

2014

The Affordable Care Act, Remedy, and Litigation Reform

Brendan S. Maher

Texas A&M University School of Law, brendan.maher@law.tamu.edu

Follow this and additional works at: <https://digitalcommons.wcl.american.edu/aulr>



Part of the [Law Commons](#)

Recommended Citation

Maher, Brendan S. "The Affordable Care Act, Remedy, and Litigation Reform." *American University Law Review* 63, no.3 (2014): 649-714.

This Article is brought to you for free and open access by the Washington College of Law Journals & Law Reviews at Digital Commons @ American University Washington College of Law. It has been accepted for inclusion in *American University Law Review* by an authorized editor of Digital Commons @ American University Washington College of Law. For more information, please contact kclay@wcl.american.edu.

The Affordable Care Act, Remedy, and Litigation Reform

Keywords

Patient Protection & Affordable Care Act, Employee Retirement Income Security Act of 1974, Health insurance, Law & legislation Law reform, Actions & defenses (Law) Remedies (Law), United States, Health care reform -- United States

ARTICLES

THE AFFORDABLE CARE ACT, REMEDY, AND LITIGATION REFORM

BRENDAN S. MAHER*

The Patient Protection and Affordable Care Act of 2010 (ACA) rewrote the law of private health insurance. How the ACA rewrote the law of civil remedies, however, is a question largely unexamined by scholars. Courts everywhere, including the U.S. Supreme Court, will soon confront this important issue.

This Article offers a foundational treatment of the ACA on remedy. It predicts a series of flashpoints over which litigation reform battles will be fought. It identifies several themes that will animate those conflicts and trigger others. It explains how judicial construction of the statute's functional predecessor, the Employee Retirement Income Security Act of 1974 (ERISA), converted a protective statute into a uniquely effective piece of federal litigation reform. Ultimately, it considers whether the ACA—which incorporates, modifies, and rejects ERISA in several notable ways—will experience a similar fate.

TABLE OF CONTENTS

Introduction.....	650
I. Health Insurance Remedy Before the ACA.....	655
A. ERISA Remedy.....	656
B. State Law Remedy.....	662
C. ERISA Realism.....	664

* Associate Professor and Robert D. Paul Scholar, *University of Connecticut School of Law*, J.D., *Harvard Law School*; A.B., *Stanford University*. This Article benefited from presentation of an earlier draft at the University of Michigan's "Regulation of Benefit Plans: The Most Consequential Subject to Which No One Pays Enough Attention" conference on March 22, 2013. I thank the conference participants for their comments and criticism. All errors and foolish notions, of course, are mine alone. I thank the University of Connecticut School of Law for the research grant that made the completion of this work possible.

II. Remedial Concepts in the ACA.....	668
A. Internal Review.....	668
B. External Review.....	670
C. Judicial Review.....	672
D. Remedial Interaction and Litigation Reform.....	674
III. ACA Litigation Reform Battles: Realism and Specifics.....	675
A. Realist Influences Reconsidered.....	676
B. Litigation Reform Specifics.....	678
1. Self-insured plans.....	679
2. Group-insured plans.....	685
3. Individual insurance.....	692
IV. ACA Litigation Reform Themes.....	700
A. Flexible Jurisprudential Devices.....	701
B. The ACA as Consumer Choice.....	704
C. The ACA as Anti-Judicialism.....	706
D. The ACA as Non-Judicial Justice.....	712
Conclusion.....	713

INTRODUCTION

Tort reform is a loaded term. Reform, after all, is multi-directional: it can make rules more or less friendly to plaintiffs. For practical purposes, however, tort reform aims to alter legal rules so that plaintiffs have a harder time getting to court, winning, or collecting damages. Tort reform's larger but equally loaded cousin, litigation reform, is simply reform applied to all claims, not just tort.¹

For a long time, tort reform got most of the press.² Recently, however, litigation reform has crept onto front and opinion pages.³

1. Litigation reform is called by other names, for example "justice reform," "lawsuit reform," and "legal reform." See *American Tort Reform Foundation*, JUDICIAL HELLHOLES, <http://www.judicialhellholes.org> (last visited Nov. 7, 2013) (listing litigation reform organizations that employ those terms). Although these terms can be used interchangeably, for the purposes of this Article, I use "litigation reform."

2. See, e.g., Philip K. Howard, *Why Medical Malpractice Is Off Limits*, WALL ST. J. (Oct. 14, 2008, 10:29 PM), <http://online.wsj.com/article/SB10001424052970204488304574432853190155972.html> (emphasizing the enormous cost of medical malpractice); Alicia Mundy, *Bush Legacy Could Be Found in Tort Reform*, WALL ST. J. (Oct. 14, 2008, 7:53 PM), <http://live.wsj.com/video/bush-legacy-could-be-found-in-tort-reform/15854491-F804-4CCD-8D04-B912CCE9D90D.html#!15854491-F804-4CCD-8D04-B912CCE9D90D> (assessing the George W. Bush administration's primary strategy related to tort reform, namely federal preemption); Anne Underwood, *Would Tort Reform Lower Costs?*, N.Y. TIMES (Aug. 31, 2009, 3:45 PM), <http://prescriptions.blogs.nytimes.com/2009/08/31/would-tort-reform-lower-health-care-costs> (discussing some of the theories behind medical practice costs and offering other explanations for the high cost of medical care).

3. See, e.g., Editorial, *Gutting Class Action*, N.Y. TIMES (May 12, 2011), http://www.nytimes.com/2011/05/13/opinion/13fri1.html?_r=0 (complaining that the Supreme Court's decision in *AT&T Mobility LLC v. Concepcion*, 131 S. Ct. 1740 (2011), "will bar many Americans from enforcing their rights in court and, in many cases like this one,

News tracks power, and the current Supreme Court is more solicitous of litigation reform—and more willing to act on that preference—than any Court in living memory. Since John G. Roberts, Jr. became Chief Justice in 2005, the Court has issued landmark decisions regarding pleading, arbitration, and class actions that have significantly curtailed plaintiffs' abilities to bring and win lawsuits.⁴ Whether that is desirable, disastrous, or somewhere in between depends on your point of view.

Litigation reform is particularly relevant to health care legislation. Health insurance is a contentious matter, in both the grand and petty sense. Policy intuitions differ fiercely, and there are frequent coverage disputes. Unsurprisingly, the appropriate remedy for the wrongful denial of a health insurance claim has long been a subject of intense interest for litigation reformers and their opponents.⁵ Overly expansive remedies are decried as wasting money on the litigious; overly restrictive remedies are attacked as saving money on the backs of the sick. These policy quarrels are complicated by questions of statutory authority, namely, whether federal or state regulators get to decide the rules of remedy. Further, the collective amount of money at stake is enormous.

Enter the Patient Protection and Affordable Care Act of 2010⁶ (ACA). The ACA unquestionably rewrote the law of private health insurance in America. Whether and how it rewrote the law of civil remedies, however, is an important—and, to date, completely unconsidered—question of statutory federalism. This Article offers a

bar them from enforcing rights at all”); *see also infra* note 4 (listing several pro-litigation reform Supreme Court opinions from the Roberts Court).

4. *See, e.g.*, *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2556–57 (2011) (defining “common question” inquiry in class actions narrowly); *AT&T Mobility*, 131 S. Ct. at 1750–51 (preempting a California law limiting the use of collective action waivers); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556–57 (2007) (requiring that a well-pleaded complaint contain sufficient factual allegations to demonstrate entitlement for relief). The taste for litigation reform is likely related to the presence of a Court friendlier to business than ever. *See* Lee Epstein, William M. Landes, & Richard A. Posner, *How Business Fares in the Supreme Court*, 97 MINN. L. REV. 1431, 1472 (2013) (finding a pro-business slant in the Roberts Court).

5. *See, e.g.*, Peter Huber, *Safety and the Second Best: The Hazards of Public Risk Management in the Courts*, 85 COLUM. L. REV. 277, 319–20, 332–33 (1985) (arguing that “tort liability is a poor vehicle for choosing risks because judges and juries have little capacity to make risk choices wisely”); Abigail Moncrieff, *The Supreme Court’s Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2329–30 (2010) (noting that it has been “long recognized [that] generalist juries and judges are bad at understanding, evaluating, and creating healthcare regulations”).

6. The legislation is actually comprised of two acts: the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). In this Article, following convention, I refer to these acts collectively as “the ACA.”

foundation for the treatment of the ACA on remedy. It predicts a series of flashpoints over which litigation reform battles will be fought. It identifies several themes that will animate those conflicts and trigger others. And it explains how judicial construction of the statute's functional predecessor, the Employee Retirement Income Security Act of 1974⁷ (ERISA), converted a protective statute into a uniquely effective piece of federal litigation reform. Ultimately, it considers whether the ACA—which incorporates, modifies, and rejects ERISA in several notable ways—will experience a similar fate.

Part I supplies essential background by explaining the pre-ACA world. Prior to 2010, the most important statute regarding health insurance remedy was ERISA, which governs “benefit plan” arrangements incident to employment, including employment-based health insurance. This Part explains how ERISA's rules on coverage denial claims heavily favor insurers over claimants. Those rules limit available causes of action, damages, and the right to a jury. They also severely restrict the availability and scope of judicial review in a way that surprises the casual observer. Claimants must exhaust an insurer's internal review procedures before suing in court. If the plan so provides—and virtually all of them do—reviewing judges must “defer” to the determination of the internal reviewer and affirm his finding, unless it was so unreasonable as to be arbitrary and capricious.⁸ Such judicial deference is due even with respect to conflicted review, i.e., where the party reviewing claims is controlled by or beholden to the party obliged to pay claims.

By 2010, nearly 150 million people who received insurance through an employer were subject to ERISA and its remedial scheme.⁹ Because of ERISA's unusual preemptive scope, state ability to effectively regulate employment-sponsored insurance in a claimant friendly way is minimal. States can and did, however, regulate the vastly smaller “individual insurance” market; ERISA applies only to employment-sponsored insurance. In contrast to ERISA, state insurance law generally takes a more pro-claimant approach,

7. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified at 29 U.S.C. §§ 1001–1461 (2012)).

8. For explanatory purposes, in the Introduction I use “insurer” and “benefit plan” interchangeably. For the purpose of my analysis, distinctions between the two that would matter elsewhere will not matter here.

9. See GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS, 2012 ANNUAL SURVEY 1 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf> (noting that “[e]mployer-sponsored insurance is the leading source of health insurance in America, covering about 149 million nonelderly people”). Because of limited statutory exceptions, a small number of people with employment-sponsored insurance are not covered by ERISA.

providing broader legal remedies, including multiple causes of action; interpretative doctrines favoring insureds; compensatory, usually consequential, and sometimes punitive, damages; and jury rights. State limits on claimant rights pale in comparison to those imposed by ERISA.

Why ERISA diverged so materially from state law on remedy has long interested scholars. Explanations differ, but legal realism offers the most persuasive account.¹⁰ Judicial extra-statutory concerns about the cost of health care, the lack of a suitable alternative to employment-based health insurance, and a profound skepticism toward the utility of remedy in general were significant, if not dominant, variables in reading ERISA as the judiciary has done. How those concerns might influence interpretation of the ACA is an open question.

Part II offers a conceptual summary of the ACA on remedy.¹¹ The Act contemplates three remedial options for claimants: internal, external, and judicial review. Internal review refers to claim processes administered by insurers or their designees. External review refers to claim review processes handled by “independent review organizations” regulated by the government. Judicial review is litigation. Having all three options is a boon to claimants; however, having one option limit the others may not be. Unfortunately, the ACA is not perfectly clear about how the various remedial options interact. Is each option actually optional? Must one form of review be used before others? Must later reviewers defer to the conclusions of an earlier reviewer? Does the use of internal or external review extinguish judicial review or certain forms of relief? And which regulator has the power to resolve these—and other significant—questions?

Part III supplies answers. The core notion is simple: an insured’s available remedies depend on the type of insurance arrangement at issue. For Type A insurance, federal regulators answer questions of remedy. For Type B insurance, federal or state regulators answer, with the division of authority not clear. For Type C insurance, state

10. What legal realism constitutes is subject to dispute among legal philosophers. See, e.g., Frederick Schauer, *Legal Realism Untamed*, 91 TEX. L. REV. 749, 755 n.21 (2013) (describing variant schools of legal realism). I take no sides. I use the term herein to mean, broadly, the expectation that judges bring more to bear on interpreting the law than reading glasses and formal logic, and that their policy preferences influence, sometimes profoundly, the decisional law they produce. Cf. *id.* (identifying scholars who “conceiv[e] [r]ealism in terms of a judge’s general (rather than case-specific) policy or ideological preferences”). See generally MARK TUSHNET, *THE NEW CONSTITUTIONAL ORDER* 120 (2009) (describing the realist view that “a judge given a principle articulated in some prior case could faithfully deploy that principle along with others equally available in the doctrinal universe to reach whatever result the judge thought socially desirable”).

11. I define remedy fairly broadly. See *infra* Part I.A.

regulators answer, subject to a federal regulatory floor designed to protect consumers.¹²

Type A insurance arrangements are so-called “self-insured plans.” Self-insured plans are benefit plans that pay their employees’ health costs directly, without an insurance company as intermediary. The remedies for self-insured plans are defined entirely by ERISA and the ACA. How the ACA modifies ERISA is clear in some ways; in others it is not. Type B insurance arrangements are benefit plans using a group insurer to cover their employees. These arrangements are governed by a complicated welter of ERISA, ACA, and state law. The divisions of authority are not clear, but the ACA may expand state ability to regulate group insurers, at the expense of ERISA. Type C insurance arrangements are individual insurance policies, which are governed by the ACA and state law. The ACA’s insurance marketplace reforms—the mandate, limited risk underwriting, and subsidies—will make the individual insurance market larger than it has been in decades.¹³ That the ACA exercises power over the greatly expanded individual market will prompt questions about the degree to which the ACA displaces state prerogative on internal, external, and judicial review.

Interwoven with the Article’s explanation of how the ACA’s remedial regime works are predictions and observations about likely litigation reform flashpoints.¹⁴ For each type of insurance, I highlight particular conflicts likely to consume litigant and judicial resources. For example, for self-insured plans, a key battle will likely be over the

12. I use alphabetical classification to make the scheme comprehensible. “Type A/B/C” does not appear in the ACA. I consider only private health insurance, not Medicare or Medicaid. *See generally infra* note 127 (discussing unusual private insurance arrangements not here considered).

13. *See* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 20 tbl.3 (2012), *available at* <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf> (projecting that roughly 25 million people will receive insurance through exchanges between 2019 and 2022). Based on its explanatory notes, the CBO report appears to sensibly include those receiving coverage through employers using small business exchanges in the “Employer” line estimate (rather than in the “Exchanges” estimate). *Id.* Even if the exchange estimates include employer exchange purchases, the overwhelming majority of the 25 million people in the exchanges would be individual purchasers subject to state law.

14. I assume throughout, unless otherwise noted, that the current federal regulations are within the relevant federal agencies’ power. In other words, the intent here is not to assess the degree to which agency regulations will survive judicial scrutiny if challenged, but rather to ask what the ACA—under the current statutory text and regulations—means for remedy and litigation reform. Certainly the question of how agency positions on the ACA will survive challenge is important. But that question requires a full-length treatment all its own.

degree to which judges must defer to the determinations of external reviewers. For group-insured plans, a crucial dispute will be over how much the ACA's amending of ERISA empowers the states to regulate group plans without fear of preemption. For individual insurance, the central question will be whether the ACA's regulation of all insurance policies can serve as a ledge to impose, nationwide, litigation reform features inspired by ERISA. Other flashpoints are also surveyed.

In Part IV, I step back from the specific and consider big picture remedial "themes" of the ACA that will animate the above battles and trigger others. Given the elasticity of two jurisprudential devices likely to influence construction of the ACA—namely, preemption and intra-federal statutory conflict resolution—thematic analysis bears heightened predictive and descriptive power. I consider three remedial themes that could be advanced by interested players: the ACA as consumer choice, the ACA as anti-judicialism, and the ACA as non-judicial justice. Put simply, litigation reform opponents will favor the first, litigation reformers the second, and true federalists the third.

The Article concludes by speculating about the ACA's fate. It could become what it reads to be: mildly progressive federalism on remedy, in which states may freely fashion remedial regimes consistent with modest consumer-protective floors defined by federal agencies. Alternatively, it could transform the nation's system of health insurance remedies into some version of "ERISA for all." The former is more likely, but the latter—a litigation reformer's dream—is not impossible.

I. HEALTH INSURANCE REMEDY BEFORE THE ACA

Before beginning, I should offer a preliminary comment on the meaning of "remedy." While elsewhere it may have a narrower meaning, herein I mean remedy quite broadly, namely, any and all of the formal processes and recoveries available to an insured who is denied coverage.

Health insurance remedies before the ACA were defined by two sources of law: ERISA and state law, or a combination of the two.¹⁵ ERISA governed the remedial scheme for employment-based insurance,¹⁶ and state law governed insurance purchased on the

15. Cf. Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMP. L.J. 387, 395 (2009) (addressing the inadequacy of remedies within ERISA).

16. See 29 U.S.C. § 1001(b) (2012).

individual market.¹⁷ ERISA's preemptive scope significantly limited a state's ability to regulate remedy for employment-based arrangements.¹⁸ Because many more people were covered by employment-sponsored insurance rather than individual insurance,¹⁹ as a practical matter, ERISA has been much more significant in defining health insurance remedies than has state law.

ERISA and state law's treatment of remedy are crucial predicates to the ACA's remedial scheme, for several reasons. First, the ACA built upon ERISA and state law, and, in many important respects, ERISA and state law are still controlling authority. Second, regardless of any continued vitality or formal connection to the ACA, ERISA and state law's treatment of remedy will unquestionably inform resolutions of the ACA's uncertainties. Third, as is more fully explored in Part III.A, the degree to which pre-ACA matters of remedy, particularly ERISA, were influenced by extra-statutory judicial impulses must factor in to any realistic appraisal of how the ACA will be interpreted.

A. *ERISA Remedy*

ERISA was enacted in 1974 to protect the pensions and health benefits of working Americans.²⁰ It does not require that an employer offer benefits.²¹ However, if an employer does offer benefits, ERISA regulates the benefit arrangement.²²

ERISA requires that benefits be administered pursuant to a legal construct called a "benefit plan."²³ The plan is operated by a "named fiduciary," who in turn engages other fiduciaries to administer the

17. See *infra* Part II.C.

18. See *generally* 29 U.S.C. § 1144 (showing Congress's clear intent to control regulation over employee benefit plans); see also *infra* Part II.C.

19. "Individual, or non-group, health insurance covers about 14 million nonelderly people in America, making it the least common source of health insurance. In contrast, about 157 million nonelderly people are covered by employer-sponsored insurance." KAISER FAMILY FOUND., SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE 1 (2010), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8077-r.pdf>.

20. Pub. L. No. 93-406, § 2, 88 Stat. 829, 832-33 (1974) (codified at 29 U.S.C. § 1001); see also *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980) (noting that ERISA was enacted after "almost a decade of studying the Nation's private pension plans"). For a detailed discussion of the interesting political history of ERISA, see JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY 51-52 (2004).

21. See *Conkright v. Frommert*, 130 S. Ct. 1640, 1648 (2010) (stating that Congress enacted ERISA to ensure employees received the benefits they earned, but did not require employers to establish benefits plans in the first place).

22. 29 U.S.C. § 1001(b)-(c) (establishing specific requirements for already-existing employee benefit plans and private pension plans).

23. *Id.* § 1002 (defining any employee welfare plan or pension plan as a "benefit plan").

plan.²⁴ Should the fiduciary violate ERISA's requirements or the terms of the governing plan document, ERISA provides various "civil enforcement" mechanisms to beneficiaries.²⁵ One mechanism is a federally created cause of action to remediate a wrongfully denied health benefit.²⁶ This statutory remedy is set forth in 29 U.S.C. § 1132(a)(1)(B) and is often shorthand as the "benefits" remedy.²⁷ If, for example, the plan promised to pay for Treatment A in Circumstance A, a beneficiary in Circumstance A being denied coverage of Treatment A could sue for the "benefits due to him under the terms of his plan."²⁸ It is ERISA's statutory analog to a breach of contract claim.

Several crucial limitations have been grafted onto this benefit-denial remedy. These limitations involve exhaustion, deference, damages, and restricted jury rights.

Exhaustion. Limitation one is that a beneficiary must "exhaust" the plan's internal claims process before being permitted to seek judicial relief.²⁹ Although the Supreme Court has not explicitly adopted this requirement, it has spoken favorably of it,³⁰ and the circuits have overwhelmingly imposed "exhaustion" as a precondition to suit.³¹

Setting aside the policy wisdom of this limitation, ERISA by its terms imposes no such "exhaustion" requirement. Instead, it speaks of plans being required to provide beneficiaries with an "opportunity" for "full and fair review" of a benefit denial by the plan

24. *Id.* § 1102(a).

25. *Id.* § 1132.

26. *Id.* § 1132(a)(1)(B).

27. See Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 453 n.151 (2010) (describing 29 U.S.C. § 1132(a)(1)(B) as the "benefits" remedy).

28. 29 U.S.C. § 1132(a)(1)(B). The statute actually uses "his," rather than gender-neutral language.

29. *Id.* § 1133(1)–(2) (setting forth ERISA's internal claims procedure). Exhaustion—even without deference—is a modest form of litigation reform. "In fact, all but a few plan participants fail to complete the arduous appeal process available to them even before this new, external level of review." Katherine T. Vukadin, *Hope or Hype?: Why the Affordable Care Act's New External Review Rules for Denied ERISA Healthcare Claims Need More Reform*, 60 BUFF. L. REV. 1201, 1204 (2012).

30. See *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 258 (2008) (Roberts, J., concurring) (describing the administrative exhaustion requirement as a "safeguard[]" for plan administrators" that is "recognized by almost all the Courts of Appeals").

31. *Id.*; see also *Wilczynski v. Lumbermens Mut. Cas. Co.*, 93 F.3d 397, 401–02 (7th Cir. 1996) (noting Seventh Circuit precedent that courts may require exhaustion of administrative proceedings); *Diaz v. United Agric. Emp. Welfare Benefit Plan*, 50 F.3d 1478, 1483 (9th Cir. 1995) (stating a general rule that a claimant must exhaust internal claims procedures before bringing a lawsuit); *Costantino v. TRW, Inc.*, 13 F.3d 969, 974 (6th Cir. 1994) (holding that claimant must exhaust administrative remedies prior to suing); *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 826 (1st Cir. 1988) (finding an exhaustion requirement).

fiduciary.³² As scholars have tirelessly but futilely pointed out, an opportunity is not a requirement.³³

Deference. Limitation two is that plans possess the power to force courts to “defer” to the judgment of the internal reviewer. In a case called *Firestone Tire & Rubber Co. v. Bruch*,³⁴ the Supreme Court held that courts should review benefit denial claims de novo unless the plan document confers interpretative discretion upon fiduciaries charged with administering the plan.³⁵ In that case, courts must “defer” to the fiduciary’s determination, unless he has acted arbitrarily and capriciously.³⁶ To capture *Firestone* deference, virtually all plans confer discretion on those who consider and review benefit claims.³⁷

Moreover, even if a beneficiary establishes that a fiduciary is conflicted, the fiduciary is *still* entitled to deference. In such a case, a judge is simply asked to scrutinize more closely the fiduciary’s finding, with the scrutiny intensifying in proportion to the likelihood the conflict affected the decision.³⁸ Moreover, deference does not evaporate if the fiduciary behaves arbitrarily and capriciously in resolving the benefit claim. In that event, the court should merely vacate the fiduciary’s conclusion and remand it back to the fiduciary for a second bite at the apple.³⁹ Only when a fiduciary’s behavior amounts to bad faith can a court conclusively resolve the matter.⁴⁰

Deference, like exhaustion, does not grace ERISA’s pages.⁴¹ It is a judicial gloss long attacked by scholars.⁴² ERISA contemplates that

32. 29 U.S.C. § 1133(2).

33. See, e.g., Brendan S. Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 Wis. L. REV. 657, 674–76 (arguing that, as both a textual and policy matter, it is unlikely that ERISA requires administrative exhaustion).

34. 489 U.S. 101 (1989).

35. *Id.* at 115.

36. *Id.* at 109.

37. See, e.g., John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1324 (2007) (observing that “[p]lan drafters routinely seize upon *Bruch*’s invitation to instruct the courts to defer to plan decisionmaking”).

38. See *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 117 (2008) (explaining that a conflict of interest “should prove more important . . . where circumstances suggest a higher likelihood that it affected the benefits decision”).

39. See *Conkright v. Frommert*, 130 S. Ct. 1640, 1651 (2010) (holding that district court erred in refusing “to defer to the Plan Administrator’s interpretation of the Plan on remand, simply because the Court of Appeals had found a previous related interpretation by the Administrator to be invalid”).

40. See *id.* at 1647. A finding of bad faith does not create a bad faith cause of action under ERISA. It simply means that the court can interpret the insurance contract on its own. Precisely what the Court means by “bad faith” is not clear.

41. *Firestone*, 489 U.S. at 109 (“ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations.”).

the fiduciaries charged with deciding benefit claims may be employed, controlled, or otherwise influenced by the party obligated to pay on those claims.⁴³ A rule of judicial deference to a likely-conflicted decision maker makes little sense, and no sense at all in the context of a statute designed to protect the interests of beneficiaries.⁴⁴

Damages. Limitation three relates to damages. In 1985, in an opinion written by Justice Stevens, the Court ruled that “extra-contractual,” or consequential, damages are not recoverable.⁴⁵ Instead, the Court held that a beneficiary may only recover the value of the denied benefit.⁴⁶ That is, if a wrongfully denied or delayed benefit led to death or permanent injury, consequential damages are not available. Observers across the board, including scholars like Richard Epstein, have questioned the wisdom of this limitation.⁴⁷ That a party who suffers a legally cognizable injury has a right, in appropriate circumstances, to recover foreseeable damages arising from that injury is one of American law’s foundational principles. If Congress chose to eliminate such a natural feature of civil relief, one would expect Congress’s choice to have been varnished with statutory ink. No such limitation appears in ERISA’s text.⁴⁸

42. See, e.g., John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 217–20 (criticizing deference); Langbein, *supra* note 37, at 1336–42 (same); Maher & Stris, *supra* note 27, at 471–73 (same).

43. See Langbein, *supra* note 37, at 1316, 1325, n.69 (explaining that “ERISA fiduciaries are commonly aligned with the employer” and noting that “[m]ost ERISA plan benefit denials are the work of conflicted decisionmakers”).

44. See Maher & Stris, *supra* note 27, at 472–73 (arguing that deferential review encourages self-serving benefit determinations and increases the complexity of promises). Many states have attempted to limit the use of discretionary clauses, although whether those efforts will survive ERISA preemption is not settled. See generally Radha A. Pathak, *Discretionary Clause Bans & ERISA Preemption*, 56 S.D. L. REV. 500 (2011) (analyzing discretionary clause bans).

45. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

46. *Id.* at 144 (finding no “express authority for an award of extracontractual damages to a beneficiary”).

47. See Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625, 642 (2001) (acknowledging that the argument in favor of consequential damages under ERISA “has considerable force and may in the end be convincing”); see also George Lee Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 617–20 (1994).

48. Moreover, ERISA provides two other significant remedies to beneficiaries under § 1132(a)(2) and (a)(3). 29 U.S.C. § 1132(a)(2)–(3) (2012). The § 1132(a)(2) remedy is designed to police errant fiduciaries. The § 1132(a)(3) remedy is a “catch-all” remedy sounding in equity. Those remedies, while limited in other ways, are less restrictive than the “benefits” remedy. However, the Supreme Court has held that, absent unusual circumstances, a beneficiary may only avail himself of the remedies set forth in § 1132(a)(2) and § 1132(a)(3) if the benefits remedy is not applicable. See *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996) (surmising that where Congress has provided adequate relief for a beneficiary’s injury, there will be no need for (a)(3) relief). Numerous lower courts have explicitly held that the availability of the benefits remedy bars the use of other ERISA

Restricted jury rights. Limitation four relates to jury trials. In federal courts, ERISA benefit disputes are heard by a judge, not a jury. The rationale, roughly, is that ERISA is a codified form of trust law.⁴⁹ In the days of the divided bench, trust disputes were resolved by equity courts.⁵⁰ Thus, so the reasoning goes, ERISA claims—including simple disputes over coverage, which, in reality, resemble nothing more than contract claims—are “equitable” in nature and are thus heard by a judge.⁵¹ Scholars have criticized this reasoning.⁵² The Supreme Court has not considered the issue, but the circuit courts of appeals are in broad agreement.⁵³ ERISA itself is silent on the question.⁵⁴

remedies. *See, e.g.,* Korotynska v. Metro. Life Ins. Co., 474 F.3d 101, 105 (4th Cir. 2006) (“[Section] 1132(a)(3) authorizes some individualized claims for breach of fiduciary duty, but not where the plaintiff’s injury finds adequate relief in another part of ERISA’s statutory scheme.”); Ogden v. Blue Bell Creameries U.S.A., Inc., 348 F.3d 1284, 1287 (11th Cir. 2003) (explaining “that an ERISA plaintiff who has an adequate remedy under Section 502(a)(1)(B) cannot alternatively plead and proceed under Section 502(a)(3)”); Short v. Am. Cast Iron Pipe Co., 961 F. Supp. 261, 266 (N.D. Ala. 1997) (stating that because “§ 502(a)(1)(B) allows [the plaintiff] to recover any benefits he is due under the plan[,] . . . relief under § 502(a)(3) is not appropriate”).

ERISA suggests no such restriction. None of the enumerated remedies condition their availability on whether another remedy is applicable, and no remedy by its terms bars use of another enumerated remedy. *See generally* 29 U.S.C. § 1332 (providing guidelines for the civil enforcement of ERISA). Neither the fiduciary remedy nor the equitable remedy is, as of this writing, subject to exhaustion or deference. Making the benefits remedy the dominant remedy is a judicial gloss, motivated, ironically enough, by a desire to protect the *other* judicial glosses of exhaustion, deference, and no consequential damages.

49. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989) (“ERISA abounds with the language and terminology of trust law.”).

50. *See* Boone v. Wachovia Bank & Trust Co., 163 F.2d 309, 312 (D.C. Cir. 1947) (recognizing the inherent power of a court of equity to preside over the administration of trusts).

51. *See* DeFelice v. Am. Int’l Life Assurance Co. of N.Y., 112 F.3d 61, 64 (2d Cir. 1997) (“[C]ases involving ERISA benefits are inherently equitable in nature, not contractual, and . . . no right to jury trial attaches to such claims.”).

52. *See, e.g.,* George Lee Flint, Jr., *ERISA: Jury Trial Mandated for Benefit Claims Actions*, 25 LOY. L.A. L. REV. 361 (1992) (explaining and criticizing federal courts’ “trust” reasoning to deny jury trials in ERISA actions).

53. The circuit courts of appeal that have considered the issue have held that ERISA beneficiaries are not entitled to a jury trial. *Muller v. First Unum Life Ins. Co.*, 341 F.3d 119, 124 (2d Cir. 2003); *Thomas v. Or. Fruit Prods. Co.*, 228 F.3d 991, 997 (9th Cir. 2000); *Hampers v. W.R. Grace & Co.*, 202 F.3d 44, 54 (1st Cir. 2000); *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 616 (6th Cir. 1998); *Adams v. Cyprus AMAX Minerals Co.*, 149 F.3d 1156, 1162 (10th Cir. 1998); *Mathews v. Sears Pension Plan*, 144 F.3d 461, 468 (7th Cir. 1998); *Borst v. Chevron Corp.*, 36 F.3d 1308, 1324 (5th Cir. 1994); *Blake v. UnionMutual Stock Life Ins. Co. of Am.*, 906 F.2d 1525, 1526 (11th Cir. 1990) (per curiam); *Pane v. RCA Corp.*, 868 F.2d 631, 636 (3d Cir. 1989); *Berry v. CIBA-GEIGY Corp.*, 761 F.2d 1003, 1007 (4th Cir. 1985); *In re Vorpahl*, 695 F.2d 318, 322 (8th Cir. 1982).

In contrast, for section 502(a)(1)(B) claims brought in *state* court, which ERISA permits, *see* 29 U.S.C. § 1132(e)(1), state law on jury rights governs. Most state courts award jury trials. *See, e.g.,* *Shaw v. Atl. Coast Life Ins. Co.*, 470 S.E.2d 382, 386 (S.C.

ERISA as national litigation reform. ERISA's remedial system exemplifies the preference of many litigation reformers. It is a (1) mandatory, (2) no-damages, (3) private scheme of dispute resolution, subject only to (4) modest agency regulation, (5) feeble judicial oversight, and (6) no juries. Moreover, because of ERISA's enormous preemptive reach,⁵⁵ any state law that attempted to "supplement" this remedial scheme was held to be in conflict with ERISA's purposes and thus preempted.⁵⁶ The result: not only did ERISA instantiate profound litigation reform, it made it national.

The irony is that ERISA, at the time of its passage, was hailed as a landmark protective statute.⁵⁷ One of its explicit purposes was to provide beneficiaries with "appropriate remedies, sanctions, and

Ct. App. 1996) ("The majority of state courts, prior to and subsequent to the enactment of ERISA, have viewed the plans as contractual, thus granting jury trials in benefits-due lawsuits."). The practical effect of this is limited because, even though a § 1132(a)(1)(B) action can be filed in either state or federal court, a defendant may remove the dispute to federal court on federal question grounds. *See, e.g.,* *Clorox Co. v. U.S. Dist. Court for the N. Dist. of Cal.*, 779 F.2d 517, 521 (9th Cir. 1985) (holding that "ERISA contains no express provision against removal" and supplies no other indication "that Congress intended to prevent removal of employee actions filed in state courts").

54. *See* John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1355 (2003) ("ERISA's procedure and remedy sections are riddled with major omissions that the courts have had to fill in, such as whether jury trial pertains, and what statute of limitations to use."); *see also* Flint, *supra* note 52, at 399 ("ERISA contains no express provision granting a jury trial for benefits-due lawsuits . . .").

55. *See infra* note 67 (detailing the scope of ERISA's preemption clause as defined by judge-made law); *infra* Part IV.A (explaining preemption and, in particular, conflict preemption).

56. *See* *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209, 221 (2004) (explaining that state law is preempted if it "duplicates, supplements, or supplants" any of the civil enforcement remedy provisions in section 502 of ERISA and holding that state-law created causes of action against HMOs were preempted); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990) (holding that wrongful termination cause of action was preempted); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (holding that Mississippi law of bad faith denial of insurance benefits was preempted); Radha A. Pathak, *Discretionary Clause Bans & ERISA Preemption*, 56 S.D. L. REV. 500, 512-13 (2011) (concluding that discretionary clauses in state laws are likely not conflict preempted by the remedies provision of ERISA).

57. *See* H.R. REP. NO. 93-533, at 4639 (1973) ("The primary purpose of [ERISA] is the protection of individual pension rights . . ."); 120 CONG. REC. at 29,935 (1974) ("[A] pension reform law is now a reality because of the hardship, deprivation and inequity suffered by American working people The discipline of law will enable this and succeeding generations of workers to face their retirement period with greater confidence and greater security . . ."); 120 CONG. REC. 29,933, 29,935 (1974) (referring to ERISA as a "pension 'bill of rights'"); *see also* Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 358-60 (1994) (noting that the primary purpose of ERISA was to protect beneficiaries from administrative and funding abuses); Peter J. Wiedenbeck, *ERISA's Curious Coverage*, 76 WASH. U. L.Q. 311, 349 (1998) ("ERISA was enacted to inform and protect employees.").

ready-access to the Federal courts.”⁵⁸ Instead, it turned into one of the most effective pieces of federal litigation reform legislation ever passed.

There is no tidy answer as to why this happened. The text of the statute provides little justification; ERISA’s defining remedial features are judicial emendations. What explains their creation? Legal realism provides the most compelling explanation, one which not only provides a more satisfying explanation to the Supreme Court’s past behavior, but also sheds light on how the ACA might be interpreted. I revisit this issue at more length in Part III.A. First, I briefly discuss the differences between state insurance law and ERISA. The former, under ACA, will become more important than it has been in over thirty years.⁵⁹

B. State Law Remedy

While state law varies, insured individuals seeking coverage under state insurance law possess more expansive remedies than under ERISA.⁶⁰ Relative to ERISA, state law favors claimants by providing broader legal remedies, including: multiple causes of action; interpretative doctrines favoring insureds; compensatory, usually consequential, and sometimes punitive, damages; and, jury rights. Nevertheless, it is not the litigious free-for-all that is sometimes suggested.⁶¹ Sensible limits exist, in some states more than others, though none go nearly as far as ERISA.

Most states do not require that an insured exhaust any internal grievance procedures beyond that which is necessary to make clear that the insurer is actually denying coverage.⁶² Use of internal

58. 29 U.S.C. § 1001(b).

59. See CONG. BUDGET OFFICE, *supra* note 13, at 20 tbl.3 (projecting that 25 million people will receive insurance through individual markets by 2022).

60. The citations in this section are generally taken from cases that involve insurance generally, not just health insurance. Prior to the ACA, the individual insurance markets that states regulated were sparsely populated. *Supra* note 19. For that reason, expression of remedial insurance principles was more likely to come up in cases involving matters other than health insurance.

61. See Donald T. Bogan, *Saving State Law Bad-Faith Claims from Preemption*, TRIAL, Apr. 2003, at 57, 57–58 (noting that under state law plaintiffs may pursue, for example, bad faith remedies not available under ERISA); Todd J. Zywicki, *Is Forum Shopping Corrupting America’s Bankruptcy Courts?*, 94 GEO. L.J. 1141, 1160 (2006) (arguing that plaintiff-friendly states “exert a disproportionate negative influence over law,” particularly with respect to class actions).

62. As the Solicitor General has explained: “state-law insurance claims . . . generally involve no required exhaustion of plan remedies.” Brief for the United States as Amicus Curiae Supporting Petitioner at 29, *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013) (No. 12-729). Absent some salient indication that the insurer is denying coverage, the insured would have no standing to sue.

procedures, if offered by the insurance company, is optional.⁶³ Accordingly, state law does not maroon insureds in a system where conflicted adjudicators play a central role in resolving claims. Nor does the insurer benefit from favorable interpretative regimes. Contracts of insurance were the first contracts described as contracts of adhesion,⁶⁴ and in many states the interpretation of insurance contracts is either *de novo* or *contra proferentem* (where the insurance policy is construed against the drafter).⁶⁵

Various causes of action are available to remediate coverage denials, as well as to recover consequential or even punitive damages, if the insurer improperly delays or refuses to pay on the policy.⁶⁶ Juries are available to most claimants.⁶⁷ Numerous states authorize some form of consequential and punitive damages in certain circumstances, either via statute or under principles of their common law.⁶⁸ Limits on potential misuses of state remedies like “bad faith”

63. *Id.*

64. Indeed, “the first use of the term ‘contract of adhesion’ was in an article dealing with the formation of insurance contracts.” *Meier v. N.J. Life Ins. Co.*, 101 N.J. 597, 612 n.10 (1986) (citing Edwin W. Patterson, *The Delivery of a Life-Insurance Policy*, 33 HARV. L. REV. 198, 222 (1919)).

65. See 2 RCRA AND SUPERFUND: A PRACTICE GUIDE § 16:11 (3d ed. 2004) (explaining that “unless the wording of the policies is actually drafted by the insured or the insured’s representative, most courts will apply the *contra proferentem* rule and, when faced with ambiguity, will adopt an interpretation of the policy that favors the insured”).

66. In early insurance cases, the hoary *Hadley-Baxendale* rule limiting available legal relief to foreseeable consequential damages was in some jurisdictions limited by another principle, one limiting the damages in a failure to pay cases to the value of the contract. See, e.g., Bob G. Freemon, Jr., *Reasonable and Foreseeable Damages for Breach of an Insurance Contract*, 21 TORT & INS. L.J. 108, 108 (1985) (discussing the origins and limits on consequential damages in insurance cases). Such limits motivated insurers to behave aggressively. Most states responded by recognizing causes of action that permitted the recovery of consequential and punitive damages, such as bad faith, as well as by enacting “penalty statutes to cover insurer abuses with respect to claims.” Flint, *supra* note 47, at 658.

67. See *Shaw v. Atl. Coast Life Ins. Co.*, 470 S.E.2d 382, 385 (S.C. Ct. App. 1996) (concluding that most states view insurance disputes as contract disputes suitable for a jury). Whether juries are “better” for plaintiffs than judges is a matter of some dispute. See, e.g., Shari Seidman Diamond, *Beyond Fantasy and Nightmare: A Portrait of the Jury*, 54 BUFF. L. REV. 717, 731 (2006) (examining mixed empirical research on whether juries are friendlier to plaintiffs than judges). Whatever the actual answer, litigation reformers routinely back measures that limit the jury. See, e.g., Huber, *supra* note 5, at 319 (criticizing tort liability as determined by juries). The mid-1980s wave of tort reform litigation imposed caps on non-economic damages to prevent “runaway” jury awards. See CONG. BUDGET OFFICE, THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES, at vii (2004), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/55xx/doc5549/report.pdf> (“Although tort reform is a continuing issue, it gained prominence in the mid-1980s, when many states enacted reforms in response to a perceived problem in insurance costs.”).

68. See, e.g., GA. CODE ANN. § 33-4-6 (2012) (25% penalty for bad faith refusal); TENN. CODE ANN. § 56-7-105(a) (2008) (25% penalty for bad faith refusal); *Chavers v. Nat’l Sec. Fire & Cas. Co.*, 405 So. 2d 1, 7 (Ala. 1981) (per curiam) (recognizing bad

exist as well.⁶⁹ Damage caps nonspecific to insurance claims are also in effect in several states.⁷⁰

C. ERISA Realism

Why ERISA diverged so significantly from state law on remedy is a puzzle. Textual explanations fail because ERISA's statutory language is at best scant with respect to the above-listed remedial limits imposed by the judiciary. A legal realist account of judicial behavior is more convincing. American legal realism⁷¹ contends that legal outcomes depend both on official legal materials, like statutes and precedents, as well as "nonlegal" forces, like policy preferences.⁷²

Few scholars today believe that judges discharge their will unconstrained by anything other than their own sense of discretion. Virtually all credible observers accept that statutory language, agency regulation, and precedent have some constraining power, although there is disagreement over the details.⁷³ Many, including me, believe that Realist impulses (e.g., nonlegal motivations) will frequently overcome modest statutory or precedential hurdles. Put another way: if there is some ambiguity in a statute, extra-statutory inclinations are likely to drive the resolution of disputes about the statute's meaning. From that perspective, with respect to ERISA, three particular nonlegal concerns drove the interpretation of the statute: (1) the cost and uncertainty of making health insurance promises; (2) the lack of a suitable insurance alternative to employment-provided insurance; and (3) general judicial hostility, from 1980 onward, to expansive remedy.

faith claim against insurer); *Fletcher v. W. Nat'l Life Ins. Co.*, 89 Cal. Rptr. 78, 93-94 (Ct. App. 1970) (upholding damages award for intentional infliction of emotional distress arising from bad faith insurance conduct); *Arnold v. Nat'l Cnty. Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987) (recognizing a "cause of action for breach of the duty of good faith and fair dealing" against insurers).

69. Douglas R. Richmond, *The Two-Way Street of Insurance Good Faith: Under Construction, But Not Yet Open*, 28 LOY. U. CHI. L.J. 95, 143 (1996) (explaining that insurers have a variety of defenses to bad faith claims, such as comparative bad faith, recoupment, setoff, and breach of the policy's cooperation clause).

70. See, e.g., *Scholz v. Metro. Pathologists, P.C.*, 851 P.2d 901, 911 (Colo. 1993) (en banc) (holding noneconomic damage cap to be constitutional); *Univ. of Miami v. Echarte*, 618 So. 2d 189, 198 (Fla. 1993) (same); *Kirkland v. Blaine Cnty. Med. Ctr.*, 4 P.3d 1115, 1116 (Idaho 2000) (same).

71. See *supra* note 10 (discussing the author's intending meaning of legal realism).

72. See Schauer, *supra* note 10, at 752-56 (detailing the various beliefs of American legal realists). I sometimes use the term "extra-statutory" to mean essentially the same thing as "nonlegal."

73. See *supra* note 10 (listing variants of legal realism).

Cost and uncertainty. Insurance is costly and uncertain. Cost is a function of the insurance policy's expected payout. The higher the cost of the service the insurance has to provide in connection with a loss event, the more costly the insurance policy will be to buy and perform. As health care costs began to sharply rise in the 1980s and thereafter, commentators expressed a multitude of theories as to why costs were so high.⁷⁴ There was little dispute that health care costs were rising; the dispute was why. The breadth of a judicial remedy, irrespective of whether it is a primary driver of rising health care costs, increases the overall cost of making a health insurance promise. Moreover, to the extent a judicial remedy is "volatile"—that is, likely that two impartial adjudicators, on the same facts, will reach widely different liability or damages determinations—the effective cost of providing an insurance policy subject to this remedy increases for risk-averse defendants.⁷⁵

For judges aware of the problem of rising health costs and faced with multiplying disputes over coverage decisions, a natural temptation is to "trim" the remedy, so as to reduce the average cost and volatility of offering health insurance.⁷⁶ The degree to which courts have acknowledged that concerns about cost influenced the selection and application of legal rules varies, but there is little doubt that cost plays a role.⁷⁷ The only question about which reasonable minds might disagree is how large a role cost concerns played in driving the judiciary to fiercely cabin ERISA's benefit denial remedy.

74. See, e.g., PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 259 (1982) (noting an increase in medical costs attributable in part to scientific and educational advances that improved quality of care); Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 *LAW & CONTEMP. PROBS.* 93, 95 (1988) (attributing health care cost increases to the inefficiencies of "cost-based or charge-based reimbursement for health care"); Paul B. Ginsburg, *Alternative Approaches to Health Care Cost Containment*, 30 *JURIMETRICS J.* 447, 448–52 (1990) (surveying the varying success of cost containment policies and the reasons for their lack of success); Timothy Stoltzfus Jost, *Our Broken Health Care System and How To Fix It: An Essay on Health Law and Policy*, 41 *WAKE FOREST L. REV.* 537, 547–49 (2006) (attributing increasing costs of health care to a variety of variables, such as improvements in technology and growing proportion of elderly); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 *AM. ECON. REV.* 531, 535–36 (1968) (explaining why moral hazard in health insurance leads to upward price pressure).

75. See Maher & Stris, *supra* note 44, at 470 (arguing that volatility in benefit promises increases the cost of providing insurance).

76. See *id.* (suggesting that eliminating consequential damages could address concerns related to increasing cost).

77. See, e.g., *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993) (voicing concern that the rule urged by the plaintiff would impose high insurance costs upon persons who regularly deal with and offer advice to ERISA plans and would discourage growth of private pension plans).

Lack of a suitable alternative. A second reality regarding the availability of health insurance amplifies the weight of the cost concerns. Because of the nature of insurance economics, health insurance options outside of group markets are often costly or unavailable.⁷⁸ Individual insurance transactions are hamstrung by the problem of adverse selection, where the person seeking insurance could pose a greater payout risk than the insurer is able to ascertain and charge for.⁷⁹ Group insurance is less risky for the insurer. The larger the group, the more the insurance risk will approach the risk of insuring the entire community, and community risk is, generally speaking, ascertainable by insurers.⁸⁰ Employment-based insurance, a form of group insurance, thus lessens the hurdles of adverse selection and provides important access to health insurance—access that an individual could not, on his own, obtain as inexpensively, or perhaps even at all.⁸¹

ERISA does not require employers to offer health insurance to their employees.⁸² Thus, to the extent offering insurance becomes, in employers' minds, too costly or too volatile, employers in the pre-ACA world might stop offering it, leaving their employees with no realistic alternative.⁸³ When assessing questions about the contour of the ERISA benefit denial remedy, judges would have been hard pressed to ignore the consequences of interpreting the remedy expansively. If employers were deterred from offering insurance because of the cost and uncertainty associated with generous remedies—for example, runaway damage awards for pain and suffering—then quite literally many millions of Americans would have become unable to obtain health insurance.

Judicial hostility. Finally, since the election of Ronald Reagan in 1980, the federal judiciary has been reluctant to afford expansive remedies to plaintiffs in a wide variety of contexts.⁸⁴ As Professors

78. See Peter Diamond, *Organizing the Health Insurance Market*, 60 *ECONOMETRICA* 1233, 1236–37 (1992) (explaining that in individual markets, high risk individuals may be rejected or unable to obtain affordable coverage).

79. *Id.*

80. This assumes the group is one organized for some purpose *other* than to buy insurance; the group must be aggregated along some dimension that is orthogonal to risk.

81. See *supra* note 78 and accompanying text (explaining that health insurance outside of group markets is often costly or unavailable).

82. See *supra* note 21 and accompanying text.

83. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 402 (2002) (Thomas, J., dissenting) (expressing concern that expanded remedies “could create a disincentive to the formation of employee health benefit plans”).

84. See Daniel J. Meltzer, *The Supreme Court's Judicial Passivity*, 2002 *SUP. CT. REV.* 343, 345–62 (identifying four important Supreme Court cases that advance a “constricted view of statutory interpretation and of the scope of judicial power to

Meltzer and Resnick have explained, judges skeptical of the utility of court access and broad remedies, and fearful of their abuse by opportunistic plaintiffs' lawyers, have enjoyed rising reputations and influence since 1980.⁸⁵ Several such judges sat on or are currently sitting on the Supreme Court.⁸⁶

It is important to distinguish the realist motivation of "hostility to remedy" from the other realist motivations discussed above. A person could very easily be neutral on the general question of remedy and yet be inclined to interpret ERISA remedies narrowly for fear of cost and lack of an insurance alternative. One would expect such a person to alter his or her judicial behavior upon alleviation of those concerns, rather than reading litigation reform into a statute. In contrast, a judge with a natural skepticism regarding the utility of remedy will be more likely, if not eager, to trim remedies in any case where a statute does not prohibit him or her from doing so.

The objective here is not to prove beyond cavil that extra-statutory influences drove ERISA interpretation; full treatments of that question, and constituent parts thereof, have been undertaken elsewhere.⁸⁷ The point instead is to ask, if the extra-statutory

flesh out federal enactments in service of statutory and constitutional purposes"); Judith Resnik, *Constricting Remedies: The Rehnquist Judiciary, Congress, and Federal Power*, 78 IND. L.J. 223, 256–58 (2003) (discussing how Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204 (2002), represents a shift in understanding of federal remedial powers).

85. See Meltzer, *supra* note 84, at 345–62; Resnik, *supra* note 84, at 256–58; see also *infra* note 86 and accompanying text (describing the previous and current makeup of the Supreme Court and its attitude toward broad court remedies).

86. Professor Andrew Siegel has argued that a defining feature of the Rehnquist Court (1986–2005) was its hostility "towards the institution of litigation and its concomitant skepticism as to the ability of litigation to function as a mechanism for organizing social relations and collectively administering justice." Andrew M. Siegel, *The Court Against the Courts: Hostility to Litigation as an Organizing Theme in the Rehnquist Court's Jurisprudence*, 84 TEX. L. REV. 1097, 1108 (2006). The Roberts Court (2005–present) has offered no indication it feels differently. See Editorial, *supra* note 3. Chief Justice Roberts and Justices Scalia, Kennedy, Thomas, and Alito are widely believed to be skeptical of broad court remedies. See Lee Epstein, William M. Landes & Richard A. Posner, *How Business Fares in the Supreme Court*, 97 MINN. L. REV. 1431, 1472–73 (2013) (observing a shift of conservative Justices in favor of business interests following the appointment of Roberts and Alito and noting that "the Roberts Court is much friendlier to business than either the Burger or Rehnquist Courts, which preceded it, were"). Past Justices Burger and O'Connor criticized the perils of expansive remedy. See, e.g., Richard de Uriarte, *Good Lawyer/Bad Lawyer: O'Connor's Criticism of Contingency Fees Provokes Debate*, ARIZ. REPUBLIC, Sept. 9, 2001 at V.1 (describing Justice O'Connor's criticism of "out-of-control class action lawsuits and outrageous contingency fees" as being earlier expressed by Justice Burger).

87. See, e.g., Maher, *supra* note 33, at 659 (identifying concerns about promise costs as having influenced the Supreme Court's interpretation of ERISA); Dana M. Muir, *Fiduciary Status as an Employer's Shield: The Perversity of ERISA Fiduciary Law*, 2 U. PA. J. LAB. & EMP. L. 391, 425–26 (2000) (describing and criticizing the settlor doctrine); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of*

concerns listed above played a meaningful role in converting ERISA from a protective statute into a vehicle for litigation reform, to what degree will the ACA be molded by those same influences? Obviously that answer depends upon (1) the degree to which the ACA is flexible enough to yield to moderately realist interpretative behavior, and (2) the power the three nonlegal forces that affected ERISA exert on today's judges. I consider both questions in Part III. In Part II, to set the table, I offer a conceptual summary of the remedial concepts in the ACA.

II. REMEDIAL CONCEPTS IN THE ACA

What the ACA says about remedy is short—a single section of code—but it presents considerable complexity.⁸⁸ To understand the effect that section has on remedy requires familiarity with multiple sources of authority outside the ACA.⁸⁹ Before plunging into those intricacies, I provide a conceptual sketch of the legislation's three tracks of remedy.

Only one section of the ACA directly considers remedy.⁹⁰ It contemplates three important remedial concepts: internal review,⁹¹ external review,⁹² and judicial review. Section 2719 directly speaks to the first two, and indirectly speaks to the third. I consider each below.⁹³

A. *Internal Review*

The ACA contemplates an “internal claims appeal process,” which I refer to as “internal review,” for coverage claims by insureds.⁹⁴ Stated simply, internal review is a procedure for processing beneficiaries' claims and appeals that is administered by the insurer or its

ERISA, 61 HASTINGS L.J. 131, 133 (2009) (arguing that the Court has prioritized cost reduction over protecting beneficiaries, contrary to congressional wishes).

88. 42 U.S.C. § 300gg-19 (2012).

89. To wit: the ACA explicitly refers to, and relies on (1) state law; (2) complex federal regulations old and new; (3) the discretion of the Departments of Labor, Treasury, and Health and Human Services; and (4) ERISA. Perhaps more importantly, making sense of the ACA remedy provision requires understanding the federal-state division of authority prior to its passage, a power allocation defined almost entirely by ERISA preemption doctrine.

90. 42 U.S.C. § 300gg-19.

91. *Id.* § 300gg-19(a)(1)(A).

92. *Id.* § 300gg-19(a)(1)(B).

93. Section 2719, standing alone, does not resolve how the three interact. *See infra* Part II.D (discussing the ACA's lack of guidance regarding how the remedial tracks should interact and suggesting that this gap may create room for litigation reform arguments).

94. 42 U.S.C. § 300gg-19(a)(1)(A).

designee.⁹⁵ The ACA and its implementing regulations require that all insurers offer internal review.⁹⁶

Internal review can serve desirable ends. A genuine internal process requires that the handling of a benefit claim involve more than an unvarnished “yes” or “no.” Some procedure is specified, in writing and *ex ante*.⁹⁷ Adherence thereto is thought to encourage faithful and fair evaluation by the insurer, and impress that perception of fairness upon the claimant.⁹⁸

Few contend that internal processes alone will ensure fair results every time. Conversely, few dispute that for *some* number of claims, internal review will produce the correct outcome; whether that number is large or small depends largely on one’s priors. Given the reduced cost of internal review compared to litigation,⁹⁹ one would expect there to be a sincere appetite by both insurers and claimants for fair internal review processes.¹⁰⁰ On the other hand, if internal processes are not fair (relative to judicial review), then the disadvantaged party will likely prefer judicial review, even if it is more costly.

Recall that internal review is part of ERISA’s remedial scheme.¹⁰¹ Some claimant advocates have complained that internal review under ERISA was not fair.¹⁰² Of the many opinions that were offered

95. In addition to “internal review,” I also occasionally use the terms “internal process,” or “internal procedures.” All terms encompass both the initial claim and any subsequent internal appeal. *Cf.* 29 C.F.R. § 2560.503-1(b) (2013) (setting forth the baseline federal regulation, referred to explicitly in the ACA, as governing “the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations” (emphasis added)).

96. 42 U.S.C. § 300gg-19(a); *see also infra* note 148 (describing the applicable standards set forth in the implementing regulations regarding internal review). *But see infra* note 127 (identifying types of insurance beyond the scope of this Article).

97. 42 U.S.C. § 300gg-19(a)(2); 29 C.F.R. § 2560.503-1 (describing the claims procedure for beneficiaries and participants to recover employee benefits).

98. *See, e.g.*, H.R. REP. NO. 111-443, at 1005 (2010) (describing the fair “grievance and appeals mechanisms” that the ACA intends to provide).

99. *See infra* note 114 and accompanying text (explaining why internal review is much cheaper than litigation).

100. Litigation is costly. But it is costly for everybody, because everybody has to pay lawyers and devote resources to it, in one way or another. To the extent litigation confers a substantive advantage on one party over another, that party will prefer litigation. To the extent however, that litigation confers no substantive advantage, then both plaintiffs and defendants will prefer less costly dispute resolution alternatives.

101. *See supra* Part I.A (explaining that ERISA requires that all insurers provide an internal review process to adjudicate employee benefits claims).

102. *See* Langbein, *supra* note 37, at 1340 (arguing that deferential judicial review undermines the fairness of internal proceedings); Maher, *supra* note 33, at 673–76 (observing that, among other things, administrator bias results in unfair administration of claims). One critic compared internal review under ERISA to a “kangaroo court.” Joseph F. Cunningham, *ERISA: Some Thoughts on Unfulfilled Promises*, 49 ARK. L. REV. 83, 90 (1996).

criticizing internal review,¹⁰³ perhaps the primary criticism was that the administrators charged with conducting ERISA's internal reviews were often directly or indirectly beholden to the party who must pay on successful claims.¹⁰⁴ Such actual or potential conflict might imperil fair review. Other criticisms were that internal review procedures often limited claimant ability to fully present their side or were difficult to understand.¹⁰⁵

The ACA directly responds to those concerns and attempts to make internal review fairer.¹⁰⁶ Indeed, the current internal review regulations for self-insured and group health plans include all the procedural protections the federal government previously required of ERISA plans, as well as a handful of new requirements promulgated in connection with the passage of the ACA.¹⁰⁷ With respect to individual insurance policies, the regulations regarding internal review are even more stringent.¹⁰⁸

B. External Review

External review is review done by a competent party unaffiliated with either the insurer or the claimant, but who wields some

103. See, e.g., *supra* note 102 (describing commentators' criticisms of the internal review process).

104. See Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1126 (1988) (explaining that ERISA "leaves the plan sponsor to pick the fiduciary and, if the sponsor pleases, to do it from the ranks of management" and that "[s]ponsors routinely exercise this authority"). More than two decades later, the problem remains. John Bronsteen, Brendan S. Maher & Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2311-15 (2008) (explaining how conflict manifests itself across various payor-administrator relationships).

105. See Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727, 741 (2004) (noting that under ERISA, there is no right to issue subpoenas and "rarely is there an opportunity to present testimonial evidence and elicit cross-examination during the claim process").

106. See *infra* notes 107-08 and accompanying text (describing the stringent regulations governing internal review that aim to make the process fairer for claimants).

107. E.g., 42 U.S.C. § 300gg-19 (2012); see also 29 C.F.R. § 2590.715-2719(a)-(b) (2013) (promulgating regulations for internal processes of self-insured and group-insured plans). "With respect to internal claims and appeals processes for group health plans and health insurance issuers offering group health insurance coverage . . . section 2719 provides that plans and issuers must" abide by regulations promulgated by Department of Labor. Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 Fed. Reg. 37,208, 37,209 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117).

108. Individual insurers must satisfy regulations promulgated by the relevant State and the Department of Health and Human Safety. See 42 U.S.C. § 300gg-19(a)(2)(B); 45 C.F.R. § 147.136(a)-(b). Individual insurers must comply with several "additional requirements for internal claims and appeals processes" relating to appeals and notice record-keeping. 76 Fed. Reg. at 37,209, n.3 (discussing additional internal review requirements for insurers offering individual insurance).

expertise helpful in resolving the dispute.¹⁰⁹ In theory, external review is a cost-effective approach free of the potential conflict that naturally menaces internal review.¹¹⁰ It presents, in some respects, a middle ground between internal review and judicial review.

The ACA envisions and provides that external review will be available to all insured persons, whether they receive insurance from a self-insured plan, a group-insured plan, or have individual coverage.¹¹¹ The external review must be done by Independent Review Organizations, who are to be randomly assigned to disputes by regulatory officials, and who may not be otherwise conflicted.¹¹² The cost of the external review is to be borne by the insurer, with no more than a modest fee chargeable to the insured.¹¹³

External review is widely perceived as more attractive to claimants than internal review, and the ACA's embrace of external review is commendable. External review is cheaper than litigation,¹¹⁴ and the structural risk of bias is much less than with internal review.¹¹⁵ On the other hand, although external review resolves coverage disputes, it cannot grant damages. Moreover, the specter of regulatory capture exists where officials in a facially neutral government or government-sponsored body subtly favor the regulated industry over the protected

109. See *infra* note 112 and accompanying text (describing the qualifications for Independent Reviewers conducting external review).

110. Bronsteen, Maher & Stris, *supra* note 104, at 2324 (observing that impartial, third-party administrative review is a low-cost alternative to litigation that combats opportunistic insurer behavior).

111. 42 U.S.C. § 300gg-19(b) (mandating that group health plans and insurance issuers offering group or individual health insurance coverage implement an external review process).

112. 29 C.F.R. § 2590.715-2719(c)(2)(vii)–(ix). The Independent Review Organization (IRO) specifics for self-insured plans are slightly different, but can largely be ignored for the purposes of this Article. See Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37,208, 37,210–11 (June 24, 2011) (to be codified at 45 C.F.R. pt. 147) (explaining the IRO process for self-insured plans). I do pause to note, however, that as the regulations currently read, the IRO process for self-insured plans apparently contemplates random assignment from a list of external reviewers the employer has contracted with (which must be no less than three), see *infra* note 166, whereas state external review processes contemplate random assignment of external reviewers from a list compiled by the state. 29 C.F.R. § 2590.715-2719(c)(2)(vii). The former may represent an avenue for manipulation of the external review process.

113. 29 C.F.R. § 2590.715-2719(c)(2)(iv).

114. See Bronsteen, Maher & Stris, *supra* note 104, at 2324 (noting that litigation is nothing more than a very expensive, very time-consuming process, whereas external review is significantly more attractive because it is expedient and inexpensive).

115. See *id.* at 2324–26 (explaining that external review significantly diminishes agency risk because the agent's discretion for opportunistic behavior is circumscribed by the determinations of an impartial reviewer).

consumer. Just the same, one would expect there to be a significant appetite by claimants for an external review option.

C. Judicial Review

Judicial review is what it sounds like: litigation, where a federal or state court entertains an insured's denied-coverage claim.¹¹⁶ The central component of judicial review is a cause of action, i.e., a legal right to relief that arises from some applicable body of substantive law given certain conditions. Without a cause of action—the core of traditional remedy—there is nothing for a court to review.

Importantly, the ACA does not provide a cause of action to remedy a coverage denial.¹¹⁷ Instead, a claimant has the right to bring suit under whatever law, pre-ACA, governed the insurance policy his claim arises under.¹¹⁸ Figuring that out, unfortunately, necessitates an understanding of ERISA preemption, because the two bodies of law potentially applicable to a coverage denial prior to the ACA's enactment were ERISA and state law.¹¹⁹

116. By judicial review, I stress that I simply mean litigation; not that a judge (rather than a jury) will decide the case. Even when a jury decides, the judge still presides; hence, there is judicial review.

117. The ACA does not provide an explicit cause of action for coverage disputes. Nor does it seem at all likely that it creates an *implied* right of action for coverage denials, and I therefore assume it does not throughout. *See generally* *Cort v. Ash*, 422 U.S. 66, 78 (1975) (setting forth a four-part test to determine whether a statute impliedly creates a cause of action consisting of an analysis of the protected class, legislative intent, underlying statutory purpose, and traditional state law). The Supreme Court has made clear that if a federal statute does not explicitly provide a cause of action, the strong presumption is that no private cause of action should be implied. *See, e.g.*, *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta*, 552 U.S. 148, 175 (2008) (Stevens, J., dissenting) (remarking that the conservative justices are hostile toward implied causes of action); ALLAN IDES & CHRISTOPHER MAY, *CIVIL PROCEDURE: CASES AND PROBLEMS*, 310 (4th ed. 2012) (“Courts have tended to apply [the *Cort v. Ash*] factors with increasing stringency in recent years, reflecting a judicial reluctance to imply a private right of action where Congress has failed to provide one.”).

Indeed, with respect to certain issues *other* than coverage disputes, the Government Accountability Office (GAO) has already opined that the ACA does not create implied causes of action. “Congress directed GAO to consider whether . . . any guideline or other standards under the 14 PPACA quality enhancement provisions identified in section 3512 of the law would result in a ‘new cause of action or claim.’” U.S. GOV'T ACCOUNTABILITY OFFICE, B-322525, *CAUSES OF ACTION UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1* (2012), available at <http://www.gao.gov/products/B-322525#mt=e-report>. The GAO answered negatively. *Id.*; see also 156 CONG. REC. H1,857 (daily ed. March 21, 2010) (statement of Rep. Waxman) (rejecting the notion that bills that would become the ACA “may be interpreted or construed as creating a new cause of action or claim or would modify or impair existing state medical malpractice laws”).

118. I consider the possibility that the ACA “extinguishes” the pre-existing right of insured persons to bring a cause of action for coverage denial below. *See infra* Part III.B.3. It does not. The state law analysis applies with equal force to ERISA.

119. Put differently, with respect to the available cause of action for wrongful denial of coverage (and the damages recoverable), the ACA is a “pass-through”

ERISA explicitly preempts all state laws that “relate to” employee benefit plans.¹²⁰ The broadness of that preemptive grant is lessened by ERISA’s “savings clause,” which saves state insurance laws from preemption.¹²¹ Nonetheless, the power of a saved insurance law to regulate employment-based insurance arrangements is limited in two important ways.

The first limit on saved state insurance laws is a provision in ERISA called the “deemer” clause.¹²² ERISA bars states from directly regulating employment benefit plans by the expedient of deeming them to be insurers subject to saved insurance law.¹²³ A state may, however, regulate an insurance company that provides a group policy to a benefit plan. Thus if Company Benefit Plan *A* engages Insurance Company *B* to issue group health coverage for company employees, a state can regulate Insurance Company *B* by way of “saved” insurance laws.¹²⁴

The second limit on saved insurance laws is conflict preemption. If a state law—even a saved one—conflicts with ERISA’s purpose, it will be preempted.¹²⁵ The Supreme Court has not been clear on the complete set of saved state laws that are conflict-preempted, but it has held that state laws providing additional causes of action or damages beyond those provided by ERISA are conflict-preempted.¹²⁶

The upshot is that the unusual mechanics of ERISA preemption mean that the cause of action and damages that an insured is entitled to depends on the nature of the insurance arrangement he is party

statute that relies on the previously applicable body of substantive law. See Brendan S. Maher, *The Benefits of Opt-in Federalism*, 52 B.C. L. REV. 1733, 1773 (2011) (“The ACA uses federal power to create a legal meta-structure in which individuals can plausibly ‘opt-in’ to either federal (specifically ERISA) or state law governing their health bargains.”).

120. 29 U.S.C. § 1144(a) (2012) (providing that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan”).

121. *Id.* § 1144(b)(2)(A).

122. *Id.* § 1144(b)(2)(B).

123. *Id.*

124. *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) (“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.”).

125. See *Chamber of Commerce v. Whiting*, 131 S. Ct. 1968, 1979–85 (2011) (notwithstanding the savings clause preserving certain state laws from express preemption, state law might still be preempted if it conflicted with federal law); *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355, 387 (2002) (explaining even saved laws would fall to ERISA conflict preemption); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (holding that ERISA was intended to be the exclusive civil enforcement vehicle for ERISA-plan participants and state cause of action claims are therefore preempted).

126. See *Pilot Life*, 481 U.S. at 55 (analogizing the Labor Management Relations Act’s preemption of state law causes of action to the preemptive scope of ERISA).

to. The three pertinent types are (1) self-insured plans, (2) group-insured plans, and (3) individual insurance.¹²⁷

Self-insured plans (employer-based). A so-called “self-insured plan” is where the employer directly pays for employees’ incurred health care costs.¹²⁸ In that instance, because of the deemer clause,¹²⁹ the plan is entirely regulated by ERISA, including with respect to the cause of action available in the event of a coverage denial.¹³⁰

Group-insured plans (employer-based). A group-insured plan is my functional term¹³¹ for a group insurance policy purchased by an employee benefit plan for its employees. In that instance, because of conflict preemption, ERISA supplies the cause of action available for a coverage denial.¹³²

Individual insurance (not employer-based). Individual insurance—which is when an individual purchases a policy on her own—is governed by state law and subject to state law causes of action for coverage denials.¹³³

D. Remedial Interaction and Litigation Reform

In a simple world, a legislature that contemplated three tracks of review—internal, external, and judicial review—would specify how these options were to interact. Alternatively, in the absence of its own

127. These three categories describe the overwhelming majority of arrangements by which the non-elderly and non-poor receive insurance: through a traditional private employer or via the individual market. Special cases, such as church plans or multiple-employer welfare plans, are not here considered. “Grandfathered” plans—which in some ways operate under the pre-ACA regime—are also not considered, because it seems likely that few plans will retain “grandfathered” status. Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 756 (2011).

128. See *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990) (stating that a self-insured plan is where an employer satisfies its obligations to its participants without purchasing an insurance policy from any insurance company).

129. The deemer clause prevents a self-insured employer from being deemed an insurance provider. 29 U.S.C. § 1144(b)(2)(B) (2012); see *supra* notes 137–40 (explaining the effect of the deemer clause).

130. See *supra* notes 120–26 and accompanying text (explaining ERISA preemption).

131. Nomenclature for group health plans can get quite confusing. A self-insured benefit plan and a benefit plan that obtains group coverage are both, conceptually, “group health plans.” But because self-insured plans have a special regulatory status under ERISA and ACA, one must be careful to distinguish between a self-insured group plan and a group plan that buys group coverage for its employees from an insurance company. To easily distinguish those two situations, I call the latter arrangement a “group-insured plan.” Throughout, I use that convention and point out whether the statutes or regulations use different terminology that might confuse the reader. See *infra* note 181 (discussing formal nomenclature of the ACA).

132. See *supra* notes 119–26 and accompanying text (explaining the relationship between causes of action and ERISA preemption).

133. ERISA governs employee benefit plans. Individual insurance purchases are outside the scope of its coverage.

resolution of the matter, the enacting legislature would specify which regulator was to decide the issue. Although the ACA suggests answers, it falls short of lapidary precision. That feature of the legislation provides various footholds for litigation reform battles to be fought.

To see why, assume for the sake of argument that background law permits only one remedial option in connection with an insurance denial: litigation. If another remedial option is added, such as internal review, whether that addition qualifies as litigation reform depends on the terms of the internal review. If the internal review is fair and optional, it does not qualify as litigation reform,¹³⁴ because it did nothing to reduce a claimant's ability to obtain traditional relief. If, however, the internal review is bound up with a rule that limits the claimant's ability to seek judicial review or the court's ability to conduct a full and fair review, then it qualifies as litigation reform. So it goes with any rule that subordinates a strong remedy to a weaker one.

The ACA is susceptible to arguments that non-judicial remedies trump judicial ones. Whether these arguments have merit is another question, but, as they were with respect to ERISA, they will be made. Moreover, because the ACA does not in all instances clearly specify *who* decides remedy questions, litigation reform efforts will be directed at regulators perceived as welcoming. These efforts will come packaged in an analysis that insists such regulator was the precise authority the ACA envisioned to address itself to that task.

III. ACA LITIGATION REFORM BATTLES: REALISM AND SPECIFICS

This Part accomplishes three things: first, it considers the degree to which the extra-statutory influences that molded ERISA are still present; second, it analyzes the ACA and its implementing regulations at a granular level, with the aim of highlighting, for each type of insurance, specific litigation reform battles likely to consume judicial time; third, it readies the stage for a broader appraisal in Part IV. Part IV examines "themes" one can expect litigation reformers and their opponents to sound in furtherance of the particular battles here predicted or in connection with others that the fog of regulatory settling make difficult to predict.

134. As I mentioned at the beginning of the Article, litigation reform could technically mean reform in either direction, i.e., reform that helped defendants or plaintiffs. In reality, it means reforms designed to aid defendants. *See supra* note 1.

A. *Realist Influences Reconsidered*

In Part I.C., I described three non-legal influences that drove judicial interpretation of ERISA: (1) concerns over the high cost of health care, (2) worry about the lack of a suitable alternative to employment-based health insurance, and (3) a profound skepticism toward the utility of remedy in general. To what extent do any of these constitute meaningful forces today?

Insurance alternatives reconsidered. The concern that the ACA ameliorates most is fear over a lack of alternatives to employment-based insurance. Prior to enactment of the ACA, if an employer chose not to offer insurance, the result would be that a significant number of its employees would be unable to obtain affordable insurance elsewhere.¹³⁵ Moreover, employers are not in the business of insurance; an employer's core competence relates to the product or service that the business sells to its customers. The farther away a particular task is from a business's core competency, the less likely the business will be willing to perform that function, to the extent it has a choice to do otherwise. Thus, even slightly volatile or costly rules of remedy might deter employers from offering insurance, and concomitantly swell the ranks of the uninsured. The ACA changes this calculus by penalizing large employers that fail to offer insurance¹³⁶ and by opening up the individual market to everyone.¹³⁷ There should be less of a genuine concern that more protective rules of remedy will result in individuals being uninsured.¹³⁸

135. See *supra* notes 78–81 and accompanying text (noting outside of group insurance coverage, insurance is very expensive and out of reach for many individuals).

136. See 26 U.S.C. § 4980H(a)(1) (2012) (stating that large employers will face a tax penalty if they do not offer employee health insurance).

137. See *id.* § 5000A (mandating that individuals maintain minimum essential health insurance); 42 U.S.C. § 300gg-4 (prohibiting discrimination against individuals based on pre-existing health conditions); 42 U.S.C. § 18001 (providing for immediate access to health coverage for uninsured individuals with pre-existing conditions).

138. The concern that rules of remedy more expansive than those offered by ERISA will drive insurance companies (as distinct from employers) from the market remains. Unlike employers, insurance companies are in the business of insurance. Accordingly, that rules of remedy (within reason) will meaningfully discourage insurance companies from offering health insurance is a concern that applies with less force against insurers than employers. Insurers will object, predictably and perhaps understandably, but there is comparatively less of a chance that health insurance companies will en masse leave the business absent the protections of, say, judicial deference and a complete bar on consequential damages. Although insurance company flight is less of a risk than employer flight, some sitting judges may, nonetheless, believe insurance company flight is a strong and undesirable possibility. Cf. George Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 *YALE L.J.* 1521, 1523 (1987) (mentioning one early 1980s theory that rising insurance premiums were attributable in part to the expansion of corporate liability, causing, among other things, insurers to leave markets).

Judicial hostility reconsidered. Judicial hostility to remedy remains,¹³⁹ although perhaps it is subsiding as more appointees of Democratic presidents take the bench, gain influence among their peers, and ascend to federal appellate courts.¹⁴⁰ For example, the U.S. Court of Appeals for the Fourth Circuit, long unfavorable to plaintiffs, has in recent years seen its composition change, and is perceived as more neutral than in years past.¹⁴¹ The point should not be overstated. The collective federal appellate bench is not teeming with judicial friends of the wronged. And most importantly, the Supreme Court remains skeptical of the attractiveness of judicial resolutions, in ERISA and elsewhere.¹⁴² The high court exerts more gravity on the question of remedy than any other body.

Health care costs reconsidered. Of greatest concern is that the rising cost of health care remains unsolved. Although there have been some favorable reports of a slowing of the increase in health care costs,¹⁴³ the ACA failed to deal with a central cost problem associated with the provision of medical care, namely that medical care is provided through insurance, and health insurance promises hinge upon “medical necessity” with no limitation as to the marginal cost of

139. See *supra* notes 85–86 (describing judicial hostility toward litigation and skepticism toward broad court remedies).

140. See *infra* note 141 and accompanying text (noting the rise of Obama appointees in the federal courts).

141. I base this observation on a series of personal conversations with private and government lawyers who practice in the Fourth Circuit. That President Obama has appointed six judges to that circuit court of appeals is also, of course, relevant to changing perceptions. See *Obama Judicial Confirmation Statistics*, JUDICIALNOMINATION.ORG, <http://judicialnominations.org/statistics> (last visited January 12, 2014) (listing President Obama’s six Fourth Circuit nominations made during his presidency to date).

142. See *supra* note 4 (noting the significant decisions by the Roberts Court that have limited a plaintiff’s ability to bring and win cases); see also Adam Liptak, *Corporations Find a Friend in the Supreme Court*, N.Y. TIMES (May 4, 2013), <http://www.nytimes.com/2013/05/05/business/pro-business-decisions-are-defining-this-supreme-court.html?pagewanted=all> (citing Lee Epstein, William M. Landes & Richard A. Posner, *How Business Fares in the Supreme Court*, 97 MINN. L. REV. 1431, 1449 (2013), when describing the Roberts Court as limiting plaintiff rights in furtherance of a pro-business agenda).

143. See, e.g., Anne B. Martin, et al., *National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year*, 33 HEALTH AFF., no. 1, 2014 at, 67 (summarizing the results of a study conducted by the Center for Medicare and Medicaid Services (CMS) showing an increase of only 3.7% in health care expenditures, the fourth consecutive year of low growth); Jeanne Lambrew, *New Report Shows 2012 Continued Trend of Slow Growth in Health Care Spending*, WHITE HOUSE BLOG (Jan. 6, 2014, 4:00 PM), <http://www.whitehouse.gov/blog/2014/01/06/new-report-shows-2012-continued-trend-slow-growth-health-care-spending> (reporting on the CMS study, noting that 2009–2012 saw the slowest growth in health care expenditures since the 1960s); see also COUNCIL OF ECONOMIC ADVISERS, EXECUTIVE OFFICE OF THE PRESIDENT, *TRENDS IN HEALTH CARE COST GROWTH & THE ROLE OF THE AFFORDABLE CARE ACT 1* (2013), available at http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf (concluding that “real per capital health care spending has grown at . . . the lowest rate on record”).

the necessary treatment.¹⁴⁴ Until that matter is decisively addressed, the economic pressure on health care costs will remain strong.¹⁴⁵ The consequence will be that fears of cost will be lurking in the minds of judges everywhere, supplying a strong temptation to trim health insurance remedies to save pennies even as the legislature has dodged the question of pounds.¹⁴⁶

A fair presumption is that the foregoing extra-statutory concerns—diminished relative to ERISA, but not weakened so much as to fade into insignificance—will influence judicial interpretation of the ACA, both with respect to the content of the law itself and the degree to which judges will be willing to interpret it to prevent states from pursuing policies that thwart or undo litigation reform. One cannot exactly weigh the strength of these extra-statutory forces, nor predict precisely how they will guide decisional law interpreting the ACA. But it would be unwise to forget them when considering the specific and thematic analysis that follows in Part III.B and C.

B. *Litigation Reform Specifics*

As explained above, for regulatory purposes, the three relevant types of insurance arrangement are self-insured plans, group-insured plans, and individual insurance policies.¹⁴⁷ In this Part, I explain how regulatory power regarding remedy is allocated with respect to each type of insurance arrangement and suggest likely battles over rule content.

144. See Maher & Stris, *supra* note 44, at 462 (noting that there is upward cost pressure on the health insurance promise and uncertainty associate with that promise because it does not explicitly include a marginal cost limitation and often results in promisees being denied claims for medical care).

145. See *id.* at 462–63 (explaining that the lack of a marginal cost limitation results in “relentless upward cost pressure” because patients, doctors, and entrepreneurs are incentivized to make decisions “without regard for cost-adjusted utility”); cf. Pauly, *supra* note 74, at 535–36 (explaining how moral hazard drives up price of health care); Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES (July 19, 2009) (Magazine) (explaining how marginal value of treatments must be considered to arrest price increases). Two possibilities for bending the medical cost curve downward are to incorporate marginal limits implicitly (through vast government provision of health care), or explicitly, through incorporation of cost effectiveness thresholds in private contracts of insurance. Both had and have vigorous critics. The ACA does neither.

146. Limiting remedies will not meaningfully arrest the growth in health care costs, any more than sturdy buckets could have “bail[ed] out the Titanic.” Maher & Stris, *supra* note 44, at 464 n.147.

147. “Group-insured plans” is my term for plans using group insurance. See *supra* Part II.C. The statute and the regulations distinguish between the plan and the insurer, but not in ways that are important except in specific circumstances.

1. *Self-insured plans*

Self-insured plans remain exclusively subject to federal control. Internal review for self-insured plans must comply with requirements set out in the ACA itself and implementing regulations promulgated by the Department of Labor.¹⁴⁸ External review must comply with the external review process promulgated by Labor and Treasury.¹⁴⁹ The cause of action for coverage claims against self-insured plans under judicial review is provided by ERISA.¹⁵⁰

Observation one. For self-insured plans, the ACA regulations and technical releases apparently require an exhaustion of internal review processes before a claimant is eligible for external review, a convention which tracks ERISA.¹⁵¹ However, the ACA clearly modifies the application of deference. External reviewers must “review the claim *de novo* and not be bound by any decisions or conclusions reached during the health insurance issuer’s internal claims and appeals process.”¹⁵² This is significant because it means

148. 42 U.S.C. § 300gg-19(a)(2) (2012) provides that “a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures . . . set forth at section 2560.503-1 of title 29, Code of Federal Regulations, as published on November 21, 2000 . . . and shall update such process in accordance with any standards established by the Secretary of Labor.” The CFR reference in the ACA refers to the regulations that the Department of Labor formerly promulgated for self-insured plans under ERISA. The updated regulations issued pursuant to the ACA more stringently regulate internal review procedures. For example, they more carefully regulate permissible conflicts of interest than prior regulations. Insurers “must *ensure* . . . [the] independence and impartiality of the persons involved in making the decision.” 29 C.F.R. § 2590.715-2719(b)(2)(ii)(D) (2013) (emphasis added). “[D]ecisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any [person making a coverage determination] must not be made based upon the likelihood that the individual will support the denial of benefits.” *Id.*

149. See Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 Fed. Reg. 37,208, 37,210–11 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117) (“In the case of self-insured plans subject to ERISA and/or the Code, a Federal external review process supervised by DOL and Treasury applies.”); see also 29 C.F.R. § 2590.715-2719(d) (setting forth DOL requirements for federally regulated external review process). The preamble to the regulations provides that the DOL “would issue additional guidance on the federal external review process.” DEP’T OF LABOR, TECHNICAL RELEASE NO. 2010-01, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 2 (2010) [hereinafter TECHNICAL RELEASE NO. 2010-01], available at http://www.dol.gov/ebsa/pdf/ACA_TechnicalRelease2010-01.pdf. Additional guidance was set forth in a technical release issued on August 23, 2010. *Id.*

150. See *supra* Part II.C.

151. See TECHNICAL RELEASE NO. 2010-01, *supra* note 149, at 4 (requiring that an IRO need assess whether “[t]he claimant has exhausted the plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations”).

152. *Id.* at 5.

that the *Firestone* deference insurers enjoyed under ERISA with respect to court review—wherein courts needed to defer to the findings of an internal reviewer—will not apply with respect to external review. As a matter of ACA law, external reviewers may not extend *Firestone* deference to internal reviews.¹⁵³

Obviously the value of this development to insureds will depend on the fairness and competence of external reviewers. Incompetent or captured external reviewers will be no boon to claimants. But assume external reviewers are competent and impartial. Insurers highly value deference. Might insurers and litigation reform advocates argue that judges, in adjudicating an ERISA claim for wrongful denial of coverage, need only defer to the findings of the *internal* reviewer, not the *external* reviewer?

The argument is clever. Only claimants can invoke external review.¹⁵⁴ Thus, all external reviews will occur after a no-coverage or partial no-coverage finding by the insurer at the internal review stage. If the external review finds coverage and the insurer pursues the matter in court,¹⁵⁵ should the court defer to the external review or the original internal review determination?¹⁵⁶ Similarly, if the internal process finds no-coverage, the external review finds partial coverage, and the claimant pursues the matter in federal court seeking full coverage, which finding will federal courts defer to?

The answer depends, first, on which statute—ERISA or ACA—governs the relationship between external review and judicial review. Neither statute explicitly speaks to the question. Federal courts would be obliged to engage in federal common-law making to fill in the statutory gap.¹⁵⁷ But which federal statute drives the analysis?

One argument is that ERISA governs because ERISA provides the cause of action that triggers judicial review. The other argument is that the ACA governs because it requires the very internal and external review processes to which the judge might

153. *Id.*

154. The internal review is done by the insurer or its agent; seeking external review of its own determination would be odd, to say the least. None of the relevant regulations, either at the federal or state level, contemplate the possibility of an insurer seeking external review because it is unhappy with its own conclusion.

155. *But see supra* Part II.C (describing limits on insurer cause of action).

156. In cases in which the external and internal review finds no coverage, who the judge defers to is moot.

157. *Cf.* BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST AND ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 683 (7th ed. 2013) (discussing ERISA and ACA interaction and noting that “[t]he scope of review of federal courts reviewing decisions of health plans (or of external reviewers) is not, therefore, wholly clear”).

defer. The ACA, so the argument goes, invested in itself the ultimate say on deference.¹⁵⁸

The answer is not clear because judicial doctrine on how to resolve conflict between two federal statutes is not clear.¹⁵⁹ The better argument is that ERISA supplies the answer but is bounded by the ACA. The cause of action being burdened is ERISA-created, and the sensible assumption is that the prior source of law creating the cause of action retains authority to resolve burdens on its use, unless a subsequent federal statute clearly displaces it.¹⁶⁰

The matter is complicated further by the lack of clarity regarding how ERISA “handles” external review in the wake of internal review. The doctrinal justification for allowing deference in the ERISA setting is that the employer who creates and amends an ERISA plan is akin to the settlor of a trust.¹⁶¹ Settlers have the ability to award specified fiduciaries power to administer the trust, including interpreting the trust documents.¹⁶² Such a process is thought to favor the creation of trusts—or in the ERISA setting, benefit plans—and so judges must defer to administrators to whom the settlor has specifically awarded interpretative power in order to ensure the frequent creation of plans.¹⁶³ Under this justification of *Firestone* deference, it would not be proper for a judge to defer to an external reviewer because the external reviewer was not so anointed by the

158. The question is not easy as a matter of principle, policy, or politics. If the ACA, by mere dint of statutorily supplying two modes of non-judicial review, also contains the power to define the relationship between non-judicial and judicial review (including by limiting the availability of subsequent judicial review), then such implicit power might be used in the individual insurance setting to limit *state* judicial review of a *state* claim. *Cf. infra* Parts III.B.3, IV.C (examining the review processes for individual insurers and an anti-judicialism view of the ACA).

159. *See infra* notes 263–67 and accompanying text (discussing court canons on federal statutory conflict).

160. I am not suggesting that the law creating the cause of action always or entirely supplies the common law rules affecting use of the cause of action, just that it makes sense here and probably often. *Cf.* Caleb Nelson, *The Persistence of General Law*, 106 COLUM. L. REV. 503, 538–52 (2006) (discussing how “policy bundles” can determine, in a federal versus state context, which law affects a given cause of action).

161. *See* Maher, *supra* note 33, at 680 (explaining how deference is justified by describing the employer creating an ERISA plan akin to a “settlor” who, in a common-law trust, may grant discretionary power to a trustee).

162. *See* Langbein, *supra* note 42, at 218–19 (citing trust law precedent from *Nichols v. Eaton*, 91 U.S. 716, 717 (1875), supporting judicial deference to trustees exercising “discretion vested in them by the instrument under which they act”).

163. *See, e.g., id.* at 218, 221 (discussing the court’s holding in *Lowry v. Bankers Life & Cas. Ret. Plan*, 865 F.2d 692 (5th Cir. 1989), that an administrator’s determinations should be given deference when the trust instrument—i.e., the plan—evidences the power of the administrator to “construe uncertain terms” because “[d]iscretion is a touchstone of trusteeship”).

settlor.¹⁶⁴ The consequence would be that, although claimants may choose external review, upon appeal to a court afterward, the court must defer to the internal review conclusions rather than those of the external review.

Such a rule would make external review effectively useless in every case in which the internal reviewer and external reviewer differ. Assume an insurer denies coverage and an external reviewer finds coverage. If a court must defer to the internal reviewer absent arbitrary and capricious behavior, then insurance companies will appeal every adverse external review determination in order to secure a more favorable standard of review. External review would undo no more “wrong” outcomes than its absence. Given the ACA’s provision for both internal and external review, that makes no sense.

Instead, ERISA should yield to the ACA with respect to the treatment of external review by judges. The ACA bounds the inquiry: judges must either review the matter (1) *de novo*, that is, without weight afforded either to internal or external review; or (2) afford weight to the external reviewer’s finding only.¹⁶⁵ Whether judges need do the former or the latter would be resolved by ERISA, with neither option enfeebling the ACA’s external review provisions. Incidentally, it is not clear whether, from an ERISA standpoint, a judge should review external review *de novo* or with deference, although *de novo* review seems more likely.¹⁶⁶

164. Employers or insurers writing in discretionary clauses are acting as settlors under current Supreme Court doctrine. *Cf.* *In re Prudential Ins. Co. of Am.*, Advisory Opinion No. 2003-04A, 2003 WL 1785266 (Dep’t of Labor Mar. 26, 2003) (explaining that discretionary activities relating to plan formation, as opposed to plan management, are “settlor” functions and are generally not fiduciary activities governed by ERISA).

165. Conversely, affording weight to the external reviewer’s finding does *not* render internal review useless. For self-insured plans, internal review is required, and in many cases a claimant will simply stop there. Vukadin, *supra* note 29, at 1204. In other cases, external review will reach the same result as internal review, and thus provide the same uphill battle in court that would have been the case pre-ACA. Only when external review reaches a different result than internal review will internal review’s weight be “diminished” relative to the pre-ACA world. *See* TECHNICAL RELEASE NO. 2010-01, *supra* note 149, at 6 (requiring plans to provide coverage if the external review reverses the adverse benefit determination). One of the *central aims* of external review, however, is to serve as a check on internal review. Necessarily the expectation is that internal review is of diminished importance. *Cf.* Kenneth H. Chuang, Wade M. Aubry & R. Adams Dudley, *Independent Medical Review of Health Plan Coverage Denials: Early Trends*, 23 HEALTH AFF., no. 6, 2004, at 163, 163–69 (reporting the results of a study finding that 33% of internal denials in California were overturned via external review).

166. The technical arguments each will make as to what ERISA requires will depend largely on the degree to which, if at all, independent review organizations that provide the external reviews are perceived as favoring claimants or insurers. For example, the current federal guidance only provides that insurers contract with three

Observation two. ERISA requires deference to internal review only if the plan so provides.¹⁶⁷ The ACA upends that rule with respect to circumstances where a claimant has sought external review because, as explained above, not doing so would render external review a waste of time. But what of judicial deference to internal reviewers if no external review has occurred?

Presumably external review is a choice; a claimant can seek it or not, and in any event proceed with judicial review.¹⁶⁸ If a claimant does not *seek* external review, then the ACA provides no explicit reason why a judge should not extend *Firestone* deference to an internal review.¹⁶⁹ The likelihood that a judge would therefore grant *Firestone* deference to an internal review gives claimants an obvious incentive to utilize external review. If claimants proceed right to court after internal review, they face a *Firestone* obstacle.

The same goes if the claimant *cannot* seek external review because the coverage dispute relates to a matter outside the scope of external review.¹⁷⁰ Presumably in that circumstance judicial deference will still be due to the internal reviewer. In practice, we will likely see protracted arguments about what type of dispute is properly encompassed by external review regulations. Already, public comments from those in favor of litigation reform have persuaded the federal agencies charged with writing the ACA's implementing

accredited IROs. TECHNICAL RELEASE NO. 2010-01, *supra* note 149, at 4. Three might not be enough to ensure true impartiality.

167. See *supra* notes 34–37 and accompanying text (explaining *Firestone* deference).

168. The external review regulations for self-insured plans do not specify whether external review is required before judicial review, or merely an option. 29 C.F.R. § 2590.715-2719(d) (2013); TECHNICAL RELEASE NO. 2010-01, *supra* note 149, at 2–3. However, 29 C.F.R. § 2560.503-1 considers all types of non-judicial appeals of claims denial beyond the internal review process as “voluntary” appeals. 29 C.F.R. § 2560.503-1(c)(3)–(4). This regulation was expressly incorporated into the ACA, and the legislation's subsequent implementing regulations incorporated its requirements and added to them. 29 C.F.R. § 2590.715-2719(b)(2)(ii). Moreover, the federal external review process must be “similar” to the state external review processes the ACA contemplates, and the NAIC-UERMA assumes external review is a choice. See *infra* notes 234–38 and accompanying text. Finally, should an internal review process violate federal regulations, then the regulations explicitly provide that an insured may pursue external or judicial review. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1). Nothing in the statute, legislative history, or implementing regulations suggest that a choice between external or judicial review is not available to claimants merely because an insurer complied with all internal review regulations.

169. Whether it *implies* a reason I leave to the reader. See *infra* Part IV.A (discussing the flexible nature of jurisprudential devices concerning preemption and federal statutory conflict).

170. External review is available based on the plan's requirements for “medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.” 29 C.F.R. § 2590.715-2719(c)(2)(i).

regulations to, at least temporarily, modestly restrict the scope of external review coverage.¹⁷¹

Observation three. There is a final, technical wrinkle that will catch some self-insured plans unawares. Assume during internal review the plan denies coverage, but on external review coverage is found. Can the plan appeal the matter to court?¹⁷²

The ACA does not create a cause of action for coverage disputes for either insureds or insurers.¹⁷³ Self-insured plans' available causes of action are governed by ERISA.¹⁷⁴ The hitch is that ERISA does *not* provide an insurer with an § 1132(a)(1)(B) "coverage dispute" cause of action; that remedy is *only* available to beneficiaries.¹⁷⁵ An insurer must articulate a claim under one of ERISA's *other* remedial provisions to appeal an external review finding.

Plans almost certainly will invoke § 1132(a)(3). That provision of ERISA, which authorizes "appropriate equitable relief,"¹⁷⁶ has been interpreted by the Supreme Court to supply only those remedies "typically" cognizable in pre-merger equity.¹⁷⁷ The Court, however, has read equitable history to find that plans may secure equitable relief through the expedient device of a "lien by agreement."¹⁷⁸ Lien by agreement was an equitable device used to recover monies promised by prior agreement.¹⁷⁹ Plan drafters currently use the "lien by agreement" mechanism to write clauses into plans that effect, essentially by contract, expansive recovery and preference rights for

171. Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 Fed. Reg. 37,208, 37,216 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117) (explaining that public commentary led the Departments to "narrow the scope" of claims eligible for federal external review).

172. This will also affect group-insured plans, because the remedies there are supplied by ERISA. See *supra* Part II.C (explaining how ERISA supplies the cause of action for coverage denials under group-insured plans because of conflict preemption).

173. See *supra* note 117 and accompanying text (noting that the ACA does not explicitly create a cause of action, nor is it likely that an implied right of action exists).

174. *Supra* notes 128–30 and accompanying text.

175. See 29 U.S.C. § 1132(a)(1)(B) (2012) ("A civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan" (emphasis added)).

176. *Id.* § 1132(a)(3).

177. *E.g.*, CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1878 (2011) (quoting *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 361 (2006)); see also *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002) (discussing historical equity test); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993) (creating historical equity test).

178. See, *e.g.*, *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1546 (2013) ("US Airways . . . is seeking to enforce the modern-day equivalent of an 'equitable lien by agreement.' And that kind of lien . . . both arises from and serves to carry out a contract's provisions.").

179. See, *e.g.*, *id.* at 1545 (acknowledging US Airways's right to seek funds promised under a contract through an equitable lien by agreement).

plans vis-à-vis insureds.¹⁸⁰ Smart self-insurers will rewrite their plans to include lien by agreement rights against insureds to challenge unfavorable external review results in court. Whether and how exactly the lien by agreement device can be used on this question is unsettled, and there will be litigation over the details.

2. *Group-insured plans*

Group insurers must abide by internal review requirements promulgated by the Department of Labor.¹⁸¹ In contrast, with respect to external review, group-insured plans must comply with state law, with one key exception.¹⁸² If the applicable state law does not meet or exceed the consumer protections set forth in the Uniform Health Carrier External Review Model Act (“NAIC-UERMA” or “the Model Act”),¹⁸³ which was promulgated by the National Association of Insurance Commissioners, then the insurer in question must comply with a federal external review process promulgated by the Department of Health and Human Services (HHS).¹⁸⁴ Because of

180. *See generally id.* (permitting insurers to write in subrogation provisions that override both the “common fund” and “double recovery” equitable limits on subrogation recoveries by insurers); *see also* Brendan S. Maher & Radha A. Pathak, *Understanding and Problematising Contractual Tort Subrogation*, 40 *LOY. U. CHI. L.J.* 49, 81–85 (2008) (describing the “lien by agreement” mechanism, which permits insurers to effectively seek contractual subrogation against an insured—i.e., “any recovery from the tortfeasor will be diminished by the reimbursement of medical expenses advanced by the insurer”—and noting that “virtually all modern policies have subrogation provisions, many of which are of the first-dollar recovery variety”). Critics of the Court’s “lien by agreement” jurisprudence, including myself, worry that it supplies insurers with a contractual blank check against insureds. *See* Brief for Respondents at 36, *US Airways*, 133 S. Ct. 1537 (No. 11-1285) (observing that a “lien by agreement” can be applied against property unrelated to sickness or accident, such as “100 percent of any future inheritance received by the insured”).

181. The statutory language refers to “a group health plan and a health insurance issuer offering group health coverage.” 42 U.S.C. § 300gg-19(a)(2)(A). A group health plan includes a self-insured plan. *See* Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 *Fed. Reg.* 37,208, 37,208 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117) (explaining that the “group health plan” includes both self-insured plans and plans using group insurers); *see also id.* at 37,208 n.1 (“The term ‘group health plan’ is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term ‘health plan’, as used in other provisions of title I of the Affordable Care Act. The term ‘health plan’, as used in those provisions, does not include self-insured group health plans.”). The Department of Labor was given regulatory authority over the internal review processes for self-insured plans and group plans using group insurers (which I refer to as “group-insured plans”).

182. 42 U.S.C. § 300gg-19(b)(1)–(2).

183. UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT §§ 5, 8–10, 13, 17 (Nat’l Assoc. of Ins. Comm. 2010) [hereinafter NAIC-UERMA], *available at* <http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf>.

184. *See* 76 *Fed. Reg.* at 37,211 n.14 (explaining that the federal external review process applicable in the absence of sufficient state law will be determined by HHS); *see also* OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, DEP’T OF HEALTH & HUMAN

conflict preemption, the cause of action for coverage denials occurring in group-insured plans is provided by ERISA.¹⁸⁵

Observation one. The question of whether external reviewers must defer to internal reviewers in the context of group-insured plans will likely attract attention, for several reasons. First, it is clearly a matter of state law. More specifically, the ACA adverts to state authority on external review, assuming the state external review law exceeds the “consumer protections” in the NAIC-UERMA:

(b) External Review—A group health plan and a health insurance issuer offering group or individual health insurance coverage—(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or (2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or (B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).¹⁸⁶

External review state laws do not have to be “like” the NAIC-UERMA; they just need to be as protective of consumers as it is. If the state law satisfies that threshold condition, then the only additional constraint is that the state law must actually regulate external review.¹⁸⁷

SERVS., TECHNICAL GUIDANCE FOR INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW, 4–14 (2010) [hereinafter EXTERNAL REVIEW GUIDANCE], available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/interim_appeals_guidance.pdf (setting forth external review process for group-insured plans, and individual insurers, in states that lack sufficient external review rules). State external review law can be insufficient because it exists but lacks the consumer protections of the NAIC-UERMA, or because it does not exist at all. Interestingly, in contrast to the technical guidance relating to external review for self-insured plans promulgated by Labor, the technical guidance for group-insured plans subject to federal regulation because of insufficient state regulation (which is promulgated by HHS) does *not* explicitly require exhaustion of the internal process prior to seeking external review. Compare EXTERNAL REVIEW GUIDANCE, *supra*, at 5–11 (exhaustion requirement absent from HHS guidance), with TECHNICAL RELEASE NO. 2010-01, *supra* note 149, at 4 (including a provision that an IRO need assess whether “[t]he claimant has exhausted the plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations”).

185. See *supra* Part II.C.

186. 42 U.S.C. § 300gg-19(b).

187. The federally defined consumer protective minimums are set forth in 29 C.F.R. § 2590.715-2719(c)(2) (2013). The outer boundaries of the set of state

The ACA supplies two limiting conditions on a state seeking to regulate external review: (1) state rules must satisfy a federally defined consumer-protective minimum and (2) the rules must be “about” external review. The latter seems so obvious as to not need acknowledgement, but it warrants consideration. Note that from a state regulator’s perspective those two conditions are less onerous than the following three: (1) having to satisfy a federally defined minimum, (2) having to be about external review, *and* (3) having to be “like” the NAIC-UERMA. The latter set of conditions arguably imposes a ceiling on how pro-consumer a state can be, i.e., states cannot be more pro-consumer than the NAIC-UERMA. The former set of conditions does not. The former is the law.

For example, the NAIC-UERMA requires exhaustion of internal review prior to external review, absent special circumstances.¹⁸⁸ Unsurprisingly, requiring exhaustion of internal review is not a minimum consumer protection.¹⁸⁹ Accordingly, a state that otherwise satisfied the consumer protective minimums could “legislate up” from NAIC-UERMA and *not* require internal exhaustion with respect to external review.

Federal law does somewhat limit state prerogative to insert claimant-*unfriendly* provisions in its external review laws by requiring that state law contain the “consumer protection” minimums of the NAIC-UERMA.¹⁹⁰ Interestingly, current federal regulations that have defined the minimum “consumer protections” state law must provide do *not* reference the provision of the NAIC-UERMA that forbids

regulations that are “about” or “actually regulate” external review is not clear. Whether a state regulation falls within the ACA’s external review preemption carve-out will be litigated, certainly with respect to state regulations insurers dislike.

188. See *supra* note 183, § 7(A)(1) (“Exhaustion of Internal Grievance Process[:] Except as provided in subsection B, a request for an external review pursuant to section 8, 9 or 10 of this Act shall not be made until the covered person has exhausted the health carrier’s internal grievance process . . .”). The NAIC-UERMA referenced in the ACA was the NAIC-UERMA in effect on July 23, 2010. 29 C.F.R. § 2590.715-2719(a)(2)(viii).

189. See 29 C.F.R. § 2590.715-2719(c)(2) (listed consumer protection minimums do not include exhaustion of internal review before external review); *Cf.* U.S. DEP’T OF LABOR, TECHNICAL RELEASE NO. 2011-02, GUIDANCE ON EXTERNAL REVIEW FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP AND INDIVIDUAL HEALTH COVERAGE, AND GUIDANCE FOR STATE ON STATE EXTERNAL REVIEW PROCESS 2 (2011), available at <http://www.dol.gov/ebsa/pdf/tr11-02.pdf> (“If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary [in certain conditions protective of consumers].”). For group-insured plans, this clearly contemplates state prerogative bounded by a federal consumer-protective floor.

190. 42 U.S.C. § 300gg-19(b).

deference.¹⁹¹ Thus a *state* could, under the current regulations, “legislate down” and enact an external review statute that supplies all the consumer protections of the NAIC-UERMA, but permits external reviewers to defer to the findings of internal reviewers (or construe the insurance agreement in favor of the insurer).

Observation two. A second interesting issue involves the NAIC-UERMA’s language on deference. The NAIC-UERMA provides that external reviewers should exhibit no deference to the determinations of internal reviewers.¹⁹²

One may wonder whether the NAIC-UERMA requirement that the external reviewer not be “bound” by an internal reviewer’s conclusions or determinations absolutely bars deference. One expects arguments from litigation reform advocates designed to smuggle in some form of hidden deference to internal review, perhaps an argument that, although external reviewers may not be “bound” by what happened in internal review, they should attribute extra weight to the results of the internal review absent clear indication of malfeasance. Arguments may also be made over the difference between the relevant federal and state regulations. Unlike the federal regulations limiting deference, the NAIC-UERMA does not use the word “de novo”; perhaps this difference means state external reviewers can favor insurers.¹⁹³ A similar argument might urge that the NAIC-UERMA’s language forbidding external reviewers to be “bound” does not prevent external reviewers from having to honor, in the first, instance provisions in the insurance agreement that require ambiguous clauses to be construed in favor of the insurer.¹⁹⁴ To be clear, I do not find any of the foregoing arguments persuasive—the patent intent of the NAIC-UERMA as written is to

191. Compare 29 C.F.R. § 2590.715-2719(c)(2)(i)–(xvi) (required consumer protections do not include a “no deference” rule), with NAIC-UERMA, *supra* note 183, § 8(D)(2) (no deference due by external reviewers to internal reviewers).

192. NAIC-UERMA, *supra* note 183, § 8(D)(2) (“In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier’s [internal claims process].”).

193. Compare *id.* (“In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions [of internal reviewers].”), with TECHNICAL RELEASE NO. 2010-01, *supra* note 149, at 4–5 (“A contract between the plan and an IRO must provide the following: . . . [i]n reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the [health insurance issuer’s] internal claims and appeals process.”).

194. For example, consider a provision providing that “the parties agree that the meaning of this policy is such that is consistent with whatever interpretation is most favorable to the insurer.” The question is whether the external reviewer would have to interpret the meaning of the policy consistent with the expressed intent of the parties by calling all close cases in favor of the insurer.

provide consumers (at a minimum) with completely neutral and impartial review.

States, however, can avoid such quarrels by adopting language in their external review laws that more clearly prohibits deference owed to the internal reviewer and otherwise forbids the insurance contract to be interpreted under any standard less favorable to the claimant than *de novo*. In other cases, state background law may be sufficiently clear.¹⁹⁵ Because the ACA contemplates state freedom once certain protective minimums are met, those issues are questions of law for the implementing state.¹⁹⁶ Claimant-friendly states will likely not only bar deference,¹⁹⁷ but also require external reviewers to follow *contra proferentum*.

Observation three. The provision of the ACA that adverts to state power over external review processes is section 2719(b) of the Public Health Services Act (PHSA).¹⁹⁸ Section 2719 of the PHSA, in turn, is part of the ACA that was directly incorporated into ERISA.¹⁹⁹ Thus ERISA itself now includes language advertent to

195. For example, consider Illinois. The general rule is that “provisions that limit or exclude coverage are to be construed liberally in favor of the insured and most strongly against the insurer.” *Nat’l Union Fire Ins. Co. of Pittsburgh v. Glenview Park Dist.*, 632 N.E.2d 1039, 1042 (Ill. 1994). Contractual modification of that rule in health insurance policies is barred. *See* ILL. ADMIN. CODE tit. 50, § 2001.3 (2010) (“No policy . . . offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services . . . may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State.”). Of course, even states that already follow anti-deference principles as a part of their background law may wish to explicitly incorporate them into their external review statutes.

196. *See supra* notes 176–81 and accompanying text (outlining the flexibility afforded to states implementing an external review process other than the NAIC-UERMA).

197. In a piece written prior to the promulgation of the ACA’s implementing regulations, Professor Hylton concluded that states will endeavor to ban judicial deference “in order to rectify the unfairness that *Firestone* deference could continue to create for plan participants and beneficiaries.” Maria O’Brien Hylton, *Post-Firestone Skirmishes: The Patient Protection and Affordable Care Act, Discretionary Clauses, and Judicial Review of ERISA Plan Administrator Decisions*, 2 WM. & MARY POL’Y REV. 1, 25 (2010). Although Professor Hilton correctly guessed that ACA external reviewers need not defer to internal reviews, *id.* at 19, Professor Hilton did not consider (because that was not the aim of her article) how the ACA affected the relationship between external review and judicial review.

198. Section 2719(b) of the PHSA is codified at 42 U.S.C. § 300gg-19(b) (2012).

199. The ACA added section 715(a)(1) to ERISA. ERISA section 715(a)(1) incorporates by reference the requirements of PHSA section 2719, which is codified in the ACA at 42 U.S.C. § 300gg-19. ERISA section 715(a)(1) is codified at 29 U.S.C. § 1185d. Section 715(a)(1) of ERISA now reads that “part A of title XXVII of the Public Health Service Act [which includes the section of ACA advertent to state power over external review] . . . shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart [of ERISA].” Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 715, 124 Stat. 119, 270 (2010) (codified

state authority regarding external review processes.²⁰⁰ The consequence of this amendment of ERISA on its preemptive effect is potentially quite significant.

Recall that under ERISA's explicit, statutorily provided rules of preemption, states could not directly regulate benefit plans.²⁰¹ Because of the savings clause in ERISA, however, states *could* regulate insurers issuing group coverage in connection with a benefit plan, by means of "saved" state insurance laws.²⁰² Such "saved" state power is in turn limited by (implicit) conflict preemption, the scope of which is not clear, but which at a minimum prevents states from supplying group-insured claimants with state causes of action or additional heads of damages.²⁰³

With respect to the regulation of external review, one sensible way to read ERISA section 715(a)(1) is that it now permits states to entirely bypass ERISA's explicit preemption provisions.²⁰⁴ In the

at 29 U.S.C. § 1185d(a)). The language of the ERISA amendment is very strong—it even permits, on its face, direct state regulation of group health plans. They apparently no longer have to resort to the expedient of regulating group insurers.

200. Cf. Vukadin, *supra* note 29, at 1212 (asserting that the "[A]CA also amended ERISA to make clear that ERISA plans are also bound by the new external review requirement"). The external review requirements are in large part defined by states. Professors Vukadin and Jost, *see infra* note 204, are the only professors to have considered the provision. No reported decision has done so.

201. 29 U.S.C. § 1144(a)–(b); *supra* notes 122–24 and accompanying text (explaining ERISA's "deemer" clause).

202. *See supra* note 124 and accompanying text (explaining contours of ERISA preemption).

203. *See Pathak, supra* note 56, at 512–13.

204. The entire text of the relevant ERISA provision is:

§ 1185d. Additional market reforms

(a) General rule

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part [7] conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

29 U.S.C. § 1185d(a)–(b). Litigation reformers seeking to preserve ERISA preemption with respect to external review will likely argue that while section 1185d(a)(1) incorporates various sections of the ACA directly into ERISA, including the external review provisions, section 1185(d)(a)(2) has the ACA affirmatively

ACA, Congress has, in effect, withdrawn federal power to regulate the external review processes (beyond setting minimums) and amended ERISA to follow ACA. Accordingly, states would face no explicit ERISA preemption regarding legitimate regulation of external review processes. The practical effect would be that states no longer need show that a law is a “saved” insurance law; they need only show the law legitimately regulates external review, or so goes the argument.²⁰⁵

The effect that the ACA’s amending of ERISA has on ERISA’s conflict preemption is even harder to discern. The Supreme Court, however, has made clear that, as a general matter, external review is outside conflict preemption.²⁰⁶ The ACA codifies that thinking; indeed, the Model Act used by the ACA as a referent envisions external reviewers supplying no *Firestone* deference to internal

overthrowing ERISA only with respect to Part 7 of ERISA, and Part 7 of ERISA (codified at 29 U.S.C. §§ 1181–1191c) does not include the ERISA preemption provisions (codified at 29 U.S.C. § 1144). Thus, the common law of intra-federal statutory conflict would need to be resolved whether the ACA’s conferring of external review power on states diminishes ERISA’s explicit preemption provisions.

There are at least two difficulties with that argument. First, it amounts to reading the section 42 U.S.C. § 300gg-19(b)(1) of the ACA as conferring upon states no additional power to regulate external review beyond that which ERISA already permits. Second, ERISA itself has a provision denying it the power to “supersede any law of the United States . . . or any rule or regulation issued under any such law.” 29 U.S.C. § 1144(d). *But see* *Guidry v. Sheet Metal Workers Nat’l Pension Fund*, 493 U.S. 365, 375 (1990) (acknowledging 29 U.S.C. § 1144(d) in another setting but finding it inapplicable). The only other professor to have considered the matter even obliquely is Professor Timothy Stoltzfus Jost. He reads the ACA to displace contrary ERISA authority because it regulates “group health plans,” which includes ERISA plans. *See* Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 27, 28 (2011) (reading section 1185d as “not strictly necessary, as the provisions of the ACA on their own terms apply to group health plans, which are defined to include ERISA plans”). In any event, it seems highly likely that resolution of this question will depend in material part on realist forces. *See supra* Part IV.

205. Professor Jost may be alluding to this point when he reads the ACA to collapse regulatory distinctions between “group health plans” and “health insurance issuers offering group or individual health insurance coverage.” Jost, *supra* note 204, at 28. I say “may” because Professor Jost’s fine article does not squarely concern itself with preemption or remedy.

I note as an aside that perhaps in part because of my views on the importance of remedy, I may differ with Professor Jost on the degree of federalism the ACA contemplates. *See id.* at 28 (concluding that “the ACA lays out a comprehensive federal law framework for revolutionizing the underwriting practices of health insurers, stimulating competition in the health insurance industry, and protecting health insurance consumers” (emphasis added)). *Cf.* Brendan S. Maher & Radha Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL’Y REV. 275 (2013) (arguing that the ACA possesses considerable potential for states to exercise regulatory power); Brendan S. Maher & Radha Pathak, *Health Insurance & Federalism-in-Fact*, 28 A.B.A. J. LAB. & EMP. L. 73 (2012) (same).

206. *See* *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387 (2002) (rejecting the argument that external review procedures ran afoul of conflict preemption); *see also* Pathak, *supra* note 56, at 511 (explaining *Moran*).

reviews.²⁰⁷ Yet the relationship between external review and *judicial* review is more complicated than that because it edges closer to ERISA conflict preemption. Under the old jurisprudence of conflict preemption, ERISA supplies the cause of action for a coverage denial in connection with a group-insured plan.²⁰⁸ Presumably then, just like in the self-insured context, ERISA would govern how judicial review need treat internal review and external review, absent a conflict with the ACA.

In the self-insured plan context, I argued that although ERISA generally governed the way in which a court need treat internal or external review, the ACA barred judicial deference to internal reviewers where external review had occurred.²⁰⁹ The same applies here with an additional twist. The ACA explicitly gave states the power to control the external review process, and amended ERISA accordingly. What occurs, with respect to judicial review, if a state provides that external reviewers must follow *contra proferentem*? Assume in such a state that a claimant loses an internal review and then prevails partially on external review, appealing the matter to federal court. Not reviewing the matter using a *contra proferentem* standard indirectly frustrates the exercise of a state's external review power that the ACA specifically sanctions. On the other hand, requiring that *contra proferentem* be applied by judges arguably conflicts with ERISA's remedial scheme (which permits contractual modification of the review standard).²¹⁰ The question will certainly be litigated.

3. *Individual insurance*

The ACA revitalizes (and swells participation in) individual insurance markets; as a result the rules of remedy for individual insurance policies

207. *Supra* notes 187–95 and accompanying text.

208. *Supra* note 119–26 and accompanying text. I can see arguments that the ACA might relax that somewhat, and provide room for very limited “supplementary” causes of action or damages. But I think it is safer to assume, realistically, that ERISA still supplies the sole cause of action for a coverage denial and preempts all state causes of action and damages.

209. *See supra* Part III.B.1 (explaining, in “observation one,” the likely effect of the ACA on deference).

210. As Professor Pathak has explained, the status of state laws limiting judicial deference has not been conclusively resolved as a pure ERISA matter, independent of any change effected by the ACA. *See* Pathak, *supra* note 56, at 502 (observing that only three circuit courts of appeal have evaluated whether “state regulation of discretionary clauses is preempted by ERISA”); *see also supra* Part II.C (discussing judicial review under the ACA).

will achieve much more practical significance.²¹¹ Interest in and opposition to litigation reform will increase correspondingly.

ACA requires that all insurers offer internal review. Individual insurers must comply with state law existing at the date of the ACA's enactment and with any standards adopted by HHS.²¹² HHS has promulgated requirements similar to those of the Department of Labor, with a few additional requirements specific to the circumstances of individual insurance policies.²¹³ As for external review, like group-insured plans, individual insurers must comply with state law, so long as state law satisfies the consumer protective minimums.²¹⁴ Unlike self-insured and group-insured plans, however, the causes of action available to remediate coverage denials are provided by state law.²¹⁵

Prior to the ACA, federal power over individual insurance policies was largely nonexistent. The McCarran-Ferguson Act²¹⁶ provides that federal statutes—unless specifically regulating the “business of insurance”—do not preempt state insurance law.²¹⁷ ERISA was an example of a specific federal law regulating the business of insurance, but ERISA is limited to employment-based insurance provided via a benefit plan. It has no application whatsoever to individual insurance policies. The ACA, however, *does* regulate individual insurance policies, and this exercise of federal power will serve as the basis for litigation reformers to argue that the ACA “implies” various litigation-reform restrictions of state prerogative.

The consequence of the fact that state causes of action govern coverage disputes for individual insurance policies is apparent.²¹⁸ In many states, insurance litigation rules are friendly to claimants, including, in some cases, committing the ultimate crime of offering

211. See CONG. BUDGET OFFICE, *supra* note 13, at 20 tbl.3 (estimating insurance exchange enrollment).

212. 42 U.S.C. § 300gg-19(a)(2)(B) (2012).

213. Compare 45 C.F.R. § 147.136(b)(3) (2013) (outlining additional requirements for individual health insurance issuers), with 29 C.F.R. § 2560.503-1 (establishing a claims procedure under the authority of ERISA for group-insured plans).

214. See *supra* note 110 and accompanying text (noting the ACA requires external review be made available to all insureds, including those with individual coverage).

215. See *supra* Part II.C (outlining the source of a claimant's cause of action depending on the type of insurance arrangement).

216. Pub. L. No. 79-14, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015).

217. 15 U.S.C. § 1012(a)–(b).

218. ERISA's § 1132(a)(1)(B) cause of action for claim denial is quite attractive to litigation reformers, for reasons explained in Part I.B. Thus, in the self-insured and group-insured context, the temptation to argue that the ACA, by requiring internal and external review, somehow conceives of a new remedial scheme that totally *extinguishes* a claimant's ERISA rights, will be comparatively small. *But see infra* Part IV.B (discussing the anti-judicial review theme).

the most industry-reviled feature of traditional relief: punitive damages.²¹⁹ The temptation for litigation reformers to argue that the ACA extinguishes state causes of action, or severely limits them, will be overwhelming.²²⁰

Observation one. I start with the most extreme argument: that the ACA extinguishes state law claims and leaves consumers with *only* the options of internal and external review. The ACA after all, does not say that any cause of action, federal or state, survives as a third remedial option.²²¹

The statute and implementing regulations, however, offer no support for the “extinguishment” argument. The legislation’s only express acknowledgement of litigation reform is cabined entirely to the creation of a grant system for demonstrative, pilot programs that aim to offer suitable alternatives to tort litigation. Even that grant system is clearly aimed at providing alternatives to litigation over disputes more accurately characterized as being (or akin to) medical malpractice, rather than coverage denials.²²² As for the implementing regulations, both ERISA and state claims survive the ACA’s provision of internal and external review: the (1) NAIC-UERMA itself, (2) the list of minimum consumer protections state law must have, and (3) the federal external review process *all* require

219. See, e.g., FLA. STAT. § 624.155(5) (2013) (authorizing punitive damages against insurer); NEV. REV. STAT. § 42.005 (2013) (same); OKLA. STAT. tit. 23, § 9.1 (2013) (same); see also *supra* notes 60–61 and accompanying text (noting that insureds generally have more remedies available under state insurance laws than ERISA).

220. Cf. Betsy J. Grey, *Make Congress Speak Clearly: Federal Preemption of State Tort Remedies*, 77 B.U. L. REV. 559, 561 (1997) (explaining how frequently “corporations have attempted to turn [federal] statutes from regulatory swords into private shields”).

221. The House passed the “Affordable Health Care for America Act” (H.R. 3962) on November 7, 2009, while the Senate passed the “Patient Protection and Affordable Care Act” (H.R. 3590) on December 24, 2009. The latter was the statute that primarily became law. The House bill, H.R. 3962, *did* have a provision guaranteeing that the Act did not extinguish prior judicial remedies. See Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 232(e) (2009) (providing that “[n]othing in this section shall be construed as affecting the availability of judicial review under State law for adverse decisions”).

222. See 42 U.S.C. § 280g-15(a) (granting available to States “for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations,” and “allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and . . . promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved . . . by organizations that engage in efforts to improve patient safety and the quality of health care”).

that an external review decision is binding “except to the extent” that other remedies are available under state or federal law.²²³

Additionally, nothing in the legislative history of the statute supports extinguishment.²²⁴ Republican opponents of both the House and Senate bills (the latter of which would essentially become the ACA) repeatedly decried the lack of litigation reform in the bills.²²⁵ Yet not a single speaker in favor of or against the bill that became law applauded, attacked, or even mentioned any possibility that the ACA would extinguish causes of action or judicial review in the health insurance context.²²⁶

Indeed, given the statute, regulations, and legislative history, the suggestion that the ACA extinguishes by implication any coverage denial cause of action under state law (or for that matter, ERISA²²⁷) borders on the frivolous. I am mindful, however, of how constitutional scholars confidently dismissed the merit of early

223. 29 C.F.R. § 2590.715-2719 (c)(2)(xi) (2013) (“The State process must provide that the decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law.”); 45 C.F.R. § 147.136 (d)(2)(iv) (“These [federal] standards will provide that an external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law.”); NAIC-UERMA, *supra* note 183, § 11(B) (“An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.”).

Also, the model notice for a final external review decision includes the following language: “If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.” *Model Notice of Final External Review Decision*, DEP’T OF LABOR, <http://www.dol.gov/ebsa/IABDModelNotice3.doc> (last updated June 22, 2011). If the ACA extinguished post-external review judicial remedies, that line would be superfluous. It does not, of course, imply that post-external judicial remedies might not be modified.

224. Because of the unusual nature by which the ACA became law, it is difficult to say precisely what is the “official” legislative history of the ACA. See John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131, 136–68 (2013) (explaining the complicated legislative history of the ACA).

225. Virtually all of the talk running up to the bill was about medical malpractice liability reform, which Republicans ceaselessly complained the health care bills did not contain. See, e.g., 155 CONG. REC. 29,590 (2010) (statement of Sen. McCain) (“The reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers.”); 155 CONG. REC. S13719 (daily ed. Dec. 22, 2009) (statement of Senator Vitter) (“Let’s pass tort reform and take all that unnecessary cost out of the system.”); 155 CONG. REC. S13,811 (daily ed. Dec. 23, 2009) (statement of Senator Bond) (explaining that if a health care bill “eliminated frivolous lawsuits . . . [the bill sponsors] could probably get 80 or 90 truly bipartisan votes”). If the extinguishment of health insurance remedies were in the ACA, surely that would have been mentioned in the back and forth between Democratic and Republican Senators and Representatives.

226. See generally 155 Cong. Rec. S13,796 (daily ed. Dec. 23, 2009); 155 Cong. Rec. S13,719 (daily ed. Dec. 22, 2009); 155 Cong. Rec. at 29,590.

227. *Supra* Part III.A.

constitutional challenges to the individual mandate in the ACA.²²⁸ That confidence was misplaced; the mandate survived only on the thinnest of judicial margins and only on tax, rather than Commerce Clause, grounds.²²⁹ Although the extinguishment theory in my view has no credible support in the statute, legal realism suggests that sophisticated litigation reformers may rehearse the argument to sympathetic judges.²³⁰

Observation two. Meaningful federal litigation reform does not require that the ACA extinguish claims; the same end may be served by reading the ACA to impose conditions that affect the availability or scope of judicial review. Various versions of litigation reform arguments along these lines are easy to imagine. A straightforward one is that the ACA requires that either internal or external review, or both, must be completed prior to state judicial review. Alternately, the ACA could be argued to impliedly provide that the failure to exhaust internal or external review negatively affects the scope of court relief, the burden of proof, the available damages, or whether the arbiter is judge or jury.

Consider a simple version of the argument. The ACA requires all insurers to offer internal review, and imposes regulatory safeguards to ensure internal review is impartial and fair. The check on poor internal review is for external review to have numerous features that ensure speedy and fair treatment of an insured's claims. Given that statutory approach, the argument will go, clearly Congress intended judicial review as a last resort and intended to preempt state law that does not sufficiently promote internal and external review over litigation.²³¹

228. As Professor David Hyman describes it: "Virtually all law professors who opined on these issues agreed that all of the constitutional challenges to PPACA were meritless—and the federal courts would make short work of the litigation." David A. Hyman, *Why Did Law Professors Misunderestimate the Lawsuits against PPACA?*, 2014 U ILL. L. REV. (forthcoming) (manuscript at 4), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2224364.

229. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2600 (2012) (upholding mandate on tax grounds); see also Gary Lawson, *Night of the Living Dead Hand: The Individual Mandate and the Zombie Constitution*, 81 FORDHAM L. REV. 1699, 1700 (2013) (explaining that the individual mandate in the ACA survived on tax grounds, not on Commerce Clause or Necessary & Proper Clause grounds).

230. See Jeffrey W. Stempel, *New Paradigm, Normal Science, or Crumbling Construct? Trend in Adjudicatory Procedure and Litigation Reform*, 59 BROOK. L. REV. 659, 668 (1993) (noting legal realism views the courtroom as an "arena" where important policy and substantive decisions are made that have a significant impact on litigation reforms and their political impact).

231. To be sure, requiring a claimant to complete an internal claim process whose contours are regulated by the government—and permitting a beneficiary to skip the process absent the insurer's strict compliance with those government requirements—may well be reasonable as policy matter. Indeed, the more fair the internal process

The plain language of the statute, however, is not friendly to this argument. The statute does not require that either internal or external review be anything more than an option. The ACA requires that internal processes be “available,” and obligates insurers to provide an internal claims and appeals process, but does not require claimants to use those processes.²³² Additionally, the implementing regulations presume that the question of exhaustion of internal review prior to external review is a matter of state law.²³³

Similarly, the NAIC-UERMA is on its face quite clear that external review is an option, not a requirement. Section 2 of the NAIC-UERMA explains that the “purpose of this Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the *opportunity* for an independent review”²³⁴ Section 3 in turn defines a “covered person” as a “policyholder, subscriber, enrollee or other individual participating in a health benefit plan.”²³⁵ Section 5 provides that “a health carrier shall notify the covered person in writing of the covered person’s right to *request* an external review”²³⁶ Section 6 requires that “all requests for external review shall be made in writing to the [state insurance commissioner]” and that “a covered person or the covered person’s authorized representative may make a request for an external review.”²³⁷

Read plainly, the NAIC-UERMA—the model act the ACA assumes states will follow—makes external review an option only a claimant can exercise. In the alternative, the claim can proceed in state court. Moreover, if a beneficiary chooses external review, although the external reviewer’s determination is binding on both the insurer and the claimant, NAIC-UERMA contemplates that external review is

is, and the more readily a beneficiary may seek outside review if the internal process is suspect, the less of a remedial burden it becomes. Having a federally guaranteed option to do so is certainly consonant with protecting consumers. Converting an option into a requirement may also be defensible policy, if the internal review process is cheap and impartial and thus saves money without sacrificing fairness. And such arguments may apply with stronger force to external review, because there is less of a risk of conflicted denials. But the question is not what is the best policy; the question is what does the statute provide.

232. See 42 U.S.C. § 300gg-19(a)(1)(B) (2012) (referring to notice for “available” internal and external appeals processes).

233. See 29 C.F.R. § 2590.715-2719(c)(2)(iii) (2013) (“To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary [under certain conditions that favor the consumer].”).

234. NAIC-UERMA, *supra* note 183, § 2 (2010) (emphasis added).

235. *Id.* § 3(N).

236. *Id.* § 5(A)(1) (emphasis added).

237. *Id.* § 6(A)(1), (B). Elsewhere the NAIC-UERMA Model Act assumes that the invocation of external review will be done by the claimant or her representative. *E.g.*, *id.* § (7)(A)(1).

“binding . . . except to the extent [the insurer or the claimant] has other remedies available under applicable State law.”²³⁸ Per the specific language of the NAIC-UERMA, the availability and contours of judicial review of coverage disputes on individual policies is left entirely up to the states to specify; external review does not limit court remedies unless the law of a particular state says so.²³⁹

Legislative history also undermines any theory that the ACA—by requiring internal and external review be available—intended to limit judicial review and concomitantly displace any state law that failed sufficiently to do so. A Republican amendment to the House health care bill prepared by Minority Leader John Boehner specifically attempted to effect federal litigation reform by limiting judicial review of “health care lawsuits.”²⁴⁰ Boehner’s amendment, which was effectively health care legislation in itself, was entitled the “Common Sense Health Care Reform and Affordability Act,” and in pertinent part, envisioned a sweeping series of reforms that affected not just medical malpractice, but all manner of health care litigation including coverage denials.²⁴¹ It provided that any “health care lawsuit” would be subject to damage caps, voided joint and several liability, limited attorneys’ fees, required clear and convincing proof of malice to recover punitive damages, and excused from preemption any state law that imposed greater procedural or substantive protections for health care organizations (which included insurers) than the Boehner bill.²⁴² None of it was adopted.

Observation three. Insofar as federal power emanating from the ACA trumps state power over individual policies, it does so as a floor. To understand this observation, it is helpful to briefly offer an example from the world of self-insured plans.

Self-insured plans are entirely regulated by the federal government.²⁴³ On the matter of exhaustion, however, the ACA’s implementing regulations effected a significant change compared to

238. *Id.* § 11(A)–(B).

239. Whether a state could, as a matter of state law, use procedural devices to strongly favor external review over judicial review depends on whether a state doing so would be offending the “minimum consumer protections” of the NAIC-UERMA. *Supra* Part III.B.2. The current interpretation by federal authorities of the NAIC-UERMA minimum protections does not appear to bar states from engaging in such conduct.

240. H.R. REP. NO. 111-330, at 85–91 (2009) (setting forth sections 301–310 of the “Common Sense Health Care Reform and Affordability Act”).

241. *Id.*

242. *Id.* at 85–91 (setting forth pertinent provisions of Boehner’s amendment).

243. *See supra* Part III.A (explaining that the ACA incentivizes large employers to offer insurance and opens up the individual market to everyone). The subsequent analysis also applies to group-insured plans.

the old ERISA rule. Claimants against self-insured plans now need to exhaust internal processes only if such processes closely hew to the extensive protective regulations governing the internal review process. Indeed, originally the ACA regulations required strict compliance by the plan with the internal regulations; absent *strict* compliance, a claimant could proceed directly to external review or judicial review.²⁴⁴ In the latter case, devastatingly for insurers, “the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.”²⁴⁵ *Firestone* deference is only due if a fiduciary has exercised discretion. Thus, under the formulation of the originally promulgated ACA regulations, if self-insured plans did not strictly comply with federal regulations on internal review, they lost *Firestone* deference in court.

In response to industry criticism of *Firestone* deference being conditioned on strict compliance, the Departments slightly revised their rule on exhaustion.²⁴⁶ But not much. Under the rules currently in effect, exhaustion is excused, and deference lost in court, if the internal review process does not comply with the federal regulations governing internal review, unless such infirmity is de minimis, not likely to cause prejudice to the claimant, occurred for good cause and in good faith, and was not part of a pattern or practice of violative conduct.²⁴⁷ Although this is not the strict compliance the federal

244. “[T]he July 2010 regulations permitted claimants to immediately seek review if a plan or issuer failed to ‘strictly adhere’ to all of the July 2010 regulations’ requirements for internal claims and appeals processes, regardless of whether the plan or issuer asserted that it ‘substantially complied’ with the July 2010 regulations.” Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 Fed. Reg. 37,208, 37,213 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117).

245. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330, 43,351–52 (July 23, 2010) (to be codified at 45 C.F.R. pt. 147) (explaining that the initial July 2010 regulations required strict adherence to internal review requirements, and that upon failure to do so, “[i]f a claimant chooses to pursue remedies under section 502(a) of ERISA[,] . . . the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary”).

246. Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 Fed. Reg. 37,208, 37,213 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117) (“Consumer groups generally supported this ‘strict adherence’ approach, but the approach received a number of negative comments from some issuers and plan sponsors, who advocate a ‘substantial compliance’ approach.”).

247. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F) (2013); *see also* 76 Fed. Reg. at 37 (“In response to comments, the Departments are retaining the general approach to this requirement, but this amendment also adds a new paragraph (b)(2)(ii)(F)(2) to the July 2010 regulations to provide an exception to the strict compliance standard for errors that are minor and meet certain other specified conditions.”).

agencies originally required in the initial July 2010 regulations, this effectively imposes a near-strict compliance standard on insurers.

Now the relevance to state prerogative can be explained. The ACA regulates internal review for all policies, including individual policies that are otherwise governed by state law. With respect to compliance and exhaustion, the Departments could have left the treatment of that issue entirely to the states to resolve on their own, but they seemingly did not. Instead, the ACA regulations governing internal review for individual policies provide that, absent near-strict compliance with federal regulations, “the claimant is deemed to have exhausted the internal claims and appeals process.”²⁴⁸

This appears to be an attempt to ensure that states eager to favor internal review over external or judicial review cannot do so via state doctrines of exhaustion that too readily overlook insurer violations of internal review protocols. How robust this protective effort will be—that is, how resistant it will be to state efforts to circumvent it—is not clear. But the point is that, to the degree the ACA and its implementing state regulations are displacing state authority, they are doing so in a way designed to protect insureds.

It is not possible to predict precisely how extra-statutory impulses might affect the specific analyses set forth above. Readers are invited to speculate how the above issues and disputes might be resolved in the real world, outside the pages of this Article. Nevertheless, certain themes will serve useful in imagining how realist preference and statutory interpretation coherently interact.²⁴⁹

IV. ACA LITIGATION REFORM THEMES

The analysis in Part III.B was, by design, rooted in specifics. It aimed to provide academics, judges, regulators, and practitioners with a functional understanding of the ACA on remedy as well as some concrete predictions regarding the most likely litigation reform battles. By contrast, Part IV steps back and considers “themes” likely to be urged by litigation reformers and their opponents, either in connection with the specific disputes identified in Part III.B or as a launching pad for others.

For purposes of this Article, the notion of a theme is straightforward. Put simply, it is a larger story on remedy supposedly

248. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(1)–(2) (setting forth limits on use of exhaustion); *id.* § 2590.715-2719(c)(2)(iii) (explaining that state exhaustion rules are subject to § 2590.715-2719(b)(2)(ii)(F)).

249. *See infra* Part IV (considering themes likely to be urged by litigation reformers and their opponents).

told by the ACA. While thematic descriptions of statutes have been attacked as useless or harmful by various interpretative schools,²⁵⁰ I do not discuss themes here solely as formal interpretative prisms by which the ACA will be construed. I regard themes as an essential way to understand the narratives litigation reformers and other stakeholders will offer. The ACA is technical, complicated, and dry. And humans (including judges) are not tireless propositional robots. Narrative matters.

The use of themes in this fashion is particularly useful with respect to a complicated federal statute like the ACA, one that affects both federal and state law. As I explain in Part IV.A., the judicial device by which conflict between federal and state law is mediated is well known: “preemption.” The judicial means by which conflicts between federal laws are resolved does not have a tidy name; I prefer the term “intra-federal statutory conflict resolution.” Both doctrines are fairly elastic and could serve as the hook by which the remedial themes discussed below could appear in judicial and regulatory interpretations of the ACA.²⁵¹

A. *Flexible Jurisprudential Devices*

Preemption. Preemption is the doctrine by which the winners in federal versus state law conflicts are chosen. Preemption comes in two varieties: express and implied. Express preemption is when the federal statute specifies the degree to which it does or does not displace state law.²⁵² The presence of an explicit preemptive clause, however, does not bar judges from engaging in an analysis of

250. See, e.g., Gregory E. Maggs, *Reconciling Textualism and the Chevron Doctrine: In Defense of Justice Scalia*, 28 CONN. L. REV. 393, 396–97 (1996) (observing that textualist judges “give little weight to the purpose of a statute, the intent of Congress, or the current societal context in which the statute applies”).

251. Cf. Simon Lazarus, *Stripping the Gears of National Government: Justice Stevens’s Stand Against Judicial Subversion of Progressive Laws and Lawmaking*, 106 NW. U. L. 769, 772–79 (2012) (cataloging the methods by which conservative justices have used “a broad selection of doctrinal monkey wrenches to throw into the machinery of the modern progressive state” and “immuniz[e] businesses from private remedies under federal and state laws protecting customers, retirees, depositors, workers, and other individuals”).

252. Affirmative preemptive provisions are usually called “preemption” clauses. Preemption provisions that spell out where state law survives are often called “savings” clauses. See, e.g., Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727, 738 (2008) (explaining preemption clause nomenclature).

“implicit” preemption.²⁵³ Implicit preemption occurs when state law “conflicts” with federal law.²⁵⁴

Conflict preemption is often sub-divided into “impossibility” and “obstacle” preemption.²⁵⁵ The variant of conflict preemption that will be at issue with respect to the ACA is “obstacle” preemption—where state law is preempted because it frustrates the “purposes and objectives of Congress.”²⁵⁶ Conflict-obstacle preemption arises both in respect to logically contradictory state laws as well as those that hinder or obstruct Congressional purpose.²⁵⁷

The doctrine of preemption—and obstacle preemption in particular—is quite muddled. Facially neutral principles like “formalism” or “textualism” do little work, even for those judges who proclaim their merits.²⁵⁸ And the more extensive the list of contact points between federal and state law, the higher the likelihood that obstacle preemption will be wielded by “free-ranging” realist judges.²⁵⁹ The ACA contains many contact points between federal and state law.

253. See *id.* at 739 (referencing *Geier v. Am. Honda Motor Co., Inc.*, 529 U.S. 861, 861 (2000), and stating that “the Court . . . has held state law displaced even when the statute contains an express saving clause”).

254. Field preemption, a type of implied preemption, is when Congress so thoroughly regulates an area that it “occupies the field.” *Altria Grp., Inc. v. Good*, 555 U.S. 70, 76 (2008) (“Pre-emptive intent may also be inferred if the scope of the statute indicates that Congress intended federal law to occupy the legislative field.”). Field preemption is extremely rare, though it has been applied to areas implicating national security, such as atomic energy. See, e.g., *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190 (1983) (applying field preemption in the area of atomic energy); *Skull Valley Band of Goshute Indians v. Nielson*, 376 F.3d 1223 (10th Cir. 2004) (same); see also *Fellner v. Tri-Union Seafoods, L.L.C.*, 539 F.3d 237, 243 n.3 (3d Cir. 2008) (“Courts rarely find field preemption . . .”). Field preemption is often (correctly) described as an area of implied preemption, see *Merrill*, *supra* note 252, at 739, but it could be express: Congress could declare that it intends to exclusively occupy a field.

255. Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 228–30 (2000). Impossibility preemption is extremely narrow because it refers to physical, rather than logical, impossibility. *Id.* at 228. Accordingly, “even if one sovereign’s law purports to give people a *right* to engage in conduct that the other sovereign’s law purports to prohibit, the ‘physical impossibility’ test is not satisfied [because] a person could comply with both state and federal law simply by *refraining* from the conduct.” *Id.* at 228 n.15 (emphasis added). Impossibility preemption exists only when Sovereign *A* affirmatively requires Act *Z* and Sovereign *B* forbids Act *Z*. *Id.*

256. *Id.* at 228.

257. *Id.* at 228–29.

258. See, e.g., John F. Manning, *The New Purposivism*, 2011 SUP. CT. REV. 113, 114 n.5 (noting that preemption serves as an “exception” to the Court’s embrace of textualism).

259. *Wyeth v. Levine*, 555 U.S. 555, 595 (2009) (Thomas, J., concurring) (criticizing obstacle preemption as little more than a court’s “free-ranging speculation about what the purposes of the federal law must have been”); cf. *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 459 (2005) (urging restraint in implied preemption analysis so as to avoid converting the doctrine into “[a] freewheeling

The ACA incorporates some specific preemption provisions, but none appears to directly address coverage denial remedies.²⁶⁰ Instead, state rules of remedy would be subject to the ACA's general preemption provision, codified at 42 U.S.C. § 18041(d). Interestingly, that provision is facially written as an *anti*-preemption provision: "Nothing in [Title I] shall be construed to preempt any State law that does not prevent the application of the provisions of this title."²⁶¹

The meaning of the provision is unclear and prompts the question: why was it written in at all? The common law of conflict preemption already displaces state law that (1) logically conflicts with federal law or (2) poses an obstacle that frustrates Congressional intent. Does Congress's use of the expression "prevent the application" intend something broader than, equal to, or narrower than the common law of conflict preemption? Perhaps the latter. Obstacle preemption has come under attack from both conservative and liberal scholars as a thinly veiled means to instantiate judicial policy preferences.²⁶² Perhaps Congress intended for § 18041(d) to curb, in some way, the use of obstacle preemption by judges to displace state law. Yet neither the height nor slope of the curb contained in § 18041(d) is self-evident.

Intra-federal statutory conflict resolution. Scholars have often debated how different types of federal law interact—for example, treaties versus statutes, or statutes versus the federal rules of civil procedure.²⁶³ However, there has been little scholarly treatment as to how conflicts between federal statutes should be resolved. In the

judicial inquiry into whether a state statute is in tension with federal objectives" (internal quotation marks and citation omitted).

260. See, e.g., 42 U.S.C. § 280g-15 (2012) (involving tort reform demonstration projects); *id.* § 1320a-7h (involving physician transparency reports); *id.* § 18031(k) (involving regulation of exchanges).

261. *Id.* § 18041(d). The statutory note makes clear that the reference to "this title" is to Title I of the ACA. Title I added section 2719 to the PHSA, while Title X, enacted simultaneously, amended Title I, including section 2719. The amended language was codified at 42 U.S.C. § 300gg-19. Some other preemption regulations in the ACA track this language. See, e.g., 42 U.S.C. § 18054(b)(32) (tracking preemptive "prevent the application" language).

262. "Commentators on the bench and in the academy have puzzled at the seeming incoherence of decrying reliance on a statute's background purposes but finding state laws preempted as inconsistent with those purposes." John David Ohlendorf, *Textualism and Obstacle Preemption*, 47 GA. L. REV. 369, 372 (2013); see also *id.* at 372-73 n.9 (identifying a range of commentators who have criticized the Court's implied preemption analysis).

263. See, e.g., Bernadette Bollas Genetin, *Expressly Repudiating Implied Repeals Analysis: A New Framework for Resolving Conflicts Between Congressional Statutes and Federal Rules*, 51 EMORY L.J. 677, 701-26 (2002) (describing the resolution of conflicts between federal rules of civil procedure and statutes).

courts, various canons are invoked. Statutes should be read in harmony where possible.²⁶⁴ Old laws yield to new.²⁶⁵ General statutes yield to specific ones.²⁶⁶ Implied repeal is disfavored.²⁶⁷ Yet how these canons interact, particularly when operating at cross purposes, is not clear. Similarly unclear is how they apply with respect to ERISA and the ACA.²⁶⁸

B. *The ACA as Consumer Choice*

The ACA as consumer choice is a theme likely to be invoked by litigation reform opponents. The story will go something like this: the ACA's drafters intended to ensure that insureds had three robust and independent options for remedy—internal, external, and judicial review. The legislation says nothing about one remedy limiting any other. Under this thematic approach, rules that in practice limit a

264. See *Traynor v. Turnage*, 485 U.S. 535, 548 (1988) (“The courts are not at liberty to pick and choose among congressional enactments, and when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective.”).

265. See *Katz v. Gerardi*, 552 F.3d 558, 561 (7th Cir. 2009) (describing the canon as “[u]sually the older law yields to the newer”).

266. See *Brown v. Gen. Servs. Admin.*, 425 U.S. 820, 834 (1976) (“In a variety of contexts the Court has held that a precisely drawn, detailed statute pre-empts more general remedies.”); see also *Basic v. United States*, 446 U.S. 398, 406 (1980) (referring to the “principle that a more specific statute will be given precedence over a more general one, regardless of their temporal sequence”); *Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 153 (1976) (noting the “basic principle of statutory construction that a statute dealing with a narrow, precise, and specific subject is not submerged by a later enacted statute covering a more generalized spectrum”).

267. See *Traynor*, 485 U.S. at 551 (“[S]ince we ‘are not at liberty to pick and choose among congressional enactments . . . when two statutes are capable of coexistence,’ . . . we must conclude that the earlier, more specific provisions . . . were neither expressly nor implicitly repealed by the later, more general provisions” (internal quotation marks omitted)); see also *United States v. Welden*, 377 U.S. 95, 103 n.12 (1964) (holding that “[a]mendments by implication . . . are not favored”); *Posadas v. Nat’l City Bank*, 296 US 497, 503 (1936) (explaining that “repeals by implication are not favored”). But “if the later act covers the whole subject of the earlier one and is clearly intended as a substitute, it will operate similarly as a repeal of the earlier act.” *Radzanower*, 426 U.S. at 154. And “[i]t is common ground, or at least should be, that a later-enacted statute can confine the domain of an earlier one.” *Quinn v. Gates*, 575 F.3d 651, 655 (7th Cir. 2009).

268. The matter is complicated further by ERISA’s anti-supersession provision, which provides that “[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law.” 29 U.S.C. § 1144(d) (2012). The true scope of this clause is unsettled. See, e.g., *Guidry v. Sheet Metal Workers Nat’l Pension Fund*, 493 U.S. 365, 375, (1990) (finding 29 U.S.C. § 1144(d) inapplicable); *Colonial Life & Accident Ins. Co. v. Medley*, 572 F.3d 22, 27 (1st Cir. 2009) (holding that § 1144(d) subordinates ERISA to the later-enacted Americans with Disabilities Act). In any event, the same nonlegal impulses that may motivate judges to expansively read ACA’s general preemptive provision vis-à-vis state law favoring insureds could motivate them to find reason to hold 29 U.S.C. § 1144(d) inapposite in cases involving tension between ACA provisions favoring insureds and ERISA provisions that do not.

consumer's choice to pursue one form of review will be argued to have been impliedly displaced or preempted by the ACA.

To insist that insureds may choose which remedial track to pursue, with no constraint, is admittedly a tidy view of the ACA on remedy. It is also appealing because it errs on the side of consumer fairness, favors individual choice, and encourages insurers and states to make non-judicial review processes as inexpensive, competent, and impartial as possible.²⁶⁹

The challenges of this narrative, however, are twofold. First, it implies the elimination of settled ERISA doctrine. Recall that the ACA does not undo the rule that exhaustion is required for self-insured plans, nor does it explicitly end deference to internal reviewers on matters outside external reviewers' scope.²⁷⁰ The former is expressed as a matter of agency rule, while the latter is a natural implication of the regulations as written. Both clearly draw from ERISA practice. Perhaps regulators could change course, or liberal judges could reject agency regulations, with either bureaucrat or jurist having become taken with the consumer choice theme. But I highly doubt it.

I do not doubt, however, that a milder version of this consumer choice theme will be urged, perhaps with ultimate success. The milder version will go something like this: except where ERISA or the ACA's implementing regulations clearly indicate otherwise, the presumption is that the ACA promotes consumer choice.²⁷¹ This theme implies that the specific dominates the general. Given the current inclinations of the American judiciary,²⁷² this theme seems unlikely to immediately secure followers. In coming years, however, the landscape may be quite different, particularly if there is a slight change in the composition of the U.S. Supreme Court.

269. Individuals denied coverage are, with most claims, likely to want to obtain the promised benefit as quickly and cheaply as possible. If internal review is truly fair—if Insurer *A* has a reputation for fairly and promptly resolving disputes—that option will be very often selected, and Insurer *A* will benefit compared to competitors perceived as more sharp-elbowed and thus more often subject to litigation. Similarly, if a state does a poor job of ensuring its external reviewers are truly impartial, external review will attract a smaller audience, as it should.

270. See *supra* Part III.B.1.

271. So, for example, the ERISA plans' ability to contractually modify policies so as to alter background rules—which prior to the ACA's passage, was presumed to be fairly expansive, but was only confirmed in a few specific areas—would be, by dint of the ACA's purpose, now very much limited: contractual limit on consumer choice would be presumptively disfavored.

272. See *supra* Part I.C (noting significant judicial hostility to expansive remedies for plaintiffs).

Although I believe comprehensive remedy is important,²⁷³ I must admit that the ACA as consumer choice theme seems quite susceptible to overreach. For example, the statute's structure and text seemingly preserve ERISA's remedial approach in some important—and, to me, disappointing—ways.²⁷⁴ More troubling is that the “ACA as consumer choice” theme could supply insufficient regulatory space for states to operate differing remedial regimes. Ensuring pure option-choice can be costly, and some states might not adjudge the benefits to be worth such costs. It is also possible that some combination of the ACA's three remedial options that falls short of undiluted choice may yield the “best” results. While the ACA does provide a protective floor regarding remedy, preempting *all* state action that infringes upon the consumer's choice regarding any of the three options may pay short shrift to traditional federalist virtues of experimentation and heterogeneous preference, and, in any event, exceed the legislation's intent.²⁷⁵

C. *The ACA as Anti-Judicialism*

An attractive theme for litigation reformers will be that the ACA is generally hostile to judicial dispute resolution, by virtue of its extensive regulation of non-judicial processes. The theme might animate two approaches to reform: (1) to argue that the ACA modifies ERISA so as to further diminish ERISA's judicial remedies; and (2) to argue that the ACA, by dint of exercising power over individual insurance policies, preempts state laws that do not sufficiently favor non-judicial review.

As to the first approach—reading the ACA to further weaken ERISA's remedial regime—consider the following. Through the use of a series of judicial glosses, the Supreme Court has “interpreted” ERISA as creating a mandatory administrative scheme to handle coverage disputes.²⁷⁶ The ACA, in short, provides a much better administrative scheme. It more strictly regulates internal review and creates an external review system that, on its face, demands

273. On four separate occasions, I represented ERISA beneficiaries on the merits as parties before the Supreme Court: *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604 (2013); *US Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013); *Conkright v. Frommert*, 559 U.S. 506 (2010); and *LaRue v. DeWolff, Bobery & Assocs., Inc.*, 552 U.S. 248 (2008). I have never represented an ERISA plan, fiduciary, or insurer in any capacity before the Court.

274. See *supra* Part II.C.

275. See generally Heather K. Gerken, *Foreword: Federalism All the Way Down*, 124 HARV. L. REV. 4, 44–73 (2010) (describing the virtues of federalism).

276. See *supra* notes 55–59 and accompanying text (discussing ERISA as national litigation reform).

competent and impartial reviewers.²⁷⁷ It must, therefore, impose even greater limits on the use of judicial review than ERISA does, or so the argument goes.

I do not specifically see a path for this approach to prevail; I see no identifiable place where the ACA modifies ERISA so as to further weaken the judicial review of claims. That the ACA extinguishes all judicial remedy under ERISA is, as I have explained above, utterly unjustifiable.²⁷⁸ And I have, in the specific instances analyzed in Part III, expressed skepticism that the ACA in any way worsens the ERISA remedial regime.²⁷⁹ However, I cannot say that on this question the text and regulations are so clear as to foreclose any possibility that the ACA will be read as embodying this theme.

The second approach—urging the ACA as a limiting force on state judicial remedies—is more troubling. ERISA will no doubt serve as a point of reference. One might think ERISA would be readily disregarded, given the difference in the preemptive structures of the two statutes.²⁸⁰ ERISA expressly and presumptively preempted large swathes of state law and also affirmatively provided a fairly detailed set of remedies (although not nearly so comprehensive as later decisions would pretend).²⁸¹ The ACA does neither, and thus formally comes with a much weaker and narrower preemptive base.

One would naturally expect that the preemptive “penumbra” of ERISA, i.e., its implied preemptive reach, to be larger than that of the ACA, just as larger objects cast bigger shadows. But it all depends on the angle at which one shines judicial light on the statute. Tiny objects can cast very large shadows if hit with light from certain angles. Legal realism expects that judges will, for non-legal reasons, move the light.

For example, converting the ACA’s federally guaranteed options of internal and external review into an ACA command (i.e., that state

277. See *supra* Part II.A–B (outlining the internal and external review procedures in the ACA).

278. *Supra* Part III.B.3.

279. See *supra* Part III. I cannot analyze every ambiguity or possibility, and perhaps some overlooked statutory crevice could support a rule where, for example, in some circumstances a judge acting in the aftermath of non-judicial review must offer something exceeding *Firestone* deference. That is, a plaintiff might need to show something *more* than arbitrariness and capriciousness before a court were permitted to disturb the result of the non-judicial review. Cf. 9 U.S.C. § 10(a) (2012) (setting forth extremely limited grounds under the Federal Arbitration Act by which a court may overturn arbitration award). Moreover, my analyses in Part III may be wrong at the granular level. And, finally, even in those cases where a specific analysis may have been “correct,” it may fall victim to realist impulses and themes.

280. See *supra* Part II.C (explaining the broad preemptions found in ERISA and the narrow preemptions found in the ACA).

281. See *supra* Parts I.B, II.C.

law governing individual insurance policies must make non-judicial review a pre-suit requirement) is a trick ERISA already performed. For the sake of comparison, remember that ERISA provides that a claimant must have an “opportunity” to utilize a “full and fair” internal claims review process.²⁸² Nonetheless, that opportunity was merrily converted by the judiciary into a requirement that a claimant must use such a process before resorting to court.²⁸³

Admittedly, under ERISA the exhaustion requirement occurred in part based on a misunderstanding of the statute’s relation to the Labor Management Relations Act, which required internal grievance exhaustion prior to suit.²⁸⁴ But just as in persuading judges to interpret ERISA with an improper reference to the LMRA, litigation reformers advancing an anti-judicial review theme might persuade judges to interpret the ACA with improper reference to ERISA. While ERISA constitutes still-controlling law with respect to key aspects of the regulation of self-insured and group plans, it has no controlling relevance whatsoever with respect to individual insurance.

Litigation reformers will urge that judges consider the “teachings” of ERISA to “guide” interpretation of the ACA. For example, here are the words of the U.S. Court of Appeals for the Ninth Circuit, uttered over thirty years ago, in justifying the court’s reading of ERISA as requiring that claimants exhaust internal claim procedures before seeking judicial relief: “It would . . . be anomalous if the same good reasons that presumably led Congress and the Secretary to require covered plans to provide administrative remedies for aggrieved claimants did not lead courts to see that those remedies are regularly used.”²⁸⁵ Precisely the same reasoning could be offered in defense of reading the ACA to impose, via § 18041(d), limits on state power. The steps are familiar: the ACA provides more reliable and impartial means for non-judicial resolution of coverage disputes than does ERISA.²⁸⁶ It should, thus, be impliedly read to ensure that states cannot rob non-judicial review of the privileged position the ACA

282. 29 U.S.C. § 1133(2).

283. *But see* Maher, *supra* note 33, at 674–76 (arguing that, as both a textual and policy matter, it is unlikely that ERISA requires administrative exhaustion).

284. Professor Conison dismantled this argument over twenty years ago, explaining: “the reference to section 301 of the LMRA does not mean that courts should import into ERISA the specific rules that have been developed under section 301. Neither the Conference Report nor any other document suggests that Congress intended such a result or that such a reading of the passage is even remotely plausible.” Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 16–17 (1992).

285. *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980).

286. *Supra* Parts I.A, II.

takes pains to grant it. State law that fails to promote non-judicial review will be claimed to “prevent the application” of the ACA’s provisions insofar as it frustrates an asserted Congressional purpose of “maximizing” use of internal and external review.

With respect to individual policies, consider a state’s failure to require the exhaustion of external review before judicial review, or a state’s choice to judicially resolve coverage disputes with no deference owed to external review. Neither squarely prevents the application of any provisions of the ACA. After all, the legislation explicitly and affirmatively codifies state prerogative regarding external review, and the cause of action in question is created by state law.²⁸⁷ Given that external review and the cause of action that leads to judicial review are both subject to state law, the relationship between external review and judicial review seems necessarily, by design, entirely a matter of state law. But, after reading into the ACA an implicit Congressional purpose that the use of non-judicial review should be maximized, ACA’s general preemption clause could serve as the statutory ledge upon which reformers may seek to divest states of external review authority.

Consider also internal review. Regarding internal review, the ACA uses a more traditional approach to regulating state power; it adopts existing standards and directs federal agencies to further update such standards.²⁸⁸ Unlike with respect to external review, the ACA provides no explicit ongoing state carve-out.²⁸⁹ The ACA’s regulatory guidance assumes that states retain the prerogative to enact more consumer-protective rules. That is, the federal agencies’ view of the ACA is that it serves as a floor.²⁹⁰ But the language of the ACA itself, unlike with respect to external review, does not explicitly provide that states possess residual authority to regulate the relationship between internal and judicial review. It is certain that litigation reformers sounding the anti-judicial theme will cast state efforts to enact claimant-friendly rules as somehow “prevent[ing] the application” of the ACA merely by diminishing the importance of internal review.

287. *Supra* Part III.B.2.

288. *Supra* Part III.B.3.

289. The explicit incorporation of state law for internal review is limited to state law in effect at the time of the ACA’s enactment: March 23, 2010. 42 U.S.C. § 300gg-19(a)(2)(B).

290. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status of Grandfathered Health Plans under the ACA, 75 Fed. Reg. 34,538, 34,540 (June 17, 2010) (to be codified at 29 C.F.R. pt. 2590) (“State laws that impose on health insurance issuers requirements that are stricter than the requirements imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.”).

Assume, for example, that a particular state requires judges to interpret insurance contracts using *contra proferentem* without exception. One expects arguments that such a state law would “prevent the application” of 42 U.S.C. § 300gg-19(a) by discouraging people from fully participating in internal review processes.

Some of the territory discussed above falls within the specific analyses undertaken in Part III.B, and seems to have little hope of success absent a strained reading of the preemption clause and a studied effort to avoid the implication of the implementing regulations. But that is part of the point: the anti-judicial theme draws its strength from a purposive analysis, potentially overwhelming more granular analyses of how the various remedial tracks interact.

Given the statute as a whole, this theme is subject to superficially appealing purposive justifications, so much so that it may in practice be recast as something more palatable than an “anti-judicial” instinct. An enormous part of the debate over the ACA was whether it would reduce the cost of health care and health insurance.²⁹¹ The latter was important to many observers not only because cost always matters, but also because of the ACA’s requirement that everyone purchase insurance. If everyone has to purchase insurance, then immediately the cost of insurance becomes an even more scrutinized issue.²⁹² Anti-judicial reformers will argue that, because the ACA requires everyone to purchase insurance, judicial review is implicitly but significantly limited by the legislation; otherwise expansive judicial review would make insurance more costly, and unlike normal goods, there is no option not to buy it. It will be effortless to find extensive passages of legislative history that describe one of the statute’s aims as reducing costs; the title of the Act itself includes the word “affordable.” State laws that provide expansive judicial remedy, the argument goes, would frustrate this implied purpose of the ACA. Note the irony that this argument is a self-fulfilling prophecy on the “federal takeover” of health insurance.²⁹³

A more sophisticated version of this theory might argue that states are, under the ACA, expected to foot the bill for essential health

291. See Rebecca E. Zietlow, *Democratic Constitutionalism and the Affordable Care Act*, 72 OHIO ST. L.J. 1367, 1393–95 (2011) (describing the hotly contested debate between supporters and opponents of the ACA about whether it would reduce the cost of health care).

292. The individual mandate is set forth in the ACA at 26 U.S.C. § 5000A (requiring purchase of coverage).

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

benefits above a certain floor.²⁹⁴ Although this “pay the freight” provision only explicitly applies to essential health benefits, which do not include rules of remedy, it might be conscripted in furtherance of establishing a general notion that the ACA disfavors expansive remedy beyond some indication that states can pay for it. And since there is no obvious mechanism by which a state can pay for a more expansive remedy, the implication is that the ACA permits states to offer judicial remedies no more costly than those offered by ERISA. Otherwise, the ACA’s subsidies to individuals will in effect buy less actual health insurance coverage, because, presumably, states with more expansive remedy will have higher policy prices. Features of a state law that might fall to or be limited by this type of argument include consequential and punitive damages, jury rights, the availability and level of judicial review, and burdens of proof.

There are innumerable imaginable variations. Each one, however, will amount to *sub rosa* litigation reform—limiting, nationwide, judicial remedy. And that is why I have categorized this as an anti-judicial theme, rather than one seeking to reduce consumer cost. Put simply, the objective is to limit judicial remedy, i.e., litigation. The challenges to this theme are, first, that neither specific provisions of the ACA nor the obvious intent of its implementing regulations, are friendly to it. The second, again, is federalism. It seems quite clear that almost all litigation-limiting rules urged in furtherance of this theme would fall within the discretion of states.²⁹⁵ The virtues of federalism do not wane when applied to remedy; that judicial preference for federalism by self-professed proponents often vanishes on questions of remedy is regrettable, not commendable.²⁹⁶ The ACA contemplates federalism over judicial policy preference; the anti-judicial theme invites, of certain-minded judges, the opposite. I hope that invitation will be declined.

294. 42 U.S.C. § 18031(d)(3)(B)(i)–(ii); *see also* Maher & Pathak, *supra* note 205, at 77 (explaining how the “pay-the-freight” provision works).

295. This runs counter to the “consumer choice” theme, which would scrutinize closely whether state law, by limiting judicial review, was meaningfully limiting a consumer’s remedial options. If it were, consumer choice theme adherents would urge preemption. I do not at this time see a specific justification for that view of preemption in the statute, but for practical reasons I have not analyzed the question in close detail. Namely, the consumer choice theme represents a view of the ACA that may take root in the future (perhaps as soon as the next presidency, if a Democratic president succeeds President Obama) rather than today. Given the current judiciary, it seems the primary battle will be between themes described in Parts IV.C (anti-judicialism) and IV.D (non-judicial justice).

296. *See* AT&T Mobility LLC v. Concepcion, 131 S. Ct. 1740, 1762 (2011) (Breyer, J., dissenting) (remarking that the majority’s use of preemption to strike down California’s judicial rule regarding the unconscionability of class arbitration waivers in consumer contracts “do[es] not honor federalist principles”).

D. The ACA as Non-Judicial Justice

A third theme, and a milder alternative to the two set forth in Parts IV.B and IV.C, might be called “the ACA as non-judicial justice.” This theme draws upon the ACA’s extensive regulation of internal and external review to conclude that the legislation intends to ensure that coverage disputes must always, at the election of the insured, be resolvable by a competent and impartial non-judicial actor operating under fair procedures. Beyond that core requirement, this theme leaves the remainder of remedial choices to be resolved by “residual authorities” whose power pre-dated the ACA: by federal authorities in the self-insured context, by state authorities in the individual insurance context, and by a little of both in the group-insured context.²⁹⁷

Supplemental state regulation that does not undermine the competence, impartiality, and fairness of non-judicial procedures would be permitted even if, in practice, it limited consumer choice. Similarly, residual authorities would resolve the proper role that litigation and judicial review are to play. Under this view, a state might be within its rights to severely limit judicial review in the aftermath of a no-coverage finding by both the internal and external reviewer, absent some concrete showing by the plaintiff that malfeasance occurred. In the other direction, a state might be entirely free to view internal and external review as entirely optional, adopting in practice the consumer choice view and leaving expansive judicial remedies fully intact in all circumstances.²⁹⁸

This theme seems closest to what Congress intended, and largely but not entirely tracks the agency commentary preceding the implementing regulations.²⁹⁹ It also has the merit (or vice) of federalism. If this theme dominates, litigation reform battles will

297. See *supra* Part III.B. The distinction between the two themes is subtle but important. The “consumer choice” theme aims to provide consumers with a choice of options even where non-judicial review is fair. The “non-judicial justice” theme is essentially indifferent to a consumer’s option for judicial review, if non-judicial review is reliably fair. They shade together to the extent one argues that *only* robust judicial review can ensure non-judicial review is reliably fair.

298. Federal authorities would have less residual freedom to act, because they are confined in their choices by ERISA.

299. See, e.g., Group Health Plans Rules Relating to Internal Claims and Appeals and External Review, 76 Fed. Reg. 37,208, 37,213 (June 24, 2011) (to be codified at 45 C.F.R. pt. 117) (commenting that “[w]hen plans and issuers offer full and fair internal procedures for resolving claims, it is reasonable to insist that claimants first turn to those procedures before seeking judicial or external review of benefit denials”). On the other hand, agency insistence that an exhaustion requirement not be permitted unless near-strict adherence to the internal review requirements are met—which applies to the states, see *supra* Part II.B, resembles more the “consumer choice” theme. So perhaps the prevailing agency view lies somewhere between theme IV.B and IV.D, but closer to the latter.

largely occur in state legislatures and state courts across the country. One expects those battles to turn out very differently in Massachusetts than in Utah. The challenge to this theme is that it is very difficult for anyone, including judges, to remain faithful to it; much more tempting is to adopt this theme at the top of an opinion and then carve out exceptions consistent with one's policy preferences.

CONCLUSION

Perfectly clear and comprehensive statutes are the holy grail of law but as frequently found. In reality, any piece of legislation is necessarily an imperfect representation of its drafters' intentions. The Affordable Care Act is hardly an exception. It is a sprawling enactment that incorporates by reference extraordinarily complex external authorities. It is the product of a unique political process, one that did not include the fine tuning that precedes the adoption of many statutes.³⁰⁰ It is the most contentious legislation in decades. Litigation regarding what portions of its text "mean" is inevitable.

Given the ubiquity and cost of health insurance disputes, of particular interest is the ACA's treatment of remedies for insureds. This Article carefully identifies, for the first time, a series of interpretative fights to expect in the coming litigation to define litigation. Some of the battles are esoteric but of great practical consequence.³⁰¹ Others pose profound questions about federal versus state power and the judicial role in mediating it. The biggest question of all may be the simplest: will the ACA serve as an agent of nationwide litigation reform?

Although the ACA does effect important changes to remedy, read correctly it does not impose a federal ceiling on state prerogative to fashion consumer-friendly remedies consistent with the policy preferences of the state. The ACA is not federal litigation reform. The place for litigation reform in the world of the ACA is the states,

300. See *supra* note 224.

301. *Firestone* deference is the best example of an obscure but important doctrine that the ACA alters and massively weakens. See *infra* Part III.B.2. While the significance of this change has largely escaped academic comment, the Supreme Court will surely pay close attention. *Firestone* deference has reached the Supreme Court on three occasions—in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989) (articulating the principle); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 117 (2008) (explaining that *Firestone* deference survives a conflict of interest); and *Conkright v. Frommert*, 559 U.S. 506, 520–21 (2010) (explaining that *Firestone* deference survives fiduciary mistake)—and the current Chief Justice has written approvingly of the important functions it serves. See *LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 259 (2008) (Roberts, C.J., concurring) (applauding *Firestone* as desirable policy).

which retain great freedom to so act. Federalism lives, in the very statute accused of killing it.

So it should be construed, but strong extra-statutory forces complicate the picture. Health care is still perceived as too expensive. Traditional remedies are feared to be too volatile and too costly. The Supreme Court seems to believe that non-judicial resolutions are cheaper and better than litigation. And the antecedent example is worrisome. ERISA, passed as a protective shield, was transformed by federal judges into a sword to separate approximately 150 million beneficiaries from protections otherwise provided by states.³⁰² Much of that work was done by implicit, rather than express, authority. Litigation reform proponents will seek to repeat that success. The degree to which they will succeed is impossible to predict. Even still, they may well be more successful than the 111th Congress intended.³⁰³

302. *See supra* Part I.A.

303. I say this based both on the text and structure of the statute as well as the political circumstances of the legislation's passage. In the 111th Congress, the Democrats controlled both the House and Senate, and the ACA was signed by President Barack H. Obama, a Democrat. Generally speaking, Democrats do not support litigation reform, let alone national litigation reform.