CHAPTER 3.3

THE ROLE OF FEDERAL GOVERNMENT IN INSURANCE REGULATION

CONTENTS

I. INTRODUCTION

In this Chapter, we explore the ebb and flow of the federal government's role in the regulation of insurance. We begin with a discussion of federal authority over traditional areas of insurance regulation, including responsibilities of the Federal Reserve as well as the role of the Federal Insurance Office (FIO) in coordinating insurance regulation on a global basis. We then explore three other areas of insurance where federal laws are dominant: social insurance, such as Social Security and Medicare; oversight of employer-sponsored fringe benefits plans under the Employee Retirement Income Security Act of 1974 (ERISA); and the Patient Protection and Affordable Care Act of 2010 (ACA).

II. FEDERAL ENGAGEMENT IN INSURANCE REGULATION

While it is commonly thought that insurance regulation in the United States is primarily the domain of state governments, the federal government also plays a significant role in certain areas. As discussed earlier, the McCarran-Ferguson Act

has long subjected certain aspects of the business of insurance to regulation under federal antitrust laws. Though beyond the scope of this book, the federal Internal Revenue Code also has a major impact on how insurance companies operate. In addition, there are a number of specific insurance markets, like flood insurance, where the federal government is a major player. Fiscal interventions in times of financial distress, such as the CARES Act and legislation enacted later in 2020, serve as a form of social insurance against unanticipated risks. This section reviews other ways in which the federal government plays a role in the regulation of insurance companies in traditional insurance markets.

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1. ***Federal Government Involvement and Uninsurable Risks.*** Private insurers are typically reluctant to insure low-probability but high-consequence catastrophic events. *See* Dwight M. Jaffee & Thomas Russell, *Catastrophe Insurance, Capital Markets, and Uninsurable Risks*, 64 J. RISK & INS. 205, 206 (1997). In these circumstances, government intervention is thought to be appropriate. In 2002, for instance, one year after the 9/11 terrorist attacks, the Terrorism Risk Insurance Act became law and created a shared public and private compensation system "for certain insured losses resulting from a certified act of terrorism." Insurance Information Institute, Background on Terrorism Risk and Insurance (Dec. 16, 2019). While the original law created a temporary system, the law has been reauthorized numerous times. The program creates a federal backstop to the private insurance market for terrorism claims. NAIC, Terrorism Risk Insurance Act (Dec. 15, 2020). Additionally, the federal government created an insurance program for nuclear accidents to compensate "members of the public for personal injury and property damage caused by a commercial nuclear power plant accident." U.S. NUCLEAR REGUL. COMM'N, BACKGROUNDER: NUCLEAR INSURANCE AND DISASTER RELIEF (Apr. 2019). Nuclear power plant owners are charged a premium paid into an insurance pool that covers the cost of accidents. This initial pool can be supplemented in the event of a nuclear accident from each member of the pool in a prorated amount. If these tiers of insurance are exhausted, Congress must determine if more disaster relief is necessary. The federal government also provides flood insurance through the National Flood Insurance Program managed by the Federal Emergency Management Agency. Flood insurance is required for homes and businesses in high-risk flood areas that have mortgages from government-backed lenders. Critics argue that the federal government's intervention into flood insurance functions as a subsidy for people living and working in coastal areas, partially because its rates are below what a private market would provide. Ike Brannon & Ari Blask, *The Government's Hidden Housing Subsidy for the Rich*, POLITICO (Aug. 8, 2017). When the National Flood Insurance Program attempted to bring its prices closer to market rate, Congress quickly passed legislation to end that effort after an outpouring of constituent complaints. *Id.* As of September 2018, the National Flood Insurance Program was $21 billion in debt to the Treasury. U.S. GOV'T ACCOUNTABILITY OFF., HIGH-RISK SERIES: SUBSTANTIAL EFFORTS NEEDED TO ACHIEVE GREATER PROGRESS ON HIGH-RISK AREAS 111 (Mar. 2019). All three of these programs present different methods of government intervention in markets for uninsurable risk. But how well is the

government doing in insuring uninsurable risk? At pricing insurance appropriately?

2. ***Climate Change and Insurance.*** In 2008, the NAIC released a report on the potential impact of climate change on insurance regulation. That report highlighted that climate change affects insurers through two routes: the increase in insurance claims due to climate change related natural disasters and the impact on the investments in real estate or certain sectors of the economy held by insurance companies that have exposure to the effects of climate change. NAIC, THE POTENTIAL IMPACT OF CLIMATE CHANGE ON INSURANCE REGULATION (2008). A growing chorus of consulting companies have written about the challenge of climate change to the insurance business and potential business opportunities available to those who respond well. *See* ANTONIO GRIMALDI ET AL., MCKINSEY & CO., CLIMATE CHANGE AND P&C INSURANCE: THE THREAT AND OPPORTUNITY (Nov. 19, 2020); DELOITTE CTR. FOR FIN. SERVS., CLIMATE RISK: REGULATORS SHARPEN THEIR FOCUS (2019). To tackle this challenge internationally, the Insurance Development Forum was announced at the Paris Climate summit in 2015 as a partnership between the United Nations, the World Bank, and the insurance sector. *See* INS. DEV. F., INSURANCE DEVELOPMENT FORUM ANNUAL REPORT (2020). "The core goals of the [Insurance Development Forum] are to leverage the technologies, expertise and financial mechanisms native to the insurance industry to enable the world's most disaster-vulnerable governments, economies and populations to enhance risk understanding and build resilience." *Id*. at 3. How effective do you think such a collaborative approach will be to the risks associated with climate change? Or is climate change the sort of uninsurable risk that requires government intervention?

A. THE FEDERAL RESERVE AND INSURANCE REGULATION

As will be discussed in greater detail in Part VI, the Federal Reserve has long had a role in policing affiliations between financial holding companies and insurance companies. The Dodd-Frank Act saw a significant addition to Federal Reserve powers in this area by granting it authority to supervise major insurance companies that the Financial Stability Oversight Council (FSOC) designated as systemically important. The following excerpt explores some of the implications of this expanded federal engagement and the future role of federal involvement in insurance regulation, starting first with an assessment as of 2015 and then touching upon later developments.

Justin Schardin, How FSOC Undermined, and the Fed May Save, U.S. Case for Insurance Regulatory Equivalence

Bipartisan Policy Ctr. (July 30, 2015)

In 2008, the [National Association of Insurance Commissioners (NAIC)] began its Solvency Modernization Initiative (SMI) to address group capitalization and supervision, among other issues. [In part, this effort was designed to satisfy EU requirements for substantially equivalent consolidated supervision of U.S. insurance companies doing business in Europe.] The NAIC has adopted model legislation to improve group supervision, including

the Insurance Holding Company System Model Act, which gives state regulators the authority to supervise insurance groups. The NAIC has argued that its "windows and walls" approach can effectively give regulators "windows" to look at group activity and the ability to "wall" off insurance capital from the rest of any non-insurance activities of a group....

The 2015 International Monetary Fund's (IMF) assessment of U.S. insurance regulation reported that states were making progress under SMI but that changes are "a work in progress" that still face obstacles. EU officials will need to determine whether progress by states so far will be enough to grant equivalence to the United States on group supervision. The [FIO] and the U.S. Trade Representative have the authority to negotiate a "covered agreement" with the EU on certain insurance matters, which may include group supervision.

FSOC Rebuts State Regulators

The context for these negotiations will likely be informed in part by the case FSOC has made against the ability of states to engage in adequate group supervision.

In its December 2014 designation of MetLife as a SIFI, FSOC explicitly said that the company "is currently not subject to consolidated supervision," and that state insurance regulators lack the authority to require insurance holding companies or other subsidiaries of holding companies to take or not take actions to preserve the safety and soundness of insurers or to avoid risks that would threaten U.S. financial stability. Further, FSOC said that state regulators' authorities, "have never been tested by the material financial distress of an insurance company of the size, scope, and complexity of MetLife's insurance subsidiaries."

FSOC's arguments, perhaps inadvertently, effectively undermine the NAIC's case that its "windows and walls" approach is sufficient. Since FSOC's designation represents the views of all U.S. federal financial regulators, this makes it more difficult for the U.S. government to argue on behalf of a temporary or permanent granting of equivalence.

Enter the [Federal Reserve]

Dodd-Frank gave FSOC the authority to designate nonbank financial companies as SIFIs and subject them to oversight by the [Federal Reserve]. Three of FSOC's four designations have been insurers: AIG, Prudential, and MetLife. In addition, Dodd-Frank gave the [Federal Reserve] oversight of savings and loan holding companies, which includes 14 holding companies that operate significant insurance companies. A major question remains: How much will the [Federal Reserve] exercise its new authority?

Last month, [Federal Reserve] Senior Advisor Thomas Sullivan, who has been identified as the [Federal Reserve's] point person on insurance matters, said at an Institute of International Finance conference that the agency sees its role as complementary to state oversight, not duplicative. He also said the [Federal Reserve] would focus on group supervision and financial stability rather than on the kind of supervision and regulation of individual insurers that states have been doing for decades. Indeed, the [Federal Reserve's] roughly 70 employees who work to one degree or another on insurance could not duplicate the supervisory and regulatory activities of about 12,000 employees of state insurance regulators and the NAIC.

Taken together, FSOC and the [Federal Reserve] are in effect saying that states are either unable or ill-suited to deal with supervision of insurance groups and the risks they might pose to U.S. financial stability, but that the [Federal Reserve] can and will fill these gaps. Since foreign regulators generally view the [Federal Reserve's] increased role in group supervision as a positive—the IMF's 2015 assessment said that the [Federal Reserve's] new group supervisory role "has strengthened supervision"—this amounts to an argument for

U.S. equivalence on group supervision. Ironically, if the EU accepts this line of argument, it would likely cement the new federal role in insurance oversight in the long run.

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1. ***Personnel and Supervisory Sufficiency.*** The Schardin excerpt conceives of the Federal Reserve as a supplemental supervisory authority for group supervision of major insurance companies, potentially sufficient to satisfy EU requirements of substantial equivalence. Does the allocation of personnel to this task—reportedly 70 individuals—raise questions as to whether sufficient resources were being dedicated to the task? The excerpt also discusses potential weaknesses in the states' ability to regulate large insurance companies, but points out that the regulation provided by the Federal Reserve could fill the void. Should it matter to EU officials that the Federal Reserve could end up relying on state-based capital rules and guaranty funds to police these groups?

2. ***The Declining Scope of Federal Reserve Jurisdiction.*** A major change since 2015 has been the removal of all insurance groups from FSOC designation as systemically important. *See* Chapters 3.1 and 6.3. None of the previously designated insurance groups control an FDIC-insured commercial bank, although two (AIG and Prudential) own federally chartered thrifts. *See* Zachary Tracer, *AIG to Close Down Savings Bank Due to Dodd-Frank Limits*, INS. J. (July 30, 2013). Beyond SIFIs, the Federal Reserve has jurisdiction under the Home Owners' Loan Act or the Bank Holding Company Act on the order of a dozen other insurance groups that have controlling interests in FDIC-insured thrifts and banks. As of 2018, the Federal Reserve's supervisory authority extended to less than a fifth of all insurance assets, and in March of 2018, a Subcommittee of the House Financial Services Committee held hearings on H.R. 5059, a bill that would dramatically restrain Federal Reserve authority over those firms. With such limited authority over the insurance sector, can the Federal Reserve plausibly remain a major player in international dialogs on insurance regulation?

B. COORDINATING CAPITAL REQUIREMENTS

Another possible venue for federal involvement in the development of insurance regulation has been the field of capital regulation for insurance companies and insurance groups. Since the 1990s, the NAIC has worked to develop a risk-based capital regime for the insurance sector. The regime focuses on three kinds of risk—asset risk, underwriting risk, and other risks—and establishes different formulas for different kinds of insurance companies. *See Risk-Based Capital*, NAIC (Dec. 12, 2017). The NAIC capital rules are built off of accounting and valuation standards peculiar to the insurance sector and impose fewer mark-to-market requirements than U.S. GAAP. While the NAIC risk-based capital standards are generally understood to be an improvement over earlier insurance capital rules in the United States, they are also often characterized as less sophisticated than the capital requirements for depository institutions that we studied in Part II and not well suited to be applied to financial conglomerates with a wide range of activities. *See* Elizabeth F. Brown & Robert W. Klein, *Insurance*

Solvency Regulation: A New World Order, in RESEARCH HANDBOOK ON THE ECONOMICS OF INSURANCE LAW (Daniel Schwarcz & Peter Siegelman eds., 2015).

Perceived weaknesses in the NAIC's risk-based capital rules have posed a challenge for the Federal Reserve as it has attempted to come to grips with its oversight of financial holding companies with insurance subsidiaries post-the Dodd-Frank Act. In its implementation of Basel III, the Federal Reserve staff struggled with the application of modern capital requirements to insurance groups because the Basel III rules were not designed to assess the risks of insurance companies. In one of the few legislative amendments to the Dodd-Frank Act that has made its way through Congress, the Insurance Capital Standard Clarifications Act of 2014 gave the Federal Reserve greater latitude in how to apply Basel III rules or modified capital requirements to insurance groups. *See* Douwe Miedema, *Fed Talks with Insurers Proceed on New Capital Rules*, REUTERS (June 16, 2015). In the following excerpt from a speech given shortly before the Fed floated an advanced notice of rulemaking, then Governor Daniel Tarullo of the Federal Reserve discussed different approaches to capital requirements for insurance companies under the Federal Reserve's jurisdiction.

Daniel K. Tarullo, Insurance Companies and the Role of the Federal Reserve

Speech at the NAIC International Insurance Forum (May 20, 2016)

The [Dodd-Frank Act] gave the Federal Reserve regulatory responsibilities both for insurance holding companies that own a federally insured bank or thrift and for insurance companies designated as systemically important by the [FSOC]. The insurance holding companies for which the Federal Reserve is the consolidated supervisor hold about $2 trillion in total assets, representing about one-quarter of U.S. insurance industry assets. These firms are highly diverse: they range in size from firms with total assets of approximately $3 billion to firms with total assets of over $700 billion.…

There are, as all of you know, a lot of ideas out there as to how we should construct the capital requirements we will apply to insurance companies. Some, such as variations on the Solvency II approach used in the [EU], strike us as unpromising. The valuation frameworks for insurance liabilities adopted in Solvency II differ starkly from U.S. GAAP and may introduce excessive volatility. Such an approach would also be inconsistent with our strong preference for building a predominantly standardized risk-based capital rule that enables comparisons across firms without excessive reliance on internal models. Finally, it appears that Solvency II could be quite pro-cyclical....

Another set of possibilities is raised by the work of the International Association of Insurance Supervisors (IAIS). As part of its effort to create a common framework for the supervision of internationally active insurance groups, the IAIS began work on a comprehensive insurance capital standard (ICS) in 2013, issued an initial consultative proposal on the ICS in late 2014, and will continue work on the ICS for at least the next few years. The ICS would be the first international, group-wide capital standard broadly applicable to internationally active insurance groups and would incorporate internationally compatible valuation principles, definitions of capital resources, and risk-based capital requirements for assets and insurance liabilities.

Progress in developing such a global capital standard for internationally active insurance firms has been slow. I will mention some of the difficulties that have been encountered. First, there is considerable heterogeneity among the insurance products offered in different jurisdictions. As one example, annuities and other savings and retirement products tend to be offered less frequently in countries with relatively expansive

government pension programs. In the context of developing capital requirements, a second factor has been jurisdictional variations in accounting and valuation standards on which global capital requirements for insurance companies can be built. A third factor has been significant disagreement on the extent to which capital standards for internationally active insurance companies should be built on internal models. These challenges and the protracted process they have occasioned have, as a practical matter, rendered the ICS insufficiently developed to be an option as the Federal Reserve moves forward with capital requirements applicable to the insurance companies we supervise….

These are some of the paths we do not intend to take in formulating capital requirements for insurance firms. The approach we do intend to follow will...put forward two different methodologies—one for the insurance firms that we supervise solely because they own a bank or thrift and the other for the firms designated as systemically important.

A. Insurance Companies Owning a Bank or Thrift: The Building Block Approach

The Federal Reserve has traditionally set capital requirements for holding companies on a consolidated basis. Among other things, a consolidated capital standard deters firms from moving assets around its affiliates in order to take advantage of lower requirements applied to different affiliates for particular assets. Insofar as publicly traded banking organizations are required by securities laws to file consolidated, U.S. GAAP-consistent financial statements, there is both a parallelism between accounting and capital regulation and a measure of economy in the compliance costs of a consolidated capital rule.

In contrast, most insurance firms subject to our regulation only because they own depository institutions do not produce consolidated financial statements. Furthermore, Congress has prohibited the Federal Reserve from requiring insurance firms that file only Statutory Accounting Principles (SAP) financial statements to produce U.S. GAAP consolidated financial statements. Given that these firms have not been designated systemically important and that the depository institutions they own tend to be relatively small parts of the total firm, the compliance costs of requiring a move to some non-U.S. GAAP form of consolidated approach may well not be worth the incremental safety and soundness benefits of doing so. Together, these considerations are leading us to what we refer to as the building block approach (BBA), which is likely the approach that we will put forth for comment in the ANPR for this group of firms....

B. Systemically Important Insurance Companies: The Consolidated Approach

By definition, the insurance companies designated by the FSOC are systemically important. For these firms, application of an aggregated approach like that of the BBA could pose significant risks to the Federal Reserve's statutory aims of safety and soundness and financial stability. The BBA, recall, would simply aggregate capital requirements that may not be founded upon financial stability considerations. A consolidated form of capital requirements is key to ensuring that risks to the financial system as a whole (as compared, say, to investor or policyholder protection) are accounted for.

For these firms, then, the ANPR is likely to seek comment on what we have internally been calling the consolidated approach (CA). Let me note at the outset that this is not the consolidated capital framework we apply to [BHCs]. As with our capital requirements for [BHCs], the CA would categorize all of the consolidated insurance group's assets and insurance liabilities into risk segments, apply risk factors to the amounts in each segment, and then set a minimum ratio of required capital comparing the consolidated capital requirements to the group's consolidated capital resources. However, the CA would use risk weights or risk factors that are more appropriate for the longer-term nature of most insurance liabilities....

1. ***EU Acquiescence.*** Former-Governor Tarullo's speech and the advanced notice of rulemaking that accompanied it were motivated in part by concerns that U.S. insurance companies would be disadvantaged in European markets if the country's capital requirements for insurance groups were not considered substantially equivalent to Solvency II. In June 2015, the EU announced that it was adopting a provisional equivalence decision for the United States with respect to its capital standards for insurance companies. *See* Commission Decision No. 2015/2290 (June 12, 2015) (accepting provisional equivalence of the solvency regimes in force in Australia, Bermuda, Brazil, Canada, Mexico, and the United States.) The EU ruling expressly referenced the NAIC's risk-based capital rules. This equivalency determination reduced pressure on the Federal Reserve to move ahead with more elaborate federal standards in this area and no further action has been taken in this area.

2. ***Regulation of Insurance Capital Under the Trump Administration.*** The Trump Administration from the start favored an approach to insurance capital regulation that built off the NAIC model: "The group capital initiatives by the NAIC, the states, and the Federal Reserve should be harmonized, to the extent possible, to mitigate duplication and unnecessary burdens for U.S. insurers. The [Treasury] Secretary will direct FIO to consult with the state insurance regulators, the NAIC, and the Federal Reserve on their respective group capital initiatives…." U.S. DEP'T OF THE TREASURY, A FINANCIAL SYSTEM THAT CREATES ECONOMIC OPPORTUNITIES: ASSET MANAGEMENT AND INSURANCE 100–01 (Oct. 2017). The Administration also proposed to "redefine[] the FIO's mission at the IAIS" to, among other things, "advocate for the U.S. state-based regulatory system." *Id.* at 136. With respect to the IAIS initiative regarding capital standards for insurance groups, the Treasury opined, "A core goal should be to ensure that the [IAIS capital] initiative accommodates the U.S. insurance business model and the existing state-based regulatory system." *Id.* at 102.

3. ***Federal Reserve Proposed Regulation on Insurance Capital Requirements.*** In the fall of 2019, the Federal Reserve provided a Notice of Proposed Rulemaking on Regulatory Capital Rules for Depository Institution Holding Companies that are significantly engaged in Insurance Activities, routinely referred to as Insurance Depository Institution Holding Companies (IDIHCs). 84 Fed. Reg. 57,240 (Oct. 24, 2019).

> The proposed capital framework, termed the "Building Block Approach" ("BBA"),...constructs "building blocks" of entities in the company group that are covered under the same capital framework. The BBA would generally apply the capital framework applicable to a building block to the subsidiaries in that block, such that subsidiaries within an insurance building block would be subject to state insurance risk-based capital requirements and depository institution building blocks would be subject to federal bank regulatory capital requirements. After identifying all the building blocks and their applicable capital frameworks, available capital and capital requirements would be determined for each building block, subject to

> proposed adjustments. Available capital and capital requirements would then be aggregated and translated by means of so-called "scalars" into the common capital framework for the BBA, which would be the Risk-Based Capital framework ("RBC") promulgated by the National Association of Insurance Commissioners ("NAIC"). The FRB proposes to use historical bank and insurer default data to construct an approach that uses probabilities of default to translate bank regulatory capital requirements into the common RBC capital framework, using scalars. The FRB published a white paper in conjunction with the Proposal explaining its proposed scaling framework and methodology. At the top-tier enterprise level, the ratio of the amount of available capital to the capital requirement amount, called the BBA ratio, would be subject to a proposed minimum of 250%. In addition, the FRB proposes to establish a "capital conservation buffer" to limit capital distributions and discretionary bonus payments of IDIHCs that do not hold sufficient capital to satisfy the buffer. The proposed capital conservation buffer is 235% and would be in addition to the amount necessary to meet the proposed 250% minimum BBA ratio, for a total requirement of at least 485%. The FRB does not propose to apply FRB-run stress tests to IDIHCs at this time.

Federal Reserve Proposes Regulatory Capital Framework for Insurance Depository Institution Holding Companies, SULLIVAN & CROMWELL (Oct. 10, 2019). Does it make sense for the Federal Reserve to back away from the approaches that former-Governor Tarullo had recommended for the large insurance companies because FSOC had removed their designation as systemically important?

5. ***NAIC Entry into Systemic Risk.*** As the federal government's involvement in the oversight of systemic risk in the insurance sector has started to wane, the NAIC has created a new Financial Stability Task Force, which in 2017 launched a Macro Prudential Initiative, focusing initially on liquidity, capital stress-testing, recovery/resolution, and counterparty risk, all topics that have been central to the Federal Reserve's post-Financial Crisis agenda. A goal of the initiative is to address some of the weakness in enterprise oversight at the state level, as discussed earlier. How optimistic should we be that the states will be able to fulfill this role successfully?

C. FEDERAL COORDINATION REGARDING REINSURANCE

The federal government—and most especially the FIO—has played an important role with respect to state oversight of the reinsurance sector. As we explored in our discussion of the *Hartford Fire* case in Chapter 3.2, reinsurance is essentially insurance for insurers. Reinsurance allows insurance companies to protect themselves against losses by contractually "ceding" risks to third-party reinsurers. The insurance provider who pays a premium in exchange for passing along risk is referred to as the "cedent." The mechanics of how much risk is ceded can vary significantly, but one common arrangement is for the reinsurer to bear all losses over a certain dollar threshold arising within a specified time period. For example, following a natural disaster, an insurance company would normally bear

all of its insured policyholder losses. If, however, a reinsurance contract had been purchased, liability might be capped at $10 million with additional losses falling on the reinsurer. When working properly, reinsurance has no effect on the underlying policyholder who pays the same premium and receives the same payout on a claim, regardless of which company ultimately bears the risk of loss.

Reinsurance is regulated similarly to primary insurance in that individual state insurance commissions play the dominant regulatory role. There are, however, a number of important differences between the sectors. Unlike in primary insurance, reinsurance agreements are business-to-business contracts between sophisticated parties with little need for consumer protection. Direct regulation of rates and forms is therefore absent from the sector; parties to a reinsurance agreement are free to set prices and write terms without regulatory approval. Another key difference is the centrality of credit for reinsurance rules, which are explored in the following section.

1. Credit for Reinsurance

Credit for reinsurance rules dictate to what extent a cedent may claim the benefit of a reinsurance contract. Under risk-based capital standards, insurance companies have minimum capital requirements that vary with the quality and quantity of their portfolio risk. Taking on more risk generally leads to higher capital requirements and vice versa. From the cedent's perspective, reinsurance reduces risk and therefore should lower the minimum capital requirement. Regulators, however, are hesitant to allow such reductions in minimum capital because there is no contractual privity between the policyholder and the reinsurer. If the reinsurer is unable to fulfill its reinsurance obligations, the cedent is still contractually bound to compensate policyholders for the entirety of their insured losses. The risk of the reinsurer becoming insolvent is therefore borne by the cedent. Under this arrangement, an insurance company that purchases reinsurance is swapping portfolio risk for credit risk. Credit for reinsurance rules are an attempt to balance cedents' desire to reduce capital with regulators' desire to maintain capital at levels which are robust to reinsurance credit risk. Some regulators feel that allowing insurance companies to reduce their capital in full proportion to risk ceded may leave those companies with too little capital to survive a reinsurer insolvency. As a result of this concern, most states have set credit for reinsurance rules that limit reductions in minimum capital when ceding risk to a reinsurance provider.

These credit-for-reinsurance rules are strongly determinative of reinsurance provider competitiveness. Given a selection of reinsurance providers, the prospective cedent will tend to choose among those whose business is eligible for full credit under local rules. Therefore, to be competitive, reinsurance providers must ensure they are in compliance with the credit for reinsurance rules of their customers' regulatory jurisdictions. Because of this business dynamic, foreign reinsurance providers doing business in the United States are indirectly subject to U.S. credit for reinsurance law, even though U.S. regulators have no direct authority over them. The law varies from state to state but foreign reinsurers are frequently required to post collateral in return for full recognition. The theory underlying collateral requirements is that foreign reinsurers are not subject to local solvency regulation, and therefore present greater credit risk. The risk of

nonpayment, which is borne by the cedent, is reduced to the extent that collateral is posted in advance.

Although collateral requirements reduce reinsurance credit risk, they impose additional costs that may be onerous on reinsurers. For example, credit for reinsurance rules that demand 100% collateralization would require assets worth 100% of the loss reserves ceded to be posted as collateral. Typically, this takes the form of a trust that the state regulator is entitled to take possession of in the event of reinsurer insolvency. In theory, collateral posting should have no balance sheet impact, since reinsurance providers would have to hold these loss reserves anyway. In practice, however, encumbering assets in a collateral trust limits investment possibilities and capital efficiency. As such, collateral requirements are generally understood to increase the cost of reinsurance.

The international response to disparate U.S. collateral requirements has been largely critical. Although capital requirements may be prudent for high credit-risk providers, foreign reinsurers are typically required to post collateral regardless of their credit risk. The Insurance Association of Japan, in a comment letter responding to an FIO report, characterized U.S. collateral requirements as discriminatory, protectionist measures that are inequitable given that U.S. reinsurers operate in Japan without any analogous requirement. GEN. INS. ASS'N OF JAPAN, GENERAL COMMENTS ON THE "PUBLIC INPUT ON THE REPORT TO CONGRESS ON THE U.S. AND GLOBAL REINSURANCE MARKETS" 1–3 (Aug. 20, 2012). Within the United States, the Reinsurance Association of America is a trade organization representing all reinsurers, both domestic and foreign, doing business in the country. On balance, the RAA believes that eliminating collateral requirements is beneficial in ensuring that the sector remains globally competitive and financially robust. REINSURANCE ASS'N OF AM., SOLICITATION FOR COMMENT: PUBLIC INPUT ON THE REPORT TO CONGRESS ON THE US AND GLOBAL REINSURANCE MARKET (Aug. 27, 2012). The RAA's opinion seems to reflect the trend toward reducing collateral requirements.

In addition to pressure from trade groups, credit for reinsurance reform was thought to be necessary to meet substituted compliance requirements abroad. For example, the EU's Solvency II program affords deferential regulatory treatment to foreign reinsurers operating in the EU once an equivalency determination is made as to the home state's regulatory regime. Before the signing of a bilateral agreement in 2017, there was some concern that the United States' disparate credit for reinsurance rules might threaten an equivalency determination for the United States, thereby subjecting U.S. reinsurers to additional regulation and competitive disadvantage in the EU.

While the need for nationwide credit for reinsurance reform is largely accepted, there remains political debate over the most effective way to achieve it. Although a legislative act at the federal level could have produced a timely and uniform solution, legislation would represent an incursion into a regulatory regime largely left to the states since *Paul v. Virginia* in 1869. Ever since its formation in 1871, NAIC has worked to coordinate state regulatory regimes and facilitate reform by publishing model laws. Indeed, NAIC published Model Law 785 in 2011 to lower collateral requirements in an effort to modernize credit for reinsurance rules. *See* CREDIT FOR REINSURANCE MODEL LAW § 2 (NAT'L ASS'N OF INS. COMM'RS 2011). Nevertheless, implementation has been plagued by slow and non-uniform

adoption by the states. As of May 2016, 32 states had adopted the new collateral requirements. *Covered Agreement*, NAT'L ASS'N OF INS. COMM'RS (Apr. 7, 2016). While NAIC maintained that the existing system was sufficient, federal efforts to push regulatory reform have continued.

2. Covered Agreements

Under the Dodd-Frank Act, the FIO has authority to assist the Treasury in negotiating international "covered agreements." The Act defines a covered agreement as a "written bilateral or multilateral agreement regarding prudential measures with respect to the business of insurance or reinsurance" that provides a level of protection for consumers that is "substantially equivalent to the level of protection achieved under state insurance regulation." 31 U.S.C. § 313. The FIO is further granted the authority to determine that any "state insurance measure" is preempted if it is "inconsistent with a covered agreement" and results in "less favorable treatment" of a non-U.S. firm domiciled in a country subject to the agreement. *Id*. Congressional approval is neither required nor provided for in the statutory process. Because of this broad preemption language, covered agreements present the possibility for federally imposed regulatory reform. NAIC published a statement on its website making clear its opposition to the possibility of covered agreements, which it sees as infringing on state authority. *See Covered Agreement*, NAT'L ASS'N OF INS. COMM'RS (Apr. 7, 2016).

Despite NAIC's opposition, a covered agreement on prudential measures regarding insurance and reinsurance was announced with the EU in January 2017 and formally adopted on September 22, 2017. Following a year of joint negotiations, the FIO and United States Trade Representative (USTR) reached a deal with the EU to push reform in three areas: group supervision, reinsurance, and exchange of information. With respect to Article 3 on reinsurance, the agreement would eliminate collateral requirements for qualifying EU reinsurers operating in the United States. The agreement gives the states five years to adopt reforms to remove collateral requirements, and the FIO will begin the process of making preemption decisions after 42 months. *See* BILATERAL AGREEMENT BETWEEN THE EUROPEAN UNION AND THE UNITED STATES OF AMERICA ON PRUDENTIAL MEASURES REGARDING INSURANCE AND REINSURANCE art. 3, Jan. 13, 2017. The U.S.-EU covered agreement represents a significant federal intrusion into insurance regulation. Similar to one of NAIC's model laws, the agreement lays out reforms and leaves it up to the states to adopt them. Unlike NAIC's model laws however, which can be modified or ignored by the states, the covered agreement is binding. If reform is not adopted pursuant to the covered agreement, the FIO can act to preempt conflicting state laws.

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1. ***Reactions to the Covered Agreement on Reinsurance.*** Reactions have unsurprisingly varied between the sector and state regulators. Three U.S. trade groups, the American Insurance Association (AIA), the American Council of Life Insurers (ACLI), and the Reinsurance Association of America (RAA), together representing the property/casualty, life, and reinsurance industries, have issued a joint statement in support of the covered agreement. *ACLI News Release: Industry*

Welcomes Conclusion of Covered Agreement Negotiations, AM. COUNCIL OF LIFE INSURERS (JAN. 13, 2017). In contrast, NAIC and the individual state insurance commissions have expressed skepticism that this deal adequately protects cedents and policyholders. At a hearing on the agreement held by the House Financial Services Subcommittee on Housing and Insurance, Mr. Ted Nickel, commissioner of insurance for the state of Wisconsin, expressed the view of state insurance regulators that by eliminating certain collateral requirements, the agreement fails to achieve the statutorily required level of protection for consumers, which must be "substantially equivalent to the level of protection achieved under state insurance regulation." *Assessing the U.S.-EU Covered Agreement: Hearing Before the Subcomm. On Hous. and Ins. of the House Comm. On Fin. Services*, 115th Cong. 2 (2017) (testimony of Ted Nickel). Are these consumer protection concerns valid? Although the EU is a significant market, many foreign reinsurers domiciled outside the EU remain subject to disparate state credit for reinsurance rules. The U.S.-EU agreement arguably opens the door for future covered agreements with other jurisdictions. Should these agreements be pursued?

2. ***Covered Agreements and Adjustments to State Law.*** In addition to reinsurance, the September 22, 2017 agreement with the EU also covered group supervision and the exchange of information between supervisory authorities. *See* U.S. Dep't of the Treasury, Statement of the United States on the Covered Agreement with the European Union (Sept. 22, 2017). In a statement accompanying ratification, the Treasury emphasized the extent to which the agreement was intended to preserve the primacy of state insurance regulation. *Id.* The Treasury has also noted the benefits of additional covered agreements, including one with the UK, should that jurisdiction exit the EU. U.S. DEP'T OF THE TREASURY, A FINANCIAL SYSTEM THAT CREATES ECONOMIC OPPORTUNITIES: ASSET MANAGEMENT AND INSURANCE 138–40 (Oct. 2017). Following the 2017 covered agreement with the EU, the United States in late 2018 entered into a substantially similar covered agreement with the UK, anticipating Brexit. ANNUAL REPORT ON THE INSURANCE INDUSTRY, FIO, at 78 (Sept. 2020) at 78. To prevent preemption under these agreements, states have to implement laws that conform to the covered agreements. *Id.* at 79. The NAIC has been working on updating its model legal texts related to reinsurance to conform. *Id.* at 80. According to NAIC, "11 states have passed laws based on the 2019 amendments to the NAIC Credit for Reinsurance Model Law, as of July 22, 2020." *Id.* at 82. *See NAIC Updates to Credit for Reinsurance Model Law and Relation*, NAIC (June 25, 2019). Seventeen states have legislation pending on the subject. FIO is required to evaluate the progress of states by March 2021 under the covered agreement's provisions relating to preemption. States must comply within five years of the signing of the covered agreement. Additionally, under the U.S.-EU Covered Agreement, "if U.S. insurance supervisors do not develop and implement a group capital assessment applicable to U.S. groups with EU insurance operations, EU regulators would not be barred from imposing Solvency II group capital requirements on such groups." ANNUAL REPORT, FIO, at 82 (2020). The NAIC formed the Group Capital Calculation Working Group that released draft amendments to incorporate Group Capital Calculation (GCC) into the NAIC model insurance law. The GCC would only apply to "U.S. insurance groups with insurance operations in jurisdictions subject to the current covered agreements with the United States." *Id.* at 44.

3. ***A Role for State Authorities on the International Stage.*** As the foregoing discussion suggests, the capacity of the federal government to influence insurance regulation through covered agreements and engagements with international bodies has been a source of tension. In financial reform legislation enacted in 2018, Congress included the following "finding":

> [T]o the extent that the Secretary of the Treasury, the Board of Governors of the Federal Reserve System, and the Director of the Federal Insurance Office take a position or reasonably intend to take a position with respect to an insurance proposal by a global insurance regulatory or supervisory forum, [they] shall achieve consensus positions with State insurance regulators through the [NAIC], when they are United States participants in negotiations on insurance issues before the [IAIS, FSB], or any other international forum of financial regulators or supervisors that considers such issues.

Is this a sensible accommodation of state interests or an intrusion into the authority of the federal government to conduct foreign affairs? Consider the following signing statement of President Trump:

> Today, I have signed into law S. 2155...Section 211(a) of the Act, though styled as a congressional finding, purports to direct my subordinates in the executive branch to take certain positions before international bodies and to "achieve consensus positions" with State insurance regulators in negotiations before such bodies. These directives contravene my exclusive constitutional authority to determine the time, scope, and objectives of international negotiations. My Administration will give careful and respectful consideration to the preferences expressed by the Congress in section 211(a) and will consult with State officials as appropriate, but will implement this section in a manner consistent with my constitutional authority to conduct foreign relations.

See Statement by President Donald J. Trump on S. 2155 (May 24, 2018). Is Section 211(a) unconstitutional?

III. NONTRADITIONAL AREAS OF FEDERAL DOMINANCE

A. SOCIAL INSURANCE: SOCIAL SECURITY AND MEDICARE

In 2002, Peter Fisher, then Under Secretary of the Treasury, characterized the financial posture of the United States as follows: "Think of the federal government as a gigantic insurance company (with a side line business in national defense and homeland security)." *See* Remarks of Under Secretary of the Treasury Peter R. Fisher to the Columbus Council on World Affairs, Beyond Borrowing: Meeting the Government's Financial Challenges in the 21st Century (Nov. 14, 2002). Fisher's characterization is apt. The federal government operates the country's two most substantial insurance programs: Social Security, which offers a retirement income program, as well as disability and limited life insurance

coverage, for most Americans, and Medicare, which provides retirement health benefits for most Americans over 65 years of age, as well as some segments of the disabled community.

The role of these two programs cannot be overstated. A third of Americans 65 years of age or older rely solely on Social Security for at least 90% of their retirement income. In the same age bracket, 61% of individuals rely on such benefits for half or more of their income. *See* INCOME OF THE POPULATION 55 OR OLDER, 2014, Table 9.A1, SSA 287 (2016). Put another way, "[w]ithout Social Security benefits, 44.4 percent of elderly Americans would have incomes below the official poverty line, all else being equal; with Social Security benefits, only 9.1 percent do." Paul N. Van de Water et al., *Social Security Keeps 22 Million Americans Out of Poverty: A State-by-State Analysis*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 25, 2013). As structured, Social Security is funded primarily through payroll taxes, supplemented by interest paid on government securities held in the Social Security trust funds as well as a limited allocation of income tax revenues.

Medicare is similarly important to both eligible disabled and the elderly, as one of the principal sources of health insurance for those populations. Medicare covered more than 62 million Americans as of 2020. *See Medical Enrollment Dashboard,* CTR. FOR MEDICARE & MEDICAID SERVS. (2020). In terms of total health care expenses, Medicare accounted for $750.2 billion in health expenditures in 2018, or 20.6% of total health expenditures countrywide. *See National Health Expenditure Fact Sheet*, Table 03 National Health Expenditures, by Source of Funds, CTR. FOR MEDICARE & MEDICAID SERVS. (2019). Medicare coverage is available to those reaching 65, regardless of their health condition or wealth, provided they meet employment eligibility requirements. Medicare is funded through a combination of payroll taxes, general revenue funds, and income-based premiums paid by retirees.

Medicaid is another important government health insurance program that provides health care for low-income families and individuals. In 2018, Medicaid paid for $597.4 billion in health care expenditures, the equivalent of 16.4% of national health expenditures. *Id.* Unlike Medicare, Medicaid is jointly funded by federal and state governments but is administered solely by the state governments, which have leeway to determine eligibility. Though federal law does not mandate that states participate in Medicaid, all states do, at least to some extent. Adding together Medicare, Medicaid, and other federal health insurance programs, such as the Children's Health Insurance Programs and Veterans Administration benefits, the federal government's health insurance programs cover over 40% of national health care expenditures. *Id.*

Most public discussions of the financial aspects of federal social insurance focus on cash flows in and out of federal trust funds, highlighting the date on which those trust funds will be depleted. According to the 2019 Annual Report of the Social Security Trust Funds, the funds will be depleted in 2035. It is, however, also possible to estimate the current value of the federal government's implicit liabilities to pay Social Security and Medicare benefits to current workers and retirees. *See* Howell E. Jackson, *Counting the Ways*, *in* FISCAL CHALLENGES: AN INTERDISCIPLINARY APPROACH TO BUDGET POLICY 185, 206–09 (Elizabeth Garrett et al. eds., 2008). As of year-end 2019, the implicit liabilities of the federal

government to current workers and current retirees for Social Security are estimated to equal $37.6 trillion and the comparable figure for Medicare is an additional $42.7 trillion, for a total of $80.3 trillion. *See* DEP'T OF THE TREASURY, FINANCIAL REPORT OF THE U.S. GOVERNMENT: FISCAL YEAR 2019 61–62 (2020). These financial obligations dwarf the kinds of numbers discussed elsewhere in this book, and even exceed by more than four times the $16.9 trillion of federal debt outstanding to public holders as of year-end 2019.

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1. ***Are the Government's Implicit Obligations the Equivalent of Wealth?*** In a 2015 op-ed, Professor Martin Feldstein, Chair of the Council of Economic Advisers under President Ronald Reagan, drew on similar estimates to make a different point. Responding to a number of studies decrying the growth of wealth inequality in the United States, Feldstein argued that these studies fail to include the actuarial value of future benefits of social insurance programs such as Social Security and Medicare. By omitting this Social Security and Medicare wealth, Feldstein asserted, claims of growing inequality are overstated. Specifically, Feldstein noted that, for the bottom 90% of households, the addition of social insurance wealth would increase the net worth of those cohorts by approximately $75 trillion and substantially diminish other estimates of the growth in wealth inequality in the United States. *See* Martin Feldstein, *The Uncounted Trillions in the Inequality Debate: Wealth isn't so highly concentrated if you take into account Medicare and Social Security benefits*, WALL ST. J. (Dec. 13, 2015). Is Feldstein correct? Should this view of social insurance as future assets make us less concerned about the distribution, and inequality, of wealth across the country? Does it matter that Congress has reserved the right to adjust benefit levels under federal social insurance programs? *See Fleming v. Nestor*, 363 U.S. 603 (1960). Is it relevant that the political barriers to cutting back federal entitlements, especially for Social Security, are formidable, nigh unto insurmountable?

While today's political discourse proceeds on the assumption that Social Security and Medicare are uncontroversial functions of the federal government, that was not the case when these programs were established. In the 1930s when the Social Security Act was initially enacted, *Paul v. Virginia* was still good law and so the business of insurance was understood to be outside of Congress's power under the Commerce Clause. *See* Chapter 3.1. As a result, in the early years of the New Deal, although Congress did not have the authority to promulgate Social Security under the Commerce Clause, Congress justified the Social Security Act under its Article I powers. The legal basis of the Social Security Act was nevertheless challenged in a series of cases decided ultimately by the Supreme Court.

The first case, *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937), considered Title IX of the Social Security Act, which imposed a payroll tax on employers with eight or more employees. Steward Machine asserted that these taxes unconstitutionally coerced states and were beyond Congress's enumerated powers under Article I of the U.S. Constitution. In rejecting these claims, the Court

reasoned that the Act's tax was insufficiently coercive and was sufficiently related to the general welfare of the American people to fall within Congress's Article I powers. *Id.* at 588–93.

Decided on the same day as *Steward Machine*, the next case adjudicating the Social Security Act's constitutionality was *Helvering v. Davis*, 301 U.S. 619 (1937). In addition to challenging other aspects of Social Security's tax titles, the plaintiff in *Helvering,* Edison Electric Illuminating Company, known as Consolidated Edison, or ConEd, challenged the authority of Congress to create an account in the Treasury from which social security benefits were to be paid. Similar to the challenges presented in *Stewart Machine*, Edison Electric claimed that the provisions interfered with states' rights and were beyond Congress's enumerated powers. The following is an excerpt from the Court's decision in *Helvering*.

Helvering v. Davis

301 U.S. 619 (1937)

Cardozo, J.

[Congress] may spend money in aid of the 'general welfare.'… The line must still be drawn between one welfare and another, between particular and general. Where this shall be placed cannot be known through a formula in advance of the event. There is a middle ground or certainly a penumbra in which discretion is at large. The discretion, however, is not confided to the courts. The discretion belongs to Congress, unless the choice is clearly wrong, a display of arbitrary power, not an exercise of judgment. This is now familiar law.…

The problem [of poverty among the elderly] is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. Congress, at least, had a basis for that belief. States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged. This is brought out with a wealth of illustration in recent studies of the problem. Apart from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors. We have seen this in our study of the problem of unemployment compensation.… A system of old age pensions has special dangers of its own if put in force in one state and rejected in another. The existence of such a system is a bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose. Only a power that is national can serve the interests of all.

Congress did not improvise a judgment when it found that the award of old age benefits would be conducive to the general welfare.… A great mass of evidence was brought together supporting the policy which finds expression in the act. Among the relevant facts are these: The number of persons in the United States 65 years of age or over is increasing proportionately as well as absolutely. What is even more important the number of such persons unable to take care of themselves is growing at a threatening pace....In times of retrenchment the older are commonly the first to go, and even if retained, their wages are likely to be lowered. The plight of men and women at so low an age as 40 is hard, almost hopeless, when they are driven to seek for reemployment.… With the loss of savings inevitable in periods of idleness, the fate of workers over 65, when thrown out of work, is little less than desperate. A recent study of the Social Security Board informs us that 'one-fifth of the aged in the United States were receiving old-age assistance, emergency relief, institutional care, employment under the works program, or some other form of aid from public or private funds; two-fifths to one-half were dependent on friends and relatives, one-eighth had some income from earnings; and possibly one-sixth had some savings or

property. Approximately three out of four persons 65 or over were probably dependent wholly or partially on others for support.'... [O]ther studies by state and national commissions...point the same way….

When money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by Congress, not the states. So the concept be not arbitrary, the locality must yield.

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1. ***Foreshadowing Challenges to the ACA.*** From the perspective of the 21st Century, one of the striking features of the legal challenges to Social Security that dates back to the 1930s is the eerily familiar uncertainty over congressional authority to adopt the Social Security Act. Rather than justifying the Act as a whole, combining its tax provisions with its benefit formulae, the New Deal attorneys asserted separate sources of congressional authority for the various titles of the Act and were successful in persuading the Supreme Court to accept the legislation on those grounds. Flash forward nearly eight decades and government attorneys continue to attempt, albeit unsuccessfully, to defend individual mandate provisions of the ACA as a legitimate exercise of congressional power under the Commerce Clause, but then fall back on a defense of the legislation's key provision, the individual mandate, as also defensible under Congress's taxing powers. *See NFIB v. Sebelius*, 132 S. Ct. 2566 (2012), which is excerpted later in this Chapter. Why does Congress have so much trouble getting courts to accept its authority to adopt legislation affecting social insurance and so much latitude in regulating banking and securities?

2. ***Separate Sources of Constitutional Authority but a Unified Political Vision.*** While judicial acceptance of the Social Security Act proceeded title by title, the political support for the program has always been based on a unified view of the program. This public understanding is something that President Franklin D. Roosevelt foresaw. Consider the following account by Mr. Luther Gluck, an expert on public administration who met with President Roosevelt in the summer of 1941 to discuss the ongoing study of fiscal matters:

> In the course of this discussion I raised the question of the ultimate abandonment the [Social Security] payroll taxes in connection with old age security...in the event of another period of depression. I suggested that it had been a mistake to levy these taxes in the 1930's when the social security program was originally adopted. [Roosevelt] said, "I guess you're right on the economics. They are politics all the way through. We put those payroll contributions there so as to give the contributors a legal, moral, and political right to collect their pensions.... With those taxes in there, no damn politician can ever scrap my social security program. Those taxes aren't a matter of economics, they're straight politics."

Larry DeWitt, *Research Note #23: Luther Gulick Memorandum re: Famous FDR Quote*, SSA HISTORIAN'S OFF. (July 21, 2005). Was Roosevelt right?

B. THE POLICIES UNDERLYING SOCIAL INSURANCE

The following excerpt from a chapter by Professor James Kwak explores the many different policies underlying our chief social insurance programs.

James Kwak, 'Social Insurance,' Risk Spreading, and Redistribution

in Research Handbook on the Economics of Insurance Law
(Daniel Schwarcz & Peter Siegelman ed., 2015)

The core function of any insurance program is spreading risk among a pool of participants. In theory, insurance works because human beings are risk averse. If premiums are set equal to expected losses, risk-averse purchasers benefit (in utility terms) and sellers break even; even if premiums include transaction costs and a return on the capital invested in insurers, purchasers will often be made better off because of risk aversion. A private product or a government program provides insurance to the extent that it spreads the risk of uncertain future events across the people who face that risk. It is also insurance to the extent that it allows a participant to shift her resources among different future states of the world (that is, from states in which a loss does not occur to states in which it does occur).

Insurance necessarily involves redistribution in the relatively trivial sense that, seen retrospectively, cash is transferred from people who do not suffer losses to those who do. At the time people purchase insurance, however, this is not redistribution, assuming that each individual pays for her expected losses in the form of premiums. In practice, insurance also redistributes resources in another, more substantive sense. Among any group of insureds, even those whom the insurer identifies as equivalent risks, some will have a higher than average risk of loss and others will have a lower than average risk. The fact that they pay the same premiums means that, *ex ante*, there is redistribution from low-risk participants to high-risk participants…. One objective of insurance underwriting is to identify and price degrees of risk accurately in order to avoid undercharging high-risk people and overcharging low-risk people....

In unregulated private markets, some people will buy insurance and others will not. People decline to buy insurance for several reasons. The best reason is that they simply do not need it: even risk-averse people are effectively risk-neutral with respect to small changes in wealth and thus should not insure themselves against small losses….But there are many other, more worrisome reasons for underinsurance. Insurers may not offer needed insurance because of some market failure. Individuals may underestimate their own risk of loss. They may recognize the risk they face, but may not be aware that insurance exists. They may not be able to find insurance at a fair price—one that only moderately exceeds their expected losses. Or, even given a fair price, they may not be able to afford it. As a result, people face significant risks against which they have no protection. The programs generally thought of as social insurance attempt to make insurance available to these people for one or more reasons of public policy….

Social Security, Medicare, and unemployment insurance, which in the United States are typically thought of as canonical examples of social insurance. These programs typically use one or more mechanisms to provide insurance that is considered socially beneficial but that, in the opinion of policymakers, would not be sufficiently provided or purchased in a purely private market….

First, compulsory participation is a requirement that a program cover all people in a certain class. In the United States, Medicare Part A (hospital insurance) and unemployment insurance are mandatory for virtually all workers, as is Social Security with a few narrow exceptions. This means that contributions must be paid by or on behalf of workers, who thereby gain a right to benefits. Compulsory participation overcomes potential adverse selection problems because low-risk individuals cannot opt out of insurance, which would

drive up premiums for everyone else. Not all programs commonly thought of as social insurance are mandatory, however; Medicare Parts B (medical insurance)...[is] not paid for by or on behalf of workers until they become beneficiaries, and participation is voluntary.

Second, government insurance programs often place constraints on underwriting, which limit the ability of insurers to decide whom they want to insure and at what price. In a theoretical free market, insurers can use any factors to differentiate between high-risk and low-risk insureds. With social insurance—especially if it is compulsory—some limits on risk underwriting may be necessary either to make insurance affordable to everyone or because of fairness concerns. Medicare does not differentiate among participants according to their health status, either during their working years or when collecting benefits; if it did charge premiums based on existing medical conditions, many people would probably not be able to afford [coverage]….

Third, government programs often incorporate explicit subsidies either from 'outside' or from within the pool of insureds. These subsidies are in addition to the implicit subsidy created by underwriting constraints. For example, the lack of medical underwriting in Medicare Part B is an implicit subsidy from healthy people to people with chronic illnesses that helps reduce the cost of insurance for the latter. That is not enough to make Medicare Part B affordable, however: if every beneficiary were charged the average expected losses for the entire pool, Part B would likely be too expensive for most, largely because the elderly incur high health care costs on average. Therefore, approximately 75 percent of the costs of Part B are an explicit subsidy paid out of general revenues collected from income and other taxes.

Social Security, too, provides explicit subsidies from within the pool of participants. The program's founders recognized that some degree of redistribution was necessary to provide meaningful insurance to all. Social Security accomplishes this goal by using a progressive benefit formula: low earners receive a higher percentage of their contributions as benefits than do high earners. This formula compensates for the fact that high earners make higher contributions while working. On balance, the program transfers income from high earners to low earners, at least on an expected basis....

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1. ***Private Insurance versus Social Insurance.*** Many of the problems in private insurance markets that Kwak identifies are issues that we explored in Chapter 3.2. How were those problems addressed in the areas of insurance that we addressed in that chapter? Should social insurance programs be extended into other areas? What is the appropriate domain of social insurance as opposed to private insurance markets?

2. ***Social Insurance versus Means-Tested Programs.*** As the preceding excerpt explores, the major social insurance programs in the United States include a certain element of redistribution in addition to risk sharing. As Kwak explains elsewhere, "some progressives...object to the insurance features of these programs, which sometimes mandate that high-income participants receive benefits that they seem not to need. These critics prefer means-tested public assistance to social insurance because it more effectively transfers resources to those who need them most." Do you agree? When might means-tested assistance be preferable to social insurance?

C. ERISA AND EMPLOYEE BENEFIT PLANS

ERISA, as amended, is another important piece of federal legislation that has a major influence on financial functions that would traditionally have been the subject of insurance regulation at the state level. Though initially motivated over concerns about the solvency of old-fashioned defined benefit pension plans, ERISA also extends to defined contribution pension plans, like 401(k)s, and employer-sponsored plans providing "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training services, or day care centers, scholarship funds, or prepaid legal services." 29 U.S.C. § 1002(1)(A). Therefore, whenever a private employer offers a fringe benefit that insures employees against risks, ERISA's regulatory requirements potentially come into play. In many instances, those requirements supersede otherwise applicable state insurance laws.

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1. ***Regulatory Perimeters and ERISA: Emergency Savings Accounts.*** As the Pandemic has highlighted, many Americans lack adequate savings. One solution that has been proposed to combat this issue has been emergency savings accounts provided by employers. *Our Work: Emergency Savings*, Commonwealth (Nov. 13, 2020). These accounts would be funded with a portion of an employee's paycheck in much the same way 401(k) plans are funded. One potential problem for this proposal would be falling inside the ERISA regulatory perimeter. ERISA applies to any "employee benefit plan," 29 U.S.C. § 1003, which means either an "employee welfare benefit plan" or "employee pension benefit plan," 29 U.S.C. § 1002. Those terms have broad meanings. "Employee welfare benefit plan" means any plan "maintained for the purpose of providing for its participants...medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment." 29 U.S.C. § 1002(1). An "employee pension benefit plan" is any plan that either "provides retirement income to employees" or "results in a deferral of income by employees for periods extending to the termination of covered employment or beyond." 29 U.S.C. § 1002(2). While emergency savings accounts do not clearly fall under either definition, they do not clearly fall outside of them either. Nevertheless, this legal uncertainty was clarified by regulation. 29 CFR § 2510.3-1(a)(2) provides that "a system of payroll deductions by an employer for deposit in savings accounts owned by its employees is not an employee welfare benefit plan" and that "if each employee has the right to withdraw the balance in his or her account at any time, such a payroll savings plan does not meet the requirements for a pension plan."

2. ***ERISA's Substantive Coverage: Retirement Plans and Employer-Provided Health Care Plans.*** ERISA's substantive requirements are generally beyond the scope of this book. For an excellent introduction to the subject, see JOHN H. LANGBEIN, DAVID A. PRATT & SUSAN J. STABILE, PENSION AND EMPLOYEE BENEFIT LAW (6th ed. 2015). The basic structure of these requirements will, however, be familiar to students acquainted with other forms of financial institution regulation. For example, ERISA plans must file periodic financial reports with the federal agencies charged with enforcing the statute, the

Department of Labor, the Internal Revenue Service, and, for some plans, the Pension Benefit Guaranty Corporation (PBGC). Plan participants must also receive summary plan descriptions on a regular basis. Financial resources committed to ERISA plans must generally be held in trust, and federal fiduciary standards govern the management of these assets, requiring, among other things, that the resources be prudently invested and used for the exclusive benefit of plan participants and beneficiaries. In addition, ERISA imposes strict prohibited transaction rules designed to prevent plan fiduciaries and sponsors from doing business with affiliated ERISA plans. For retirement plans governed by ERISA, an additional layer of rules applies, which is discussed in greater detail in Chapter 10.4 dealing with retirement savings. Another area where ERISA's coverage has been important is that of employer-provided health insurance. According to the Kaiser Family Foundation's 2020 Employer Health Benefits Survey, released in October 2020, "Employer-sponsored insurance covers approximately 157 million people" or nearly half of the non-elderly population. Several of the cases discussed below deal with this aspect of ERISA.

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1. ERISA's Preemption Provision

In terms of the structure of financial regulation in the United States, one of the most interesting aspects of ERISA is its relationship to state insurance law. That relationship is defined by § 514 of ERISA, which states in relevant part that:

> (a) Except as provided in subsection (b) of this section, the provisions of [ERISA] supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan....
>
> (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.
>
> (B) Neither an employee benefit plan...nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

ERISA's preemption provision is essentially the inverse of the McCarran-Ferguson Act. Rather than establishing a presumption of state authority, ERISA expressly trumps state law. The scope of the preemption is also unusually broad, displacing not just conflicting state rules but all state laws that relate to employee benefit plans. The preemption provision does, however, have limits. Section 514(b)(2)(A), known as the "savings clause," carves out an exception for state insurance, banking, and securities regulation. The savings clause is limited by § 514(b)(2)(B), the "deemer clause," which stipulates that ERISA plans shall not be deemed to be financial institutions for purposes of state regulation.

A combination of reasons explains ERISA's strong bias for federal law in the field of employee benefit plans. In part, the Congress that enacted ERISA was concerned that large national corporations could be burdened by conflicting and opportunistic local regulations if the states retained concurrent jurisdiction over ERISA plans. In part, too, the premise of ERISA was that the statute would establish a regulatory framework in which employers and employees would have considerable freedom to bargain over appropriate fringe benefit packages. While ERISA thus sets various parameters on fringe benefits, much is left to private negotiation. The mandatory nature of state insurance and other local rules, it was thought, might conflict with this contractual model, see Daniel M. Fox & Daniel Schaffer, *Semi-Preemption in ERISA*, 7 AM. J. TAX POL'Y 47 (1988), and so a strong preemption provision was added to the final version of the statute. In addition, the political climate at the time of ERISA's enactment during the summer of 1974 was a high-water mark for national and congressional power in the United States. In this environment, it seemed entirely reasonable to make federal authority exclusive.

Whatever policies underlay its enactment, the ERISA preemption provision has been one of the most litigated sections of the United States Code. Since 1974, the Supreme Court has decided more than a dozen cases interpreting this provision. The following decision gives a flavor of the kinds of disputes that have arisen in this area. Is there a better way to divide jurisdiction between federal and state authorities in this field?

FMC Corp. v. Holliday

498 U.S. 52 (1990)

Justice O'CONNOR delivered the opinion of the Court.

This case calls upon the Court to decide whether [ERISA] pre-empts a Pennsylvania law precluding employee welfare benefit plans from exercising subrogation rights on a claimant's tort recovery….

Petitioner, FMC Corporation (FMC), operates the FMC Salaried Health Care Plan (Plan), an employee welfare benefit plan within the meaning of ERISA, § 3(1), that provides health benefits to FMC employees and their dependents. The Plan is self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants. Among its provisions is a subrogation clause under which a Plan member agrees to reimburse the Plan for benefits paid if the member recovers on a claim in a liability action against a third party.

Respondent, Cynthia Ann Holliday, is the daughter of FMC employee and Plan member Gerald Holliday. In 1987, she was seriously injured in an automobile accident. The Plan paid a portion of her medical expenses. Gerald Holliday brought a negligence action on behalf of his daughter in Pennsylvania state court against the driver of the automobile in which she was injured. The parties settled the claim. While the action was pending, FMC notified the Hollidays that it would seek reimbursement for the amounts it had paid for respondent's medical expenses. The Hollidays replied that they would not reimburse the Plan, asserting that § 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa.Cons.Stat. § 1720 (1987), precludes subrogation by FMC. Section 1720 states that "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to...benefits...payable under section 1719." Section 1719 refers to benefit payments by "[a]ny program, group contract or other arrangement."…

We indicated in Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), that the [ERISA preemption] provisions "are not a model of legislative drafting." Id., at 739. Their operation is nevertheless discernible. The pre-emption clause is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulat[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts….

Pennsylvania's antisubrogation law "relate[s] to" an employee benefit plan. We made clear in Shaw v. Delta Air Lines, [463 U.S. 85, 95 (1983)] that a law relates to an employee welfare plan if it has "a connection with or reference to such a plan." Id., 463 U.S., at 96–97 (footnote omitted). We based our reading in part on the plain language of the statute. Congress used the words "'relate to' in § 514(a) [the pre-emption clause] in their broad sense." Id., at 98. It did not mean to pre-empt only state laws specifically designed to affect employee benefit plans. That interpretation would have made it unnecessary for Congress to enact ERISA § 514(b)(4), which exempts from pre-emption "generally" applicable criminal laws of a State. We also emphasized that to interpret the pre-emption clause to apply only to state laws dealing with the subject matters covered by ERISA, such as reporting, disclosure, and fiduciary duties, would be incompatible with the provision's legislative history because the House and Senate versions of the bill that became ERISA contained limited pre-emption clauses, applicable only to state laws relating to specific subjects covered by ERISA. These were rejected in favor of the present language in the Act, "indicat[ing] that the section's pre-emptive scope was as broad as its language." Shaw v. Delta Air Lines, 463 U.S., at 98.

Pennsylvania's antisubrogation law has a "reference" to benefit plans governed by ERISA. The statute states that "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to...benefits...paid or payable under section 1719." 75 Pa.Cons.Stat. § 1720 (1987). Section 1719 refers to "[a]ny program, group contract or other arrangement for payment of benefits." These terms "includ[e], but [are] not limited to, benefits payable by a hospital plan corporation or a professional health service corporation." § 1719.

The Pennsylvania statute also has a "connection" to ERISA benefit plans. In the past, we have not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations. *See*, *e.g.*, Shaw v. Delta Air Lines, supra, at 95–100 (state laws making unlawful plan provisions that discriminate on the basis of pregnancy and requiring plans to provide specific benefits "relate to" benefit plans).... Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide....

There is no dispute that the Pennsylvania law falls within ERISA's insurance saving clause, which provides, "[e]xcept as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance," § 514(b)(2)(A). Section 1720 directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S., at 740–741. It does not merely have an impact on the insurance industry; it is aimed at it. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987). This returns the matter of subrogation to state law. Unless the

statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore, it is not pre-empted.

We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer...or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.…Our interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it.…

Justice STEVENS, dissenting.

The Court's construction of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans).…From the standpoint of the beneficiaries of ERISA plans—who after all are the primary beneficiaries of the entire statutory program—there is no apparent reason for treating self-insured plans differently from insured plans. Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation. The Court's anomalous result would be avoided by a correct and narrower reading of either the basic pre-emption clause or the deemer clause.

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1. ***The Advantages of Self-Insured Plans.*** Opinions such as the *FMC* decision confirmed the advantages of self-insured plans for employers, and over the past few years, self-insured plans have become increasingly prevalent in the United States. While only six million Americans were covered through self-insured plans when ERISA was enacted in 1974, some 55 million people and 40% of all group coverage was through self-insured plans by the late 1980s. *See* Gail A. Jensen & Kevin D. Cotter, *State Insurance Regulation and the Decision to Self-Insure*, 62 J. RISK & INS. 185 (1995). To qualify as self-insured for purposes of ERISA's preemption provision, a plan need not sever all ties with the insurance sector. Most self-insured plans contract with insurance companies to process claims and provide other administrative services. Suppose an employer was concerned about incurring unexpectedly large medical claims from its self-insured plan. Suppose further that the employer purchased stop-loss coverage from an insurance

company to recover losses incurred if its medical plan experienced more than $1 million in claims in any calendar year. How would ERISA's preemption provision apply to this arrangement? *See Thompson v. Talquin Bldg. Prods. Co.*, 928 F.2d 649 (4th Cir. 1991).

2. ***Who Decides on Subrogation?*** The Pennsylvania legislature presumably made a considered choice that subrogation clauses should not be permitted with respect to injuries arising out of car accidents. Who decided the appropriate scope of subrogation in the *FMC* case? Who is best positioned to make such decisions?

3. ***ERISA Preemption as a Barrier to Health Care Reform.*** One of the unanticipated consequences of the Supreme Court's broad interpretation of ERISA's preemption provisions was the barrier it imposed on state efforts to reform health insurance programs. To the extent that large segments of the population were covered by self-insured, employer-sponsored plans, states had relatively little latitude to require large employers to provide health insurance coverage or limit the acceptable terms of that coverage, for example by placing restrictions on the ability of self-insured plans to limit coverage for preexisting conditions. While the states did retain the ability to regulate the practice of medicine and the operation of hospitals, even that authority was limited when self-insured employers provide coverage through health maintenance organizations. These restrictions were one of the reasons that the Affordable Care Act, discussed later in this Chapter, had to be adopted at the federal level. *Compare Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (finding that state law claims against an ERISA plan administrator for wrongful denial of benefit coverage are preempted), *with Pegram v. Herdrich*, 530 U.S. 211 (2000) (permitting state law claims that involve mixed decisions of treatment and coverage but are held to not involve fiduciary functions under ERISA). For a critical view of the Supreme Court's jurisprudence in this area, see John Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1365 (2003).

2. Fiduciary Duties Under ERISA

Another distinctive feature of ERISA is its imposition of fiduciary duties on a variety of parties and how they manage ERISA plans. The application of these fiduciary duties to traditional pension plans is relatively straightforward, as a trustee is typically required to hold those assets in a structure quite similar to a traditional trust. As the following case demonstrates, the application of fiduciary duties to other sorts of employee benefit plans is less straightforward.

Firestone Tire & Rubber Co. v. Bruch

489 U.S. 101 (1989)

Justice O'CONNOR delivered the opinion of the Court.

[This case involved a dispute arising out of the sale of Firestone's Plastics Division. At the time of the sale, Firestone maintained a severance plan, covered by ERISA, which would have provided the plaintiffs severance benefits in the event of a "reduction in workforce."

Payment of those severance benefits would have imposed additional costs on Firestone because the plan was not required to have advanced funding. Firestone concluded, however, that the sale of the division did not constitute a "reduction in service" for purposes of the plan. The question before the Supreme Court was the standard of review that should be applied to Firestone's interpretation of plan terms. The courts below had split over whether Firestone's decision should be reviewed under a deferential "arbitrary and capricious standard" or a more taxing "de novo" review.]

ERISA provides "a panoply of remedial devices" for participants and beneficiaries of benefit plans. Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985). Respondents' action asserting that they were entitled to benefits because the sale of Firestone's Plastics Division constituted a "reduction in work force" within the meaning of the termination pay plan was based on the authority of § 502(a)(1)(B). That provision allows a suit to recover benefits due under the plan, to enforce rights under the terms of the plan, and to obtain a declaratory judgment of future entitlement to benefits under the provisions of the plan contract....

ERISA abounds with the language and terminology of trust law. *See*, *e.g.*, ERISA § 3(7) ("participant"), 1002(8) ("beneficiary"), 3(21)(A) ("fiduciary"), 403(a) ("trustee"), 404 ("fiduciary duties"). ERISA's legislative history confirms that the Act's fiduciary responsibility provisions, ERISA §§ 401–414, "codif[y] and mak[e] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts." H.R.Rep. No. 93-533, p. 11 (1973), U.S.Code Cong. & Admin.News 1974, pp. 4639, 4649. Given this language and history, we have held that courts are to develop a "federal common law of rights and obligations under ERISA-regulated plans."...

Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. *See* Restatement (Second) of Trusts § 187 (1959) ("[w]here discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion"). A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable. Whether "the exercise of a power is permissive or mandatory depends upon the terms of the trust." 3 W. Fratcher, Scott on Trusts § 187, p. 14 (4th ed. 1988). Hence, over a century ago we remarked that "[w]hen trustees are in existence, and capable of acting, a court of equity will not interfere to control them in the exercise of a discretion vested in them by the instrument under which they act." Nichols v. Eaton, 91 U.S. 716, 724–725, 23 L.Ed. 254 (1875).... Firestone can seek no shelter in these principles of trust law, however, for there is no evidence that under Firestone's termination pay plan the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference....

Finding no support in the language of its termination pay plan for the arbitrary and capricious standard, Firestone argues that as a matter of trust law the interpretation of the terms of a plan is an inherently discretionary function. But other settled principles of trust law, which point to de novo review of benefit eligibility determinations based on plan interpretations, belie this contention. As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation. "The extent of the duties and powers of a trustee is determined by the rules of law that are applicable to the situation, and not the rules that the trustee or his attorney believes to be applicable, and by the terms of the trust *as the court may interpret them*, and not as they may be interpreted by the trustee himself or by his attorney." 3 W. Fratcher, Scott on Trusts § 201, at 221 (emphasis added). A trustee who is in doubt as to the interpretation of the instrument can protect himself by obtaining instructions from the court....The terms of trusts created by written instruments are "determined by the provisions of the instrument as interpreted in light of all the circumstances and such other evidence of the intention of the settlor with respect to the trust as is not inadmissible." Restatement (Second) of Trusts § 4, Comment d (1959).

> The trust law de novo standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA. Actions challenging an employer's denial of benefits before the enactment of ERISA were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claim as it would have any other contract claim—by looking to the terms of the plan and other manifestations of the parties' intent….
>
> As this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue. Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 502(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan....
>
> Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals..., we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries. Thus, for purposes of actions under § 502(a)(1)(B), the de novo standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion." Restatement (Second) of Trusts § 187, Comment d (1959)….

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1. ***Contracting Out of*** **Bruch.** What is the significance of the *Bruch* decision? How would you expect employers to respond to it? Suppose, for example, employers amended their plans to grant a plan administrator discretion to deny benefits. To what sort of judicial review would such a provision be subject? *See* John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207.

2. ***ERISA as Illustrative of the Fourth Stage of Capitalism.*** Just seven years after ERISA was enacted, Professor Robert Clark characterized the legislation as heralding the arrival of a new stage of economic and legal development:

> Today, decisions about whether and how much to save are increasingly being made by group representatives on behalf of a large number of group members, rather than by each individual whose present consumption is being deferred in favor of future consumption. The objective signs of this change are the steadily increasing predominance of group over individual health and life insurance policies, and the rapid growth since World War II of employee pension plans, especially as compared to the relative stagnancy of the individual annuities business. Today, the decision to save is only indirectly controlled by many of the workers who are to benefit from these plans (which can no longer accurately be described as "fringe" benefits), just as the decision to invest in particular financial claims is only rarely controlled by public suppliers of capital to financial intermediaries. And those new professional savings planners—for example, the sponsors and administrators of large corporate pension plans—rarely

> perform the active investment function. Most pension plan sponsors and administrators contract with outside bank trust departments, insurance companies, and investment advisory firms for investment management services.

Robert C. Clark, *The Four Stages of Capitalism*, 94 HARV. L. REV. 561, 566–67 (1981). Against this framework, should the *Bruch* decision be seen as creating appropriate space for savings planners to devise appropriate savings plans for group members? Should ERISA's preemption provision, previously discussed, be understood to serve a similar function? Should the more rigid restrictions of traditional insurance regulation discussed in Chapter 3.2 be considered obsolete and anachronistic in this brave new world, or perhaps not?

D. THE AFFORDABLE CARE ACT OF 2010

Further federal involvement in insurance regulation came with the passage of the ACA in March of 2010. Colloquially known as Obamacare, the ACA sought to implement a broad overhaul of the health care system with the goal of ensuring that all Americans have access to affordable, quality health care. Before its passage, health insurers were generally free, absent contrary state laws, to deny coverage based on preexisting medical conditions and to set insurance premiums as they desired. Insurance companies confronting the prospect of higher costs due to sickly individuals often chose to charge those individuals more, instead of raising rates for everyone and potentially losing customers. As a result, many Americans found themselves either denied coverage or priced out of it when they needed it most. Moreover, the young and healthy frequently chose to forgo insurance altogether, and insurance risk pools were often slanted towards higher risk and higher rates. Higher rates made it even less likely for these groups to buy coverage and more difficult for low-income families to do so, further exacerbating the problem. Individuals without insurance could also delay seeking medical treatment until absolutely necessary, whereupon they would go to the local emergency room. Hospitals were required by law to treat the emergency needs of these patients and would pass on a lot of the associated costs to insurers by raising their fees in turn. The net effect was that those buying insurance were in no small part subsidizing the cost of those who were not.

The ACA undertook to address these problems through a series of complementary measures. First, under the guaranteed issue provision, it required health insurers to accept anyone who seeks coverage regardless of health status. Second, it sought to make health insurance affordable by prohibiting premium variation based on health using a community rating, by implementing tax subsidies and other cost sharing arrangements for persons with qualifying incomes, and by expanding Medicaid coverage. Third, it required most individuals to maintain health insurance or pay a penalty pursuant to the individual mandate. These measures were broadly modeled on a similar system that Massachusetts adopted successfully in 2006.

The ACA's reforms were targeted primarily towards the individual and small-group health insurance markets, and not employer-provided health coverage

discussed earlier in connection with ERISA. As of March 2016, the Department of Health and Human Services reported that some 20 million people gained insurance due to the passage of the ACA, representing an overall decline from about 15% of uninsured Americans, or approximately 48 million people, to about 9% uninsured. This increase in coverage includes 6.1 million young adults whom, pursuant to the Act, insurers providing employer-sponsored health insurance must allow to remain on parental plans until age 26. The Department also reported over 14 million new enrollees in Medicaid programs, including 12 million in states that expanded Medicaid coverage and 2 million in states that did not. In addition, as of the close of the enrollment period on January 31, 2016, 12.7 million people enrolled in individual insurance plans through the new government health insurance marketplaces, 9.6 million on HealthCare.gov and 3.1 million through state marketplaces. It should be noted, however, that the Medicaid and marketplace numbers do not accurately represent previously uninsured individuals as some of these people had alternative prior coverage. OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, DEP'T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010–2016 (Mar. 2016).

The passage of the ACA proved politically contentious, engendering strong opposition from the Republican Party and polarized views on its merits among Americans. Numerous lawsuits were filed in federal courts, and the Supreme Court has heard two prominent cases challenging elements of the Act and its implementation. In particular, many saw the mandate to purchase insurance as encroaching on individual freedom. The Act also authorized the withdrawal of current Medicaid funding from states that refused to expand their Medicaid programs, and many states did not take well to what they saw as federal coercion. These two issues were addressed by the Court in the following case, *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012).

1. *National Federation of Independent Business v. Sebelius*

In *NFIB v. Sebelius*, the Court heard the argument that the individual mandate and the accompanying penalty of the ACA are unconstitutional, as no enumerated power authorized Congress to mandate a purchase by an individual. *NFIB* also challenged the validity of the Medicaid expansion as violating the principles of state sovereignty embedded in the Tenth Amendment by coercing state decision-making through the threat of lost funding. Writing for the Court, Chief Justice John Roberts found that the individual mandate was an unconstitutional extension of the Commerce power, but upheld the accompanying penalty as a legitimate use of Congress's Taxing power. The Court's holding did not rely on the *Paul v. Virginia* theory that insurance was not a form of commerce but on the theory that Congress could not compel an individual's activity under the Commerce power. The Court explained that:

> The individual mandate...does not regulate existing commercial activity. It instead compels individuals to *become* active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely *because* they are

> doing nothing would open a new and potentially vast domain to congressional authority.

Id. at 2587. Given that the Act never envisioned any sanctions other than a modest penalty, as Congress had assumed that four million people would just opt to pay the penalty, the Court's holding functionally left the individual mandate in place while generally restricting congressional authority under the Commerce power.

The Court also held that the Medicaid expansion was an unconstitutional coercion of the states under the Tenth Amendment. This holding left the states with the option to refuse to expand their Medicaid programs without losing their current government funding. As of January 2018, according to the Kaiser Family Foundation, 32 states plus the District of Columbia had adopted the Medicaid expansion, despite the availability of federal funding for at least 90% of the additional Medicaid insurance costs.

2. *King v. Burwell*

Three years later, the Court entertained another major challenge to the Affordable Care Act in *King v. Burwell*, 135 S. Ct. 2480 (2015). To understand the nature of this challenge, some background is necessary. As noted earlier, the individual mandate was a critical feature of the Act. Without it, healthy individuals could elect not to purchase insurance, knowing that the guaranteed issue and community rating requirements assured them the right to purchase insurance in the future at a similar price to those with insurance. The prospect of sick individuals buying insurance in the future at the common price meant that insurers would have to raise rates on everyone to accommodate tomorrow's more costly risk pool. Higher rates would mean that more people would choose to forego insurance and only purchase it when necessary, leading in turn to an even riskier pool and even higher rates in a process known as adverse selection. The ACA's mandate solved these problems by pushing everyone into the risk pool. The lower costs of healthy individuals would offset the higher costs of those who became ill. The mandate only applied, however, if the cost of insurance was not more than 8% of income, and for many Americans it was more.

To account for this, the Act introduced tax subsidies to reduce insurance costs for Americans with an income between 100% and 400% of the federal poverty level. The subsidies were calculated to reduce insurance costs below the 8% threshold such that virtually everyone would be subject to the mandate. The Act also called for each state to establish a health insurance exchange, a central marketplace for health insurance in the state, with federal grant money, and authorized the federal government to create the exchange for the state if it failed to do so. As of January 2021, 30 states have exchanges run entirely by the federal government while only 15 exchanges are regarded as purely state-run; the balance have hybrid arrangements. *See State Health Insurance Marketplace Types*, KAISER FAM. FOUND. (2021). The essence of the challenge in *King v. Burwell* was that the language of the Act only authorized the provision of these subsidies for plans purchased on exchanges "established by the State," and not those established by the federal government on behalf of a state. The Court ultimately held that, in context, the term "established by the State" was ambiguous and that the structure and purpose of the Act "lead[] us to conclude that...tax credits [are allowed] for insurance purchased on any Exchange created under the Act." *Id.* at 2496.

1. ***Challenges in Implementing the ACA.*** From the start, federal authorities faced challenges in rolling out the ACA. In addition to technical problems with the launch of the ACA's website, the cost of health insurance policies in the ACA exchanges was off-putting to some, especially for those with income above the level eligible for federal subsidies. One of the key elements of the ACA's community rating system was a requirement that insurance policy prices not vary too greatly based on age, imposing a maximum age factor of 3:1 for those 64 years of age as opposed to those 21 years old. This price compression increased the cost of ACA insurance policies for younger and typically healthier individuals, who as a result joined the exchanges at lower rates than anticipated, increasing the overall cost of insurance and threatening a "death spiral" from increasing adverse selection. In its initial years, enrollments in the ACA exchange were lower than originally anticipated, although that drop in demand was largely offset by higher than expected enrollments in the ACA's Medicaid expansion notwithstanding the fact that many states chose not to opt into the expansion after the *NFIB v. Sebelius* decision. *See CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014–2016*, CBO (Dec. 2017) ("[I]n their March 2010 estimates, CBO...projected that 92 percent of people under 65 would have some type of health insurance in 2016; in their May 2013 estimates, the [CBO] projected 89 percent. According to the National Health Interview Survey, 90 percent of the population had health insurance in that year.").

2. ***The ACA Under the Trump Administration.*** Despite much-publicized efforts in 2017, the Trump Administration was unable to repeal the ACA in its entirety. The Administration did, however, take a number of actions that will likely alter the impact of the ACA in coming years. First, as part of the tax reform legislation adopted in December of 2017, Congress eliminated the individual mandate, effectively making health insurance coverage optional for individuals starting in 2019. The U.S. Department of Health and Human Services also expanded the availability of short-term health insurance policies that do not comply with the ACA's essential benefits requirements and that will likely cost substantially less than ACA-compliant policies. In addition, the Trump Administration substantially decreased funding for the ACA's navigator programs, which are intended to help individuals enroll in plans for which they are qualified. Taken together, the Trump Administration's policies threatened to encourage healthier individuals to move away from the ACA exchanges, exacerbating adverse selection problems. To the extent that the ACA subsidies remained in place, lower income individuals would largely be insulated from these effects, but moderate and higher-income individuals could face substantially larger premiums. In the face of these policy shifts, the percentage of uninsured Americans increased slightly from 2017 to 2018. However, as a number of additional states have opted to expand Medicaid, this decline has been somewhat muted and, at least up until the Pandemic, the rolls of uninsured Americans have remained well below the levels that existed before the ACA: "Under the ACA, Medicaid coverage has been extended to nearly all adults with incomes at or below 138% of poverty in states that have expanded their programs, and tax credits are available for people who purchase coverage through a health insurance marketplace. As a result, the number of uninsured dropped from more than 46.5

million in 2010 to fewer than 26.7 million in 2016. In 2018, the number of uninsured increased to 27.9 million nonelderly individuals." *Kaiser Family Foundation Issue Brief: Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Dec. 2019).

3. ***A Greater Role for States?*** In another related initiative, the Trump Administration announced an openness to new waivers for state Medicaid programs, allowing for greater experimentation in the design of Medicaid programs, potentially affecting availability and coverage terms. *See Medicaid Waiver Tracker*, KAISER FAM. FOUND. (Feb. 21, 2018). While the original ACA envisioned some degree of state autonomy in implementing ACA requirements (particularly in the area of approving annual price increases), the Trump Administration's approach contemplated a much greater degree of latitude for state authorities, including the capacity for states to retain or reimpose elements of the original ACA—such as the individual mandate—that no longer exist at the federal level. This possibility has led some experts to predict the devolution of health care policy to state legislatures. *See* Margot Sanger-Katz, *A Big Divergence Is Coming in Health Care Among States*, N.Y. TIMES (Feb. 28, 2018). Employer plans would, however, remain insulated by ERISA's preemption. For a discussion of how the ACA altered the relationship between beneficiaries and sponsors in the health insurance context and the litigation that might follow, see Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649 (2014).

4. ***One More Constitutional Challenge to the ACA.*** Shortly after Congress set the penalty for failure to comply with the ACA's individual mandate to zero, states and private citizens filed suit and contended that this change meant that the mandate was no longer constitutional as a tax, as Chief Justice Roberts had held in *NFIB v. Sebelius*. The challengers argued that the mandate could no longer be considered a tax since it did not generate revenue. *Texas v. United States*, 945 F.3d 355, 374 (5th Cir. 2019). The Fifth Circuit applied the four-part test set out in *NFIB* to determine if the mandate is a tax: (1) that it generates revenue, (2) that the penalty is paid into the Treasury by taxpayers, (3) that the amount owed is depending on factors similar to factors that determine taxable income, and (4) that the requirement was found in the Internal Revenue Code—to find that the mandate is no longer a tax. *Texas*, 945 F.3d at 389–90. The court then found that the individual mandate was unconstitutional. *Id.* at 390. Those challenging the ACA also asked the court to strike down the entirety of the ACA, arguing that the individual mandate could not be severed from the rest of the statute. *Id.* at 393. The Fifth Circuit remanded to the district court on the severability issue. *Id.* The Supreme Court granted certiorari in March 2020 and will likely decide the question sometime in 2021, *Texas v. California*, 140 S. Ct. 1262 (2020) (mem.), marking the third time a challenge to the ACA has reached the Supreme Court. The Trump Administration supported the challengers' claims that the individual mandate is now unconstitutional and that the entire ACA should be invalidated. Brief for the Federal Respondents, *California v. Texas*, No. 19-840 (U.S. argued Nov. 10, 2020).