2015, 20 million in 2016, and between 22 and 23 million from 2017 to 2022.⁹⁸ Individuals who purchase insurance on an exchange are governed by state law. The ACA will thus increase the size of each state's regulatory market.

In addition to facilitating⁹⁹ the purchase of insurance by individuals who previously did not have it—through use of mandates, no-risk underwriting, and subsidies—the ACA also sets up a regulatory regime in which states can persuade subjects of a competing regime (i.e., ERISA) to opt-in or migrate.¹⁰⁰ One recent estimate from the Congressional Budget Office is that 3 to 5 million people annually will migrate from employment-based insurance to the individual market.¹⁰¹ Other analysts suggest larger numbers.¹⁰² Such migration will allow further state regulatory growth.

97. See Hall, *supra* note 76; Hall & Schneider, *supra* note 76; Jost, *supra* note 77.

98. See CONG. BUDGET OFFICE, *supra* note 24, at tbl.2 (projecting 8 million people on exchanges in 2014, 12 million in 2015, 20 million in 2016, 22 million in 2017, 23 million in 2018 and 2019, 22 million in 2020, 23 million in 2021, and 22 million in 2022). An updated estimate from the CBO suggests that the numbers may even be slightly higher. See CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION, at tbl.3 (July 2012).

99. We choose the word “facilitating” rather than “requiring” because some individuals may choose to pay the penalty rather than purchase health insurance.

100. See, e.g., Bronsteen, Maher & Stris, *supra* note 36, at 2319-28 (discussing competition between different health regimes); Maher, *supra* note 10 (examining theoretical appeal of federalism opt-ins); Monahan & Schwarcz, *supra* note 14, at 129 (identifying and analyzing possibility that insureds will migrate to the exchanges because employers will no longer cover some employees).

101. See CONG. BUDGET OFFICE, *supra* note 24, at 1.

102. Douglas Holz-Eakin & Cameron Smith, *Labor Markets and Health Care Reform: New Results*, AM. ACTION F. (May 27, 2010), http://americanactionforum.org/sites/default/files/OHC_LabMktsHCR.pdf (suggesting that 35 million fewer people would have employment insurance). Moreover, as the current analysis makes clear, the primary obstacle to market movement is differential tax treat-

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While the growth of state regulatory markets via the infusion of individuals who previously lacked health insurance is straightforward, more explanation is required to understand how the ACA might cause people to migrate from employer-provided health insurance to state exchanges. The ACA does not bar those with employment insurance from purchasing a policy on the individual market; it expressly allows it.¹⁰³ There are, nonetheless, obstacles to doing so. First, obtaining insurance through one's employer allows one to benefit from the employer's contribution to health insurance premiums. This "contribution," regardless of the fact that it is styled as coming from the employer, is really nothing more than foregone wages. In economic terms, an employee could ask to receive as cash that portion of his wages currently expressed as an "employer contribution" to health insurance. An employer would be no worse off.

Tax rules, however, complicate the matter. When part of an employee's overall compensation (the portion consisting of the "employer contribution" plus the "employee contribution") goes toward purchasing employment-based health insurance, that compensation is not taxed as income.¹⁰⁴ Were an employee to simply accept that contribution in the form of cash and purchase an individual policy, he would have to pay income taxes on the cash. He could buy the policy only with after-tax dollars.¹⁰⁵

There is a potential (but unlitigated) work-around under current tax law. An employer could establish a health reimbursement account (HRA) for the employee and contribute to the account the amount that otherwise would have been ex-

ment—something that long predated the ACA—not any substantive provision of the ACA. If tax treatment were equalized and made simpler—for example, if all health insurance purchases up to a certain point were not taxable, either to the employer or the employee—then even more people would enter state markets.

103. 42 U.S.C. § 18032(d)(3)(C) (2012) ("A qualified individual may enroll in any qualified health plan . . ."); *id.* § 18032(f) (defining "qualified individuals" as anyone who "is seeking to enroll in a qualified health plan in the individual market offered through the Exchange," "resides in the State that established the Exchange," and is not incarcerated at the time of enrollment); *see also id.* § 18031(d)(2)(A) ("An Exchange shall make available qualified health plans to qualified individuals and qualified employers.").
104. *See, e.g.,* Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 B.Y.U. L. REV. 1229, 1229 (explaining that employer contributions to health insurance are deductible, and that the value of health insurance received is not included in employee income).
105. *Id.* at 1229; *see* 26 U.S.C. § 213 (2012) (stating that tax preferential treatment attaches only "to the extent that such expenses exceed 7.5 percent of adjusted gross income"). One solution to this problem is legislative: the federal government could simply treat all expenditures for the purchase of health insurance equivalently, i.e., by offering the same tax and subsidy treatment for health insurance purchases whether employment-based or not.

pended to purchase employment-based insurance.¹⁰⁶ An employee could then use the money in that HRA to purchase individual insurance with tax-free dollars.¹⁰⁷

Putting aside the HRA approach, employers and their advisors may well seek to obtain regulatory approval of a tax-neutral, compensation-equivalent way to move their employees into state insurance markets, where the employee will be out of the employer's administrative hair. And the reason is not ill intent, it is core competency. Employers are not in the business of being insurers or administering policies, and have little independent desire to do so. They provide health insurance to their employees in response to labor market pressures that are occasioned largely by the fact that, pre-ACA, employees could not get comparable insurance elsewhere at the same price.

In acquiescence to that pressure, many employers provided insurance, but were unhappy about the costs and uncertainty that providing such insurance imposed.¹⁰⁸

106. INTERNAL REVENUE SERV., DEP'T OF THE TREASURY, HEALTH SAVINGS ACCOUNTS AND OTHER TAX-FAVORED HEALTH PLANS, PUBLICATION 969, at 18-19 (Jan. 11, 2012).

107. The challenge with the HRA path to state markets is regulatory uncertainty. It is not clear how either the ACA or ERISA would treat an HRA set up to be used exclusively for purchasing an individual policy on a state insurance exchange (and funded adequately to ensure purchase of a median-level policy on the change). Use of an HRA in that fashion might not satisfy the current conception of the ACA's various requirements—and thus result in either an employer being penalized or prohibited from using the HRA at all. Alternatively, use of an HRA might cause a low-income employee to lose a subsidy. However, as a policy matter, it is difficult to see why either an individual or employer should be disadvantaged if the employer is in essence willing to pay for an acceptable policy, while (1) lessening its administrative responsibilities, and (2) giving all of its employees choice among those menu of policies offered on a state-sanctioned exchange.

ERISA poses a similar regulatory hurdle, occasioned by past practice. HRAs are, according to the Department of the Treasury, presumptively “group benefit plans,” and thus subject to ERISA. *Id.* Whether an HRA set up to provide funds exclusively for purchase of an *individual* policy on a state-exchange will be a “group plan” subject to ERISA is not definitively clear. If such an HRA is governed by ERISA, then such an arrangement will *not* push the worker entirely into the state market, because the policy will be regulated by ERISA. Such a policy would be subject to a state's sickness rules (because of the savings clause), but not its benefit denial remedies. Past regulatory treatment of HRAs—in which they were used as adjuncts to true group plans and thus held to be a part of the plan—makes little sense in the current environment, in which the HRA is simply being used as a tax-equivalent means to provide the employee with an individual policy, rather than forcing the employer to buy and administer a group plan that would provide the same benefits.

108. David A. Hyman & Mark Hall, *supra* note 24, at 23 n.6 (2001) (citing S. SILOW-CARROLL ET AL., THE STATE OF EMPLOYMENT-BASED HEALTH COVERAGE AND BUSINESS ATTITUDES ABOUT ITS FUTURE (2001)); James Robinson, *The End of Managed Care*, 285 JAMA 2622, 2623 (2001); Interview by Patrick Mullen with Regina Herzlinger, Professor, Harvard Business Sch. (May 1998), http://www.managedcaremag.com/archives/9805/9805.qna_herzlinger.shtml.

There is little reason to believe that—in a guaranteed issue, tax-neutral market—employers would choose to provide health insurance to employees instead of providing the cash spent on acquiring the insurance.¹⁰⁹ The latter option not only improves employee choice, but separates the employers nearly entirely from the line of decisions, obligations, and conduct that are outside of the employers' core competency. Indeed, the ERISA Industry Committee, an advocacy organization for employers, proposed in 2007 to create a health-insurance system in which employers would be empowered to remove themselves from the health-insurance process, beyond voluntarily funding employee purchase of health insurance through community collectives.¹¹⁰

Nor is there any reason to believe that employees on average would be upset by this change. If they are receiving health insurance worth X in pretax dollars (X being the sum of employer and employee contributions), then they should be equally happy to receive X in pre-tax dollars to spend on state-law-governed insurance of their choosing. Indeed, as we explained above, the federal rules governing employment-based insurance (in ERISA) are not favorable to beneficiaries, almost certainly because policymakers cautiously determined that employers would simply stop offering insurance if it became too costly or uncertain.¹¹¹ An employee, in short, is more likely to prefer (and pay some amount more for) the legal rules that govern state insurance over those that govern ERISA insurance.¹¹²

Some have argued that employees prefer employment-based insurance because the employer goes through the trouble of selecting insurance (which is complicated) and of monitoring the insurer.¹¹³ The benefit of employer choice and monitoring is questionable, given the divergent interests of employer and employees, as well as the fact that in some cases the employer is the insurer. Moreover, the benefit becomes extremely small when the employee is moving into a regime—state-run exchanges—in which those key functions are performed by the government, rather

109. *A New Benefit Platform for Life Security*, ERISA INDUS. COMMITTEE 20-21 (2007), http://www.eric.org/forms/uploadFiles/ccea00000007.filename.ERIC_New_Benefit_Platform_FL0614.pdf.

110. *See id.*

111. *See, e.g.,* *Conkright v. Frommert*, 130 S. Ct. 1640, 1648-49 (2010) (“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.” (quoting *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 215 (2004) (internal citations and quotation marks omitted))).

112. *See supra* text accompanying notes 44-49 (describing how, by narrowly interpreting ERISA, the federal courts have significantly limited damages, court access, and the availability of impartial review, resulting in a system that notoriously favors defendants). Of course, if a state chooses to enact non-sickness rules that are no more favorable to insureds than ERISA, the employee will not prefer state-governed insurance. However, even if state rules were the same or worse for beneficiaries than ERISA rules, employers would still prefer offloading employees onto individual markets, assuming the employee blowback was less than the benefit of being out of the health insurance business.

113. *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, 2329 (2010).

than private employers.¹¹⁴ And it may be outweighed by the continuity of coverage that can be obtained when insurance is not based on one's employment.

Small employers are particularly likely to push employees into state markets, because employers with less than fifty workers face no penalty for not offering insurance.¹¹⁵ Large employers must pay a penalty, based on the number of employees, if they do not offer insurance that is "affordable" and of "minimum value."¹¹⁶ Thus, the ease with which an employer can affect migration into state market policies varies. Small group employers are largely unconstrained in their choice, aside from normal market pressures; they could simply drop coverage altogether, raise wages by the saved cost, and weather employee complaints about the less favorable tax treatment (which would be counterbalanced by low-income employees gaining subsidies). Large employers might do the same: they could simply offer no insurance and increase wages by the saved insurance cost less the offsetting penalty borne by the employer. That approach, while securing for the employer the benefit of being out of the health insurance business, would reduce the money an employee would be able to put toward obtaining health insurance (and offer less desirable tax treatment to high-income individuals).¹¹⁷ Large group employers would need to use

114. See Maher, *supra* note 85.

115. Cf. Monahan & Schwarcz, *supra* note 14.

116. Large group insurers need to provide to their employees coverage that is affordable and provides "minimum value." 26 U.S.C. § 4980H(a) (2012) (requiring "any applicable large employer" to provide "minimum essential coverage under an eligible employer-sponsored plan" to employees); *id.* § 36B(c)(2)(C) (clarifying that minimum essential coverage for employer-provided plan requires the coverage to be "affordable," meaning that the employee's contribution does not exceed 9.5% of her household income, and to provide "minimum value," meaning that the plan pay at least 60% of the costs of the covered benefits). *But see infra* note 118 and accompanying text (discussing flexibility of large employers).

The size of the penalty varies with circumstance and number of employees. 26 U.S.C. § 4980H. The penalty is a poor way to force employers to help pay for health insurance. Employers who drop coverage will need to raise wages or face a labor disadvantage. To the extent employers can drop coverage and not raise wages, that is a labor-wage problem, not a health insurance problem. It is not a health insurance problem because those who lose employer coverage can, under the ACA, purchase a policy on the exchange. That such a purchase is not tax-favored is also not a health insurance problem. It is a tax and subsidy problem. Cf. David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms Are Needed To Prevent Avoidable Costs for Low and Moderate Income Workers*, 65 TAX L. REV. 669, 672 (2012) (discussing problems arising from "the mismatch that the ACA will create between the tax subsidies available for employer-sponsored health insurance and those available for the health insurance purchased by individuals").

117. Small businesses with fewer than twenty-five full-time employees earning less than \$50,000 may be eligible for a tax subsidy regarding employer contributions to employer-provided insurance. See INTERNAL REVENUE SERV., DEP'T OF THE TREASURY, INSTRUCTIONS FOR FORM 8941 (Dec. 19, 2011). This tax credit will reduce the number of employees who will end up on the exchanges, depending on how many small employers set up their benefit arrangements to secure the tax

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a regulatory workaround (either one currently existing but not yet pursued or via regulatory adjustment) to give employees an option to use tax-protected dollars to purchase a policy on the exchange.¹¹⁸

States might push both groups in their direction in a variety of ways. They can hold public forums and send out information circulars to the public, to labor leaders, and to human resource and benefit decisionmakers at companies. They can include on their websites a section titled, “Have a job? Get coverage here!” They might coordinate with interested employers, and provide on the online exchange a default coverage option for those looking to spend HRA funds set up by employers.¹¹⁹ They can promote a “choose [name of State] insurance” option in online state materials published in connection with the exchange. States can even offer subsidies to encourage both small and large businesses to push employees onto the state ex-

credit. For many small employers, offering no coverage at all while raising wages will be a simpler solution than adjusting their affairs to take advantage of the tax credit.

118. One way to set this up is to couple a high-value HRA (equal to the total amount of employee and employer contributions that would have been spent on a group policy) with an extremely barren policy. Monahan & Schwarcz, *supra* note 14 at 148 (“To take an extreme example, a self-insured employer could implement a health plan that covers preventive services, the four coverages required by ERISA, routine patient care costs of individuals participating in clinical trials, *and nothing else.*”). In such a case, the affordability and minimum coverage requirements would be easily satisfied and no employer mandate penalty would be triggered. *Id.* at 158 (“An employer plan is unaffordable for this purpose only if the employee’s required contribution for coverage exceeds 9.5% of her annual household income, which the employer can easily control in setting employee premium contributions. And the term ‘minimum value’ refers not to the scope of benefits offered, but to a requirement that the plan pay at least sixty percent of the costs of the benefits that are covered by the plan.” (internal citations omitted)).

Because HRAs cannot be refunded to employees, *see* INTERNAL REVENUE SERV., *supra* note 106, offering coverage plus an HRA means the employer must provide *both* to any employee who chooses the barren policy. Presumably, however, the cost of a barren policy is modest and could be recouped by subtracting that expected cost from the aggregate monies the employer contributes to HRAs. Large employers—those who have over 200 employees—who must auto-enroll employees in group coverage, with an employee option to opt-out of group coverage, *see* Leonard, *supra* note 28 —would likely do the foregoing. While barren policies could have an adverse selection effect vis-à-vis who migrates to state markets—because the employees most likely to choose a barren policy are healthy employees—extremely barren policies are likely to capture few employees. An employer could combat this, moreover, by explaining to employees that the barren policy is being offered only for tax reasons, namely that the company can contribute X to HRA accounts without having to pay the mandate penalty and that virtually every employee is better off buying a policy on the exchange. *But see supra* note 107 (discussing the question of the HRA’s ERISA status).

119. *But see supra* note 107 (describing the uncertain status of HRAs used to purchase individual policies). Even then, a state’s choice of essential health benefits would apply to individual policies purchases.

changes. After all, state exchanges should offer lower prices the larger the participating population. Conversely, states can decline to take any of these measures. A state could, conceivably, adopt many of ERISA's legal rules as the state's legal rules (although, candidly, we would be astonished if that happened wholesale).

In sum, there are several paths through which a state's regulatory market could become enlarged because of the ACA. One—and by current estimates the far larger one—is the pickup of individuals who previously were in no market. The second is through migration from the employer market; most of the migrating employees would end up in the state market.¹²⁰ Current estimates are that roughly three to five million employees will lose employer coverage and end up on the individual market. Moreover, to the extent an HRA workaround exists or a similar workaround arises in the regulatory settling of the ACA's implementation, both large and small employers may have an option to put employees into the state market assured of at least a median value policy, while washing their hands of insurance selection and administration. That path would lead to something considerably more than the three to five million regulatory migrants currently predicted.¹²¹

D. Important Acknowledgments

To this point, we have focused our analysis on the degree to which prior discussion of the ACA paid insufficient heed to the regulatory context in which it arose. Doing so, we have argued, makes clear that there are important ways in which the legislation bolstered, or can be exploited to bolster, state power.

We must pause to consider a crucial objection to our version of the story: could not states have, *on their own*, chosen to adopt measures—mandates, exchanges, subsidies—that would have empowered them to recapture the giant share of the insurance regulatory market that had been lost to ERISA? If so, does the states' failure to do so represent an intentional choice to surrender, of their own choosing, the majority of the health insurance regulatory market? And is that not the most impor-

120. Without an individual mandate, they would likely end up in no market, or, if poor, as recipients of Medicaid. While this Article was in late stages of editing, some states have suggested that Medicaid recipients will be given vouchers to purchase individual insurance on exchanges. See, e.g., Robert Pear, *Expanding Medicaid with Private Insurance*, N.Y. TIMES, Mar. 21, 2013, at A14. While there is considerable uncertainty regarding how such proposed vouchers would work, there is reason to believe that such individual policies would be meaningfully governed by state law in a way akin to individual policies purchased by non-Medicaid consumers.

121. There is nothing inherently better in any material way—in policy terms—about employer-provided insurance, when compared to a guaranteed issue, community rated individual market. The possibility of lower administrative costs is outweighed by the benefits of employee choice and the reduction of agency costs associated with the selection and maintenance of employment based insurance. To the extent that (1) the revenue to the government would be the same, (2) the employer would contribute roughly the same amount of money toward the individual policy as it would toward a group policy, and (3) the employee would not be treated materially worse, there is no compelling reason why employers should not have the option of providing employees money to spend on the individual state exchanges.

tant idea behind federalism, that subnational agents should reserve power to act or not in the first instance?

We respond in parts. First, a concession: yes, in federalism terms, it would be much cleaner and more elegant had the states themselves either enacted reform that would open up state markets and revitalize state power (as we have claimed the ACA does) or, alternatively, squarely chosen not to do so. Reality is neither clean nor elegant, however, and there are many reasons why states chose not to consider legislative possibilities that are independent of an affirmation or rejection of the merits of those possibilities. Indeed, there may well have been states where the majority of the population was relieved that the health reform battle was fought out on a federal level, with the benefit being that their sovereigns could focus on other matters. After all, the federal battle exhausted the chief executive, the national legislature, the electorate, and the Supreme Court.

Our broadest response to the objection, however, is that the federalism-in-fact “grade” one is willing to give the ACA will depend on the adjudged weight of the infringements compared to the adjudged weight of the state enhancements. We have identified some reasons why the infringements are less weighty than they initially appeared, but we realize, of course, that some observers may feel differently. If one believes, for example, that the mandate infringement is, on a scale of 1 to 100, a 100, whereas the recapture by the states of regulatory insurance markets is a 2, then one will adjudge the federalism-in-fact quotient of the ACA to be very low. We suggest, however, that the sharp reaction against the mandate was based on liberty rather than federalism concerns.

Here’s why: well over 150 million people are covered by employment health insurance plans, which are mostly or totally governed by ERISA.¹²² In other words, the majority of those plans are self-insured and, thus, totally outside of state regulation; the rest are plans that are subject to only the state regulation that can survive preemption. Virtually no one, outside of a few law professors, complained about the titanic federal intrusion into a field historically dominated by the states.

In contrast, the reaction to the ACA was acute, in some cases hysterical, not because that level of federal regulation was unprecedented—it is hard to beat ERISA on that score—but because the federal involvement amounted to a direct restraint on liberty. Yes, there is a federalism version of this liberty argument—i.e., that states, being closer to their citizenry, would not have been so foolish as to impose such a constraint—but we are not persuaded the boil against the mandate would have significantly diminished if the mandates were state-imposed. We can make this point even more starkly. ERISA was an historic federal intrusion into insurance without a pure liberty constraint; ACA was an historic federal intrusion into insurance with a pure liberty constraint. The latter received vastly more criticism, even though it allows states to roll back the former.

Finally, even if one separates out the liberty objection and believes the magnitude of the mandate, essential health benefit, and exchange infringements are very high, then one must *still* acknowledge the work the ACA has done to revitalize state regulatory markets—work that we have explained here in detail for the first time.¹²³ Before considering a second objection, we pause to note an important point. We have talked about the ACA promoting growth in state regulatory markets, but we must distinguish that from the ACA promoting growth in state regulation. Al-

122. See *supra* notes 7, 24.

123. See *supra* Section III.C.

though we believe much affirmative regulation on insurance has merit, a state can be anti-regulation and still wish to grow its regulatory market. Imagine, for example, a state that was very successful at persuading private players to migrate into the state insurance market in the ways we have suggested. The regulatory market of the state will have increased. Does that mean the state will have to “fill” that market with “progressive” regulations? It does not. A state can wish to grow its regulatory market and then take a hands-off approach to regulation. Indeed, ERISA captured a market and then filled it with very little. We believe that some states will do that, while others may not. That is the beauty of federalism.

We now turn to a second objection leveled against our assessment of the ACA, namely, that the ACA is not really designed to empower the states in the ways we discuss. The objection goes something like this: the ACA envisions that most players will stay in the employment-based health insurance (and federal) market, and in fact makes it difficult for private parties, be they employers or individuals, to leave that federal market in favor of a state market.

There is merit to such criticism. Our claim in this Article is not that the ACA was written as a statute with the primary intent of permitting states to regain regulatory authority that was long-lost to the federal government. The primary aim of the ACA, with respect to health insurance, was to ensure that non-poor and non-elderly individuals could obtain private health insurance. The mechanisms the statute employs to do so, however, exist within a profoundly complicated regulatory maze—a maze that, as we have emphasized, may have more than one exit. And one exit leads to state regulatory markets. Of course, the path we have described by which state regulators could attract more people into their markets depends on interpretations of the ACA, ERISA, and the tax code—all complicated matters that may change or, alternatively, be too uncertain for state actors to exploit.

Statutes, particularly complicated ones, frequently have unintended (or only partially intended) consequences. Accordingly, we have attempted to demonstrate that the ACA—cobbed together furiously and resuscitated through the reconciliation process¹²⁴—may provide, in reality, an opening for state actors to exploit and reclaim their historic preeminence with respect to health insurance regulation. That point, and that possibility, has been almost entirely ignored during the ACA’s two-year run as the most polarizing topic of our national conversation.

CONCLUSION

It is one of the ironies of history that long before the term “Obamacare” was ever uttered as a term of disparagement, health insurance had been federalized by ERISA—a statute sponsored by a Republican Senator, signed by a Republican President, and largely interpreted by Justices appointed by Republicans. Given the baseline of ERISA, we conclude that, with respect to private health insurance, the ACA contains features that have the potential to promote state authority; state authority that, in the past, had been significantly neutered by ERISA and its regulatory consequences.

124. The election of Republican Senator Scott Brown deprived the Democrats of a 60-person “filibuster-proof” majority in the Senate; use of the reconciliation process was their political solution. See Vincent L. Frakes, *Partisanship and (Un)Compromise: A Study of the Patient Protection and Affordable Care Act*, 49 HARV. J. ON LEGIS. 135, 139-40 (2012).

HOW STATES CAN REGULATE HEALTH INSURANCE UNDER THE ACA

The ACA, in our view, represents a less static version of federalization than ERISA. In some important ways, it limits state prerogative. But in others it incorporates state preferences, grows state regulatory markets, and provides possibilities for state regulators to attract millions more to their spheres of influence. It is important that the federalism-in-fact reality is appropriately acknowledged, whether used for criticism, praise, or reform. At a minimum, future interpretations of the statute should be guided by a nuanced, accurate understanding of the ways in which the statute leaves room for state health insurance regulation, so that such state laws are not, for example, reflexively struck down as preempted.

More dramatically, however, the ACA's consequences may be more significant than originally imagined by the statute's supporters or critics. In our view, the pre-ACA world was about employment-based, federally regulated health insurance with no serious private alternative. ERISA's extensive and unusual preemption regime bolstered the natural advantage group markets have over individual markets. This natural advantage privileges, in terms of actual power to regulate health insurance, whichever sovereign regulates group markets. That natural advantage was compounded by the significant limits that ERISA put on state ability to meaningfully regulate private health insurance.

The post-ACA world offers employment-based, federally regulated insurance that faces competitive pressure from individual, but group-rated, health insurance that is regulated cooperatively between federal and state governments. There may be reason to welcome this competitive threat, rather than bemoan it. As has been recognized by scholars for decades, employment-based health insurance is an historical accident, and, but for the grouping function it serves, not an especially desirable way in which to deliver health insurance.¹²⁵ For years, however, it was difficult to see a politically viable alternative. The ACA, however imperfectly or unintentionally, has created one. And this alternative restores significant power to the states.

Policymakers and scholars may wish to recognize and build on that. To the extent the ACA as written serves as an uncertain obstacle to state recrudescence, there are fairly simple reforms that could solidify state power to compete for insureds, of which the simplest would be legislative: the federal government can simply treat all expenditures for the purchase of health insurance tax-neutrally¹²⁶ and only penalize employers who do not contribute above a certain amount to be used for that purpose. To us, it seems the federal government's decision not to do so was motivated by political concerns about preserving employment-based insurance rather than by a policy analysis regarding the appeal of allowing individuals to choose between receiving a policy from a guaranteed-issue federal market or receiving a policy from a guaranteed-issue state market.

Thus, whether through employer desire to get out of the business of health insurance, ambitious state action, legislative reform, or all three, the ultimate legacy of the ACA may be a movement away from an ossified system of employment-based insurance almost exclusively regulated by the federal government toward a more fluid system of state-inspired regulatory competition and coverage for all.

125. See, e.g., Jeffrey Ralph Pettit, *Help! We've Fallen and We Can't Get Up: The Problems Families Face Because of Employment-Based Health Insurance*, 46 VAND. L. REV. 779, 784 (1993) ("Health insurance became employment-based almost by accident.").

126. By tax-neutrally, we mean treated equivalently. We take no position on the appropriate level of preferential tax treatment.

