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MANDATORY ARBITRATION IN INSURANCE DISPUTES: INVERSE PREEMPTION OF THE FEDERAL ARBITRATION ACT

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INTRODUCTION

Mandatory binding arbitration provisions have generated a great deal of debate. This article focuses specifically on arbitration in the context of insurance for three reasons. First, arbitration provisions are appearing with increasing frequency in all types of insurance policies,[1] given the

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1. Such types of insurance policies include: health insurance, *see, e.g.*, Lesley Mitchell, *Utah Businesses Rethink Health Care Benefits*, SALT LAKE TRIB., Dec. 7, 2003; United Wis. Life Ins. Co. v. Tankersley, 880 So. 2d 385 (Ala. 2003); Murphy v. Mid-West Nat'l Life Ins. Co., 78 P.3d 766 (Idaho 2003); attorney's malpractice insurance, *see, e.g.*,

Congressional approval of arbitration in the Federal Arbitration Act[2] ("FAA") and the United States Supreme Court's rulings that the Act preempts state law.[3] Second, concern over the fairness of arbitration, especially in consumer contracts, is magnified in the insurance context. Unlike most other agreements, the insurance agreement is sequential and contingent. Purchasers of insurance pay premiums in advance. In exchange, the insurer promises to pay, up to a particular amount, if a specified but uncertain event occurs in the future. Third, states concerned about consumer arbitration can do something about it in the insurance context: under the inverse preemptive effects of the McCarran-Ferguson Act, state insurance law overrides the FAA. The McCarran-Ferguson Act provides that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance."[4] In every context except insurance, the FAA preempts state laws which prohibit or limit arbitration.

Part I briefly discusses the FAA. Part II identifies concerns about arbitration and explains why those concerns have particular force in the insurance context.[5] Part III explains the McCarran-Ferguson Act and

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McConnell v. Lawyers' Mut. Ins. Co., No. B154697, 2003 WL 21490947 (Cal. Ct. App. June 30, 2003); homeowner's insurance, *see, e.g.*, Am. Bankers Ins. Co. v. Crawford, 757 So. 2d 1125, 1127 (Ala.1999) (homeowner's insurer began including arbitration provisions in January 1996 in policies issued in Alabama); life insurance, *see, e.g.*, Metro. Life Ins. Co. v. Glisson, 295 F.3d 1192 (11th Cir. 2002), Cox v. Woodmen of the World Ins. Co., 556 S.E.2d 397 (S.C. Ct. App. 2001); disability insurance, *see, e.g.*, Standard Sec. Life Ins. Co. v. West, 267 F.3d 821 (8th Cir. 2001); employment practices liability policies, *see, e.g.*, Roberto Ceniceros, *Arbitration Victory in Coverage Dispute Gives Buyers Hope: EPL Cover Sought for Overtime Lawsuits*, BUS. INS., Mar. 4, 2002, at 34; excess liability policies, *see, e.g.*, Kenneth S. Abraham & J.W. Montgomery, III, *The Lawlessness of Arbitration*, 9 CONN. INS. L.J. 355, 358 (2003); maritime policies, *see, e.g., id.*; special purpose policies, *see, e.g., id.*

The insurance industry has routinely used arbitration provisions in various types of policies for many years. These uses include settlement or loss calculation procedures for claims under homeowner's policies, and arbitration of uninsured motorist claims. This article does not address these routine arbitration provisions.

2. 9 U.S.C. §§ 1-14 (1999).

3. The Court has interpreted the FAA expansively. *See infra* Part. I.

4. 15 U.S.C. § 1012(b) (1997).

5. This article will not address the insurance industry's long-term and routine use of arbitration provisions in reinsurance, and uninsured and underinsured motorist coverages, and other typically small stakes first-party coverages. The insurance industry has routinely used arbitration to resolve reinsurance disputes for more than a century. In such disputes, the parties are all part of the insurance industry. The goal of maintaining interdependent business relationships among direct and reinsurers, based on common industry practices and customs, is paramount. Accordingly, arbitration is unquestionably appropriate. Arbitration agreements have also been standard in uninsured and underinsured motorist coverage for

examines its inverse preemptive effect as applied to various types of insurance regulation. Insurance statutes and administrative regulations promulgated in accordance with state rulemaking procedures are clearly encompassed by the language of the McCarran-Ferguson Act, but the question is open with respect to various other administrative materials, such as bulletins, guidelines, policy statements and the like, and to decisional law. Part III examines issues surrounding inverse preemption of the FAA through these administrative materials and through case law.

I. FEDERAL ARBITRATION ACT

The common law traditionally rejected arbitration as a deprivation of the jurisdiction of the courts and therefore contrary to public policy. Over time, the legal system has become increasingly open to arbitration. The enactment of the FAA in 1925[6] signaled the United States' acceptance of arbitration as a permitted method of dispute resolution. The United States Supreme Court currently reads the FAA as embodying "a national policy favoring arbitration,"[7] the purpose of which is "to reverse the longstanding judicial hostility to arbitration agreements . . . and to place [them] on the same footing as other contracts."[8]

In its early years, the reach of the FAA was limited. It applied in federal court only,[9] it did not apply to statutory claims,[10] and it did not

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many years due to insurers' concerns about suits directly against them. *See, e.g.*, NAT'L BUREAU OF CASUALTY UNDERWRITERS, 1966 STANDARD UNINSURED MOTORIST FORM, *reprinted in* 2 ALAN I. WIDISS, UNINSURED AND UNDERINSURED MOTORIST INSURANCE app. A, at 9 (2d ed.1985). Some states have held such provisions unenforceable, but as hostility to arbitration has diminished, such provisions have typically been upheld. *See, e.g.*, *Ex parte* Dyess, 709 So. 2d 447 (Ala.1997). Given the small amounts typically involved in such claims, including automobile personal injury payments which typically have limits of $2,500 to $5,000, arbitration is appropriate.

6. 9 U.S.C. §§ 1-14 (2000).

7. Southland Corp. v. Keating, 465 U.S. 1, 10 (1983) (O'Connor & Rehnquist, JJ., dissenting).

8. Green Tree Fin. Corp.-Ala. v. Randolph, 531 U.S. 79, 89 (2000) (quoting Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20, 24 (1991)). This statement appears in the legislative history of the FAA. *See* H.R. REP. NO. 96, at 1 (1924).

9. Southland Corp., 465 U.S at 15-16. The Court stated: "We are unwilling to attribute to Congress the intent, in drawing on the comprehensive powers of the Commerce Clause, to create a right to enforce an arbitration contract and yet make the right dependent for its enforcement on the particular forum in which it is asserted. And since the overwhelming proportion of all civil litigation in this country is in the state courts, we cannot believe Congress intended to limit the Arbitration Act to disputes subject only to *federal*-court jurisdiction. Such an interpretation would frustrate Congressional intent to place '[a]n

apply absent significant connections to interstate commerce.[11] These limitations have disappeared over time. A series of modern decisions have resulted in the FAA's almost complete preemption of state law relating to arbitration. Under the rule of *Southland Corp. v. Keating*, decided in 1983, the Act applies in state as well as federal court.[12] It preempts state laws which prohibit[13] or limit[14] arbitration. In 1989, the Court overruled its earlier decision prohibiting the arbitration of statutory claims[15] and has rejected arguments that the Act is grounded in anything less than Congress's full commerce power,[16] despite the contrary implications of

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arbitration agreement . . . upon the same footing as other contracts, where it belongs.'" *Id.* (quoting H.R. REP. NO. 96, at 1 (1924)).

10. Wilko v. Swan, 346 U.S. 427, 438 (1953) (Securities Act of 1933 prohibits waiver of a judicial remedy through pre-dispute agreement to arbitrate), *overruled by* Rodriguez de Quijas v. Shearson/Am. Express, Inc., 490 U.S. 477, 484 (1989). *See also* Greater Cont'l Corp. v. Schechter, 422 F.2d 1100, 1103 (2d Cir. 1970) (claims under 1934 Securities Exchange Act not subject to arbitration); Am. Safety Equip. Corp. v. J.P. Maguire & Co., 391 F.2d 821, 828 (2d Cir. 1968) (claims under federal antitrust laws not subject to arbitration).

11. Bernhardt v. Polygraphic Co. of Am., 350 U.S. 198, 200-01 (1956) (evidence failed to show that an employment contract made in New York between New York residents, but performable in Vermont, evidenced a transaction involving interstate or foreign commerce as required by § 2 of the FAA).

12. Southland Corp. v. Keating, 465 U.S. 1 (1984). The Court reaffirmed its *Southland* decision in 1995 over the arguments of twenty state Attorneys Generals. Allied-Bruce Terminix Co. v. Dobson, 513 U.S. 265 (1995). Three United States Supreme Court justices have criticized *Southland*, and two have indicated a readiness to overrule it. *Id.* at 282-98. Justice O'Connor stated in her concurrence in *Allied-Bruce*, "I continue to believe that Congress never intended the Federal Arbitration Act to apply in state courts, and that this Court has strayed far afield in giving the Act so broad a compass," but stopped short of overruling based on special considerations of stare decisis in statutory interpretation. *Id.* at 283-84. Justices Scalia and Thomas dissented in *Allied-Bruce*, both based on the conclusion that the FAA does not apply in state courts. *See id.* at 284-98.

13. Allied-Bruce Terminix Co. v. Dobson, 513 U.S. 265 (1995).

14. Doctor's Assocs., Inc. v. Casarotto, 517 U.S. 681, 688 (1996) (FAA preempted Montana statute which conditioned enforceability of arbitration agreements, but not contracts generally, on compliance with special notice requirements).

15. *Rodriguez de Quijas*, 490 U.S. at 484-85. *See also* Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614 (1985) (federal antitrust laws); Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20, 26-27 (1991) (Age Discrimination in Employment Act); Green Tree Fin. Corp.-Ala. v. Randolph, 531 U.S. 79 (2000) (Truth in Lending Act).

16. Section 2 of the FAA applies to written arbitration agreements in a "contract evidencing a transaction involving commerce." 9 U.S.C.A. § 2 (2000). The Supreme Court's response to the Alabama Supreme Court's interpretation of this clause is illustrative. Alone among the states, Alabama prohibits pre-dispute arbitration. The Alabama Code, § 8-1-41 (1975), first enacted in 1923, provides in pertinent part: "The following obligations cannot be specifically enforced:...(3) An agreement to submit a controversy to arbitration."

some earlier cases[17] and portions of the legislative history.[18] These expansive interpretations of the FAA have furthered the public policy favoring arbitration and greatly increased the use of arbitration to resolve disputes, including insurance disputes.

II. CONCERNS ABOUT ARBITRATION[19]

A. INDIVIDUAL POLICYHOLDERS

Proponents of arbitration list as its primary advantages: confidentiality (no public record of proceedings); limited discovery; speed; independent decision-makers who have an expertise in the subject matter in dispute; reduced costs; and preservation of business relationships.[20] In the abstract, these features appear to be positive and neutral. However, in the context of disputes involving insurance consumers, each of these purported

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In the face of the FAA's mandate, the Alabama Supreme Court avoided application of the FAA to strike down arbitration agreements in two ways. First, the court utilized a "contemplation of the parties" test to assess whether a transaction involved commerce. Allied-Bruce Terminix Cos., Inc. v. Dobson, 628 So. 2d 354, 355 (Ala. 1993). This approach requires that the parties contemplated substantial interstate activity when they entered the contract. *Id.* The United States Supreme Court rejected this approach. Allied-Bruce Terminix Cos., Inc. v. Dobson, 513 U.S. 265 (1995). Second, the Alabama Supreme Court required that an individual transaction have a "substantial effect" on interstate commerce before the FAA applied. Sisters of the Visitation v. Cochran Plastering Co., 775 So. 2d 759, 764 (Ala. 2000). In this line of cases, the Alabama Supreme Court relied on United States v. Lopez, 514 U.S. 549 (1995), which found that the Gun-Free School Zone Act exceeded Congress's commerce power, rather than *Allied-Bruce Terminix*, which affirmed Congressional power to regulate arbitration agreements affecting commerce. The United States Supreme Court rejected this approach also in Citizens Bank v. Alafabco, Inc., 539 U.S. 52, 56-57 (2003) (holding that the commerce power may be exercised in individual cases without showing any specific effect upon interstate commerce if, in aggregate, the economic activity is subject to federal control).

17. *See, e.g.*, Bernhardt v. Polygraphic Co. of Am., 350 U.S. 198, 200-01 (1956).

18. Despite an apparent legislative intention to limit the FAA to the commercial context, *Sales and Contracts to Sell in Interstate and Foreign Commerce, and Federal Commercial Arbitration, Hearing on S. 4213 and S. 4214 before a Subcomm. of the Senate Comm. on the Judiciary*, 67th Cong., 9-10 (1923), the Supreme Court has ruled that the FAA evidences a congressional intent to extend the FAA to the limits of Congress's commerce clause power. Allied-Bruce Terminix Cos. v. Dobson, 513 U.S. 265 (1995). Thus, under § 2 of the FAA and the Supremacy Clause, arbitration provisions in any contract affecting commerce are enforceable. *Id.*

19. The number of states which prohibit or limit arbitration in the insurance context lends credence to each of the arguments below. *See infra* Part III.C.

20. *See, e.g.*, American Arbitration Association website, *at* http://www.adr.org (last visited Apr. 9, 2005).

advantages, with the exception of speedy resolution, are likely to benefit the insurance company at the expense of policyholders.

Arbitration agreements typically include a provision which states that the arbitration award and any decision by the arbitration panel shall be confidential. Confidentiality is generally of minimal concern to insureds in typical actions against insurance companies. For insurance companies, however, confidentiality may be critical. The confidentiality of arbitration proceedings and awards shields an insurer's practices from the public scrutiny that accompanies the judicial process and thus may permit continuation of those practices. Where confidentiality is required, an insurance company may avoid publicity which can result in similar claims, or a decrease in public confidence, minimizing and perhaps eliminating important bargaining points important to policyholders in settlement negotiations. Thus, insurance companies have much to gain from confidentiality while individual insureds, and insurance consumers collectively, have a great deal to lose.

Limited discovery makes proceedings simpler and shorter. However, simplicity and brevity, at the expense of information, does not necessarily advantage insurance consumers. Often the insurance company has information which the policyholder needs to press a claim successfully, and discovery may be the only way to get that information. Limitations on discovery may prevent a policyholder from obtaining crucial information about the policyholder's specific claim, as well as information about company procedures and policies generally. Such limits may defeat a claim where the claimant has the burden of production. Limited discovery advantages the party with greater information (typically the insurance company) and disadvantages the party with lesser (typically the insurance consumer).

Independent decision-makers are essential to the fairness of any proceeding. However, there are at least three reasons to question the independence and neutrality of insurance arbitrators. First, insurance companies draft arbitration provisions and may specify the method of choosing arbitrators or require particular qualifications in order to favor their own interests. Second, while insurance arbitration is likely to be a once-in-a-lifetime event for an insurance consumer, insurance companies engage in repeated arbitrations. That means that insurance companies know arbitrators' records, and perhaps have experience before them,

facilitating the choice of a sympathetic arbitrator.[21] A related advantage is the creation of a group of arbitrators whose employment is dependent on the insurance industry, potentially creating inherent bias in favor of the industry. The development of a strong and organized contingent of attorneys representing insurance consumers could correct imbalances. However, there may be reason to question whether this will occur.[22] Finally, arbitrators generally have direct connections with the insurance industry. As the American Arbitration Association[23] indicates, one of the "primary advantages" it offers is "industry expertise," with "expert neutrals highly-trained in specific industries."[24] Knowledge of the insurance industry is a reasonable requirement for an arbitrator of insurance disputes. However, experts "highly trained in specific industries" often are or have been involved with those industries rather than consumer groups and may be predisposed to favor the industry or to see disputes from its perspective.

To the extent that arbitration is less adversarial and less formal than litigation, it may preserve relationships between business entities which would not withstand litigation. This advantage is largely irrelevant to consumer transactions.

As to cost, there is disagreement about whether arbitration typically costs less than litigation. Various studies dispute the supposed superiority of arbitration with respect to cost and efficiency.[25] However, even if overall costs of arbitration are less than for litigation, many insurance consumers may be better able financially to participate in litigation than arbitration. First, plaintiffs' lawyers who typically work on a contingent fee basis may be less willing to handle arbitrations on that basis.[26] For the

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21. The requirements of confidentiality discussed *supra* text accompanying notes 13-14, may make it difficult or impossible to obtain information about an arbitrator's past arbitrations.

22. *See infra* text accompanying note 26.

23. The American Arbitration Association is one of several organizations offering arbitration services. *See* American Arbitration Association website, *at* http://www.adr.org (last visited April 9, 2005).

24. American Arbitration Association, *Focus Area*, *at* http://www.adr.org/FocusAreas (last visited Apr. 9, 2005).

25. *See, e.g.*, Mark E. Budnitz, *The Cost of Consumer Arbitration*, 67 J.L. & CONTEMP. PROBS. 133, 135-44 (2004) (costs for some arbitrations higher than court costs); JAMES S. KAKALIK ET AL., *AN EVALUATION OF MEDIATION AND EARLY NEUTRAL EVALUATION UNDER THE CIVIL JUSTICE REFORM ACT* (Institute for Civil Justice ed., 1996) (finding that time and cost of dispute resolution through ADR not significantly lower than for courts).

26. *See, e.g.*, Young v. Jim Walter Homes, Inc., 110 F. Supp. 2d 1344, 1348-49 (M.D. Ala. 2000) (plaintiff's counsel filed an affidavit stating he would not represent plaintiffs if arbitration was compelled); Rollins, Inc. v. Foster, 991 F. Supp. 1426 (M.D. Ala. 1998)

reasons outlined above, plaintiffs' lawyers often view the arbitral forum as less favorable than a courtroom, with settlement less likely and awards lower.[27] Consequently, a plaintiff who must arbitrate may pay up-front legal fees as opposed to a percentage of any ultimate award. Additionally, arbitration typically requires payment of one-half of the arbitrator's hourly fees, often in advance. These fees are the plaintiff's responsibility. Even if the plaintiff is represented by counsel under a contingent fee arrangement, arbitral fees are typically excluded from the retainer agreement. An arbitrator's fees can be substantial, especially relative to the minimal filing fees required in litigation. Empirical research suggests that arbitration reduces costs for those who obtain legal representation on an hourly basis, i.e. insurance companies, but not for those who have contingent fee arrangements, i.e. policyholders.[28]

Some concerns about costs have been addressed by arbitration organizations. For example, the American Arbitration Association recently capped consumer costs at $125 for claims of $10,000 (excluding claims for punitive damages or nonpecuniary losses) or less. For claims between $10,000 and $75,000 (excluding claims for punitive damages or nonpecuniary losses), consumer costs are capped at $375. These amounts go toward the arbitrator's fee. The cost of case administration and remaining arbitrator's fees must be paid by the business. There are no additional fees for subpoenas or discovery orders. The American Arbitration Association also offers pro bono services for individuals unable to afford the fees.[29] For claims between $75,000 and $150,000, costs are substantially higher. Administrative fees are $2250, and the consumer is

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(claim of unconscionability bolstered if no attorneys willing to take case on contingency basis due to arbitration provision).

27. *See, e.g.*, Public Citizen, *Arbitration Clauses in Insurance Contracts: The Urgent Need for Reform* (December 10, 2001), *at* http://www.citizen.org/congress/civjus/arbitration/articles.cfm?ID=6561.

28. A. Leo Levin & Deirdre Golash, *Alternative Dispute Resolution in Federal District Courts*, 37 U. FLA. L. REV. 29, 34-35 (1985) (reporting research comparing litigation with non-binding arbitration and showing savings for defendants with hourly basis fee arrangements, but not for parties with contingent fee arrangements or fixed fee arrangements). *See generally* Edward A. Dauer, *The Future of ADR*, 1 PEPP. DISP. RESOL. L.J. 91 (2000); David S. Schwartz, *Enforcing Small Print to Protect Big Business: Employee and Consumer Rights Claims in an Age of Compelled Arbitration*, 1997 WIS. L. REV. 33 (1997).

29. American Arbitration Association, *Supplementary Procedures for Consumer-Related Disputes*, effective March 1, 2002, *at* http://www.adr.org/sp/asp?id=22193. *See also* John C. Emmert, Jr., *Arbitration is Cost Effective; Overloaded Courts, Consumers Benefit from Valuable Alternative*, THE CHARLOTTE OBSERVER, May 13, 2002 at 12A.

responsible for one-half of the arbitrator's compensation.[30] The American Arbitration Association has pledged to use its hardship provisions to enable consumers to pursue claims.[31]

Finally, although arbitrators are bound to apply the law, they may fail to do so, depriving individual policyholders of an appropriate resolution of a claim. District courts may vacate an arbitral award under the FAA only in very narrow circumstances, typically involving an arbitrator's misconduct or bias,[32] but not including failure to apply the law. Under the common law, proof of an arbitrator's "manifest disregard of the law" may warrant a district court's vacatur of an arbitral award.[33] The standard is

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30. American Arbitration Association, *Supplementary Procedures for Consumer-Related Disputes*, effective March 1, 2002, *at* http://www.adr.org/sp/asp?id=22193.

31. *Id.*

32. **Same; vacation; grounds; rehearing**

(a) In any of the following cases the United States court in and for the district wherein the award was made may make an order vacating the award upon the application of any party to the arbitration--(1) where the award was procured by corruption, fraud, or undue means; (2) where there was evident partiality or corruption in the arbitrators, or either of them; (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or (4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made . . . .

(b) If an award is vacated and the time within which the agreement required the award to be made has not expired, the court may, in its discretion, direct a rehearing by the arbitrators.

(c) The United States district court for the district wherein an award was made that was issued pursuant to section 580 of title 5 may make an order vacating the award upon the application of a person, other than a party to the arbitration, who is adversely affected or aggrieved by the award, if the use of arbitration or the award is clearly inconsistent with the factors set forth in section 572 of title 5.

Federal Arbitration Act, 9 U.S.C.§ 10 (2002).

Award of arbitrators; confirmation; jurisdiction; proceeding

Within three years after an arbitral award falling under the Convention is made, any party to the arbitration may apply to any court having jurisdiction under this chapter for an order confirming the award as against any other party to the arbitration. The court shall confirm the award unless it finds one of the grounds for refusal or deferral of recognition or enforcement of the award specified in the said Convention.

Federal Arbitration Act, 9 U.S.C.§ 207 (2002).

33. *See* Wilko v. Swan, 346 U.S. 427, 436-37 (1953), *overruled on other grounds,* Rodriguez de Quijas v. Shearson/Am. Express, Inc., 490 U.S. 477, 485 (1989); *see also, e.g.*, Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Bobker, 808 F.2d 930, 933 (2d Cir. 1986). Other common law grounds also exist. District courts may vacate awards that are arbitrary and capricious, *see* Williams v. Signa Fin. Advisors Inc., 197 F.3d 752, 758 (5th

difficult to satisfy, and courts apply it narrowly. "Manifest" disregard of the law requires an "obvious" error, "capable of being readily and instantly perceived by the average person qualified to serve as an arbitrator."[34] In addition, "disregard" of the law requires that the arbitrator appreciates the existence of a clearly governing principle but ignores it.[35] Proof is extremely difficult. It is a well-established rule, for example, that arbitrators may not be deposed absent "clear evidence of impropriety."[36] As the United States Supreme Court has recognized, "the rudimentary procedures which make arbitration so desirable in the context of a private dispute often mean that the record is so inadequate that the arbitrator's decision is virtually unreviewable."[37] And even if a court finds manifest disregard of the law by the arbitrator, the award must still be upheld unless doing so would produce significant injustice.[38]

B. THE PUBLIC INTEREST

Arbitration creates serious problems for policyholders collectively. The confidential nature of arbitration creates significant disadvantages. First, the collective construction of insurance policies which occurs through the judicial process will become increasingly limited as arbitration of consumer insurance disputes becomes more widespread. Judicial decision-making ensures a record of established law. Arbitration guarantees that policy interpretations will be inconsistent and undiscoverable, preventing

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Cir. 1999), or contrary to explicit, well-defined, and dominant public policy. Prestige Ford v. Ford Dealer Computer Servs., Inc., 324 F.3d 391, 396 (5th Cir. 2003); Exxon Corp. v. Baton Rouge Oil & Chem. Workers, 77 F.3d 850, 853 (5th Cir. 1996). Proof of such grounds is extremely difficult. It is a well-established rule, for example, that arbitrators may not be deposed absent "clear evidence of impropriety." *See, e.g.*, Hoeft v. MVL Group, Inc., 343 F.3d 57, 66 (2d Cir. 2003).

34. Schoch v. InfoUSA, Inc., 341 F.3d 785 (8th Cir. 2003); Hoeft v. MVL Group, Inc., 343 F.3d 57 (2d Cir. 2003) (reversing rare case where district court vacated arbitral award for manifest disregard of the law); Carter v. Health Net of Cal., Inc., 374 F.3d 830 (9th Cir. 2004).

35. *See, e.g.*, Brabham v. A.G. Edwards & Sons Inc., 376 F.3d 377 (5th Cir. 2004) (claim that arbitrators manifestly disregarded case law discussing measure of damages in case of broker misconduct rejected); Birmingham News Co. v. Horn, Nos. 1020552-557, 2004 WL 1293993 (Ala. June 11, 2004) (collecting state and federal cases).

36. Andros Compania Maritima, S.A. v. Marc Rich & Co., A.G., 579 F.2d 691, 702 (2d Cir. 1978); *see also* Lyeth v. Chrysler Corp., 929 F.2d 891, 899 (2d Cir. 1991).

37. Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, 473 U.S. 614, 656-57 (1985).

38. *See, e.g.*, Bridas S.A.P.I.C. v. Gov't of Turkmenistan, 345 F.3d 347 (5th Cir. 2003); Evans Indus., Inc. v. Int'l Bus. Machs. Co., No. Civ.A.01-0051, 2004 WL 241701 (E.D. La. Feb. 6, 2004).

policyholders from ascertaining the meaning of their policies through reliance on established interpretations. Insurance companies, as repeat players unencumbered by precedent or estoppel, may take varying positions on the same policy provision in successive arbitrations, or continue to advance an oft-rejected interpretation.[39] Such effects contribute to inefficiency and unfairness.

Second, the scrutiny of insurance company practices which accompanies public resolutions of disputes will not occur. Public opinion can serve an important function in preventing unfair or inappropriate conduct by insurers. The possibility of negative publicity, and resulting unfavorable consumer reactions, provides an incentive for good behavior. The assurances of confidentiality which attend private dispute resolution eliminates these incentives.

Perhaps most importantly, arbitration will undercut and perhaps ultimately eliminate the role of decisional law in regulating the insurance industry. It has long been acknowledged that the judiciary plays a significant role in the regulation of insurance.[40] Judicial decision-making often affects the conduct of insurance companies not party to the litigation; private arbitral decisions create no precedent and are unlikely to have such effects. As Robert E. Keeton and Alan Widiss observed in their treatise on insurance, "[t]he influence of the courts on insurance transactions through doctrinal developments has sometimes been considerably more significant than the enforcement of regulatory measures by the commissioner of insurance."[41] This important regulatory function will diminish, with adverse consequences for the fair and appropriate operation of insurance institutions, as insurance arbitration increases.[42]

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39. Insurance companies engage in this behavior in litigation contexts as well, since state law governs insurance. However, the public nature of judicial decisions minimizes adverse effects. *See* Abraham & Montgomery III, *supra* note 1, at 363-64 (explaining how arbitration of insurance issues may adversely affect the development of the law).

40. *See, e.g.* Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981); Kenneth S. Abraham, *Interpretation or Regulation? Gaunt v. John Hancock Mutual Life Insurance Co.*, 2 NEV. L.J. 312 (2002); Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970); *see also* ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW § 25 (3d ed. 2002).

41. ROBERT E. KEETON & ALAN WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES § 8.1(c) (1988).

42. At most, the judiciary will regulate the character and content of arbitration agreements through the contract-based defenses to enforcement of arbitration agreements enumerated in the FAA.

III. McCARRAN-FERGUSON PREEMPTION

The mechanism for avoiding the preemptive effect of the FAA in insurance is the McCarran-Ferguson Act, which provides for inverse preemption of federal law by state insurance law:

> No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . . .[43]

Thus, inverse preemption occurs if: (1) the federal statute at issue does not specifically relate to the business of insurance; (2) the state law was enacted for the purpose of regulating the business of insurance; and (3) application of the federal statute will invalidate, impair, or supersede the state law.[44] As the statutory language makes clear, inverse preemption requires satisfaction of each of these factors.

The next sections examine the inverse preemptive effects of state statutes, various types of state regulation, and state decisional law. It is clear that state legislatures may prohibit or limit insurance arbitration, inversely preempting the FAA.[45] Whether state regulators have the same power is less clear, and depends on the nature and form of the particular state regulatory action. Generally, rules promulgated pursuant to legislative delegation according to established rulemaking procedures inversely preempt the FAA, while agency "guidance" documents not promulgated through rulemaking procedures do not.[46] Although the question has not been fully considered, the nature and structure of both the FAA and the McCarran-Ferguson Act suggest that state decisional law limiting or prohibiting insurance arbitration cannot inversely preempt the FAA.[47]

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43. 15 U.S.C. § 1012(b) (2004).
44. United States Dep't of the Treasury v. Fabe, 508 U.S. 491, 500-01 (1993).
45. *See infra* Part III.A.
46. *See infra* Part III.B.
47. *See infra* Part III.C.

A. STATUTORY LIMITATIONS OF ARBITRATION IN INSURANCE

Under the test for inverse preemption, state statutes which prohibit or limit mandatory arbitration of insurance disputes[48] preempt the FAA. Applying the first prong of the test set out in the McCarran-Ferguson Act, it is clear that the FAA does not specifically relate to the business of insurance under the first factor. It is a law applicable to contracts generally; it does not mention insurance. Thus, any state statute enacted for the purpose of regulating the business of insurance under the second prong, which would be impaired or invalidated by application of the FAA under the third prong, inversely preempts the FAA through the McCarran-Ferguson Act.

Courts test whether state statutes prohibiting mandatory insurance arbitration are enacted for the purpose of regulating the business of insurance, under the second factor, in several ways. Most courts focus on whether the state statute regulates the relationship between the policyholder and the insurance company.[49] The United States Supreme Court in *SEC v. National Securities, Inc.*[50] identified the policy relationship as central to defining the business of insurance:

> The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the

48. *See infra* Part III.A for a discussion of state statutes prohibiting arbitration of insurance disputes. Courts have also ruled that arbitration clauses in an insurance contract which interfere with a receivership for an insolvent insurer inversely preempt the FAA through Section 2(b) of the McCarran-Ferguson Act. *See* Davister Corp. v. United Republic Life Ins. Co., 152 F.3d 1277 (10th Cir. 1998); Munich Am. Reinsurance Co. v. Crawford, 141 F.3d 585 (5th Cir. 1998).

49. *See, e.g.*, Nat'l Home Ins. Co. v. King, 291 F. Supp. 2d 518 (E.D. Ky. 2003) (Kentucky legislature's exclusion of insurance contracts from statute providing for general enforceability of arbitration agreements directed specifically at the relationship between the insurer and insured with the aim of protecting policyholders from mandatory arbitration agreements reached in the context of an adhesion contract; therefore, statute enacted for the purpose of "regulating the business of insurance" within McCarran-Ferguson Act).

50. 393 U.S. 453 (1969).

> focus was—it was on the relationship between the insurance company and the policyholder.[51]

Other courts have used an alternative test developed by the United States Supreme Court in *Group Life & Health Insurance Co. v. Royal Drug Co.*,[52] and *Union Labor Life Insurance Co. v. Pireno*.[53] In this line of cases, the Supreme Court identified three factors which help to determine whether a particular practice is the part of the "business of insurance" for purposes of the McCarran-Ferguson Act.[54] The factors, none of which is determinative, are:

1. Whether the practice has the effect of transferring or spreading a policyholder's risk;
2. Whether the practice is an integral part of the policy relationship between the insurer and the insured; and
3. Whether the practice is limited to entities within the insurance industry.[55]

Subsequent cases utilizing these factors to assess the preemptive effects of ERISA in the context of the McCarran-Ferguson Act added another

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51. *Id.* at 460.

52. 440 U.S. 205 (1979).

53. 458 U.S. 119 (1982).

54. Some courts have rejected application of these factors in the arbitration context, using instead a more general test. Their rationale is that these factors were developed in cases involving antitrust laws under the second clause of 15 U.S.C. §1012(b), rather than its broader first clause. Allen v. Pacheco, 71 P.3d 375, 382 n.8 (Colo. 2003).

55. These factors were developed in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979) and Union Labor Life Ins. Co. v. Pireno, 458 U.S. 189 (1982) both of which were antitrust cases. In United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993), the Supreme Court diminished to some extent the importance of these factors, focusing instead on the test articulated in SEC v. Nat'l Sec., Inc., 393 U.S. 453 (1969), which emphasized that the McCarran-Ferguson Act focuses on the relationship between the insurance company and its policyholders. *Fabe* held that an Ohio statute establishing priorities in bankruptcy against an insolvent insurer preempted the federal priority statute to the extent it protected policyholders. 508 U.S. at 499-510. Although the Court held that each of the *Pireno* factors was satisfied, it indicated that:

> [L]aws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance. This category necessarily encompasses more than just the 'business of insurance.' . . . [T]he actual performance of an insurance contract is an essential part of the 'business of insurance.'

Fabe, 508 U.S. at 505.

determination: whether the practice constitutes a regulation of insurance as a matter of "common sense."[56]

Where a state legislature explicitly prevents enforcement of mandatory arbitration provisions in insurance contracts, or imposes conditions on the use of arbitration in insurance, it regulates the "business of insurance" for purposes of the McCarran-Ferguson Act under each of these tests.[57] State

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56. Cases construing the phrase "regulates insurance" for purposes of ERISA preemption, 29 U.S.C. § 1144(b)(2)(A) (2005), utilized this "common sense" test focusing on the policy relationship in addition to the *Royal Drug-Union Labor Life* factors. *See, e.g.*, Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 366 (2002) ("combined "common sense" and McCarran-Ferguson factors as parsing the "who" and the "what": when insurers are regulated with respect to their insurance practices, the state law survives ERISA); UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368-69 (1999) (California notice-prejudice rule, under which insurer can deny for breach of notice condition only if it proves prejudice as a result, regulates the business of insurance); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (common sense understanding of the phrase "regulates insurance" does not support conclusion that Mississippi bad faith law falls under ERISA savings clause, since bad faith law not "specifically directed toward" insurance industry); Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985) ("common sense view" of Massachusetts statute requiring minimum health care benefits in insurance policies regulates insurance within meaning of ERISA savings clause).

57. Mut. Reinsurance Bureau v. Great Plains Mut. Ins. Co., 969 F.2d 931, 932 (10th Cir. 1992) (explaining that the Kansas statute which excluded insurance contracts from general statute validating arbitration agreements regulated the "business of insurance" even though it was not in the state insurance code and inversely preempted the FAA through Section 2(b) of the McCarran-Ferguson Act); Friday v. Trinity Universal of Kan., 939 P.2d 869, 872 (Kan. 1997) (explaining that the Kansas statute which excluded insurance contracts from general statute validating arbitration agreements regulated the "business of insurance" even though it was not in the state insurance code and inversely preempted the FAA through Section 2(b) of the McCarran-Ferguson Act); Smith v. Pacificare Behavioral Health of Cal., Inc., 113 Cal. Rptr. 2d 140, 151 (Cal. App. Dep't Super. Ct. 2001) (stating that disclosure requirements relating to arbitration in Cal. Stat. §1363.1 constituted regulation of insurance, regulating the relationship between insurer and insured under the protection of the McCarran-Ferguson Act, and thus, health service plan's arbitration provisions that did not satisfy statutory disclosure requirements were not enforceable; the law regulated the relationship between the insured and the policyholder, which was at the core of the business of insurance); *But see* Little v. Allstate Ins. Co., 705 A.2d 538 (Vt. 1997) (explaining that the FAA preempted the Vermont Arbitration Act, which excluded from arbitration "agreements contained in a contract of insurance"; although "the business of insurance" includes whether disputes between insurer and insured are resolved in litigation or arbitration, Vermont statute did not intend to "regulate" the business of insurance); Triton Lines v. Steamship Mut. Underwriting Ass'n, 707 F. Supp. 277, 279 (S.D. Tex. 1989) (stating that the disputed claim was not the "business of insurance," and the McCarran-Ferguson Act does not abrogate procedural practices such as the FAA in favor of state anti-arbitration provision in insurance code). The Supreme Court's most recent holding in this area found that the Texas Health Care Liability Act was outside the scope of ERISA's

statutes prohibiting or limiting arbitration of insurance disputes constitute the regulation of insurance from a common sense view. They control an important aspect of the insurance relationship—how disputes are to be resolved—and are directed only at insurance contracts.[58] Such statutes satisfy the Royal Drug-Pireno test as well. Some courts have concluded that prohibiting arbitration satisfies the first factor, affecting the transfer or spreading of risk by specifying the means through which disputed claims may be resolved.[59] The second factor, which many courts have identified as the heart of the inquiry,[60] is plainly satisfied. The dispute resolution

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provision saving state insurance regulation from preemption; ERISA's comprehensive remedial scheme completely preempts any state law action asserting a claim for benefits. Aetna Health Inc. v. Davila, 542 U.S. 200, 124 S.Ct. 2488, 2502 (2004).

58. *UNUM*, 526 U.S. at 366-67, 373 (stating that the California notice-prejudice rule regulates insurance from common sense perspective: it "controls the terms of the insurance relationship" and "is applicable only to insurance contracts").

59. *See, e.g.*, McKnight v. Chi. Title Ins. Co., 358 F.3d 854, 858 (11th Cir. 2004) (stating that Georgia Code § 9-9-2(c)(3) transfers or spreads insured's risk by introducing possibility of jury verdicts and by limiting enforceability of parties' agreement to spread risk); Standard Sec. Life Ins. Co. v. West, 267 F.3d 821, 824 (8th Cir. 2001) (explaining that the statute transfers or spreads the risk by introducing the possibility of jury verdicts into the process for resolving disputed claims); *Mut. Reinsurance Bureau*, 969 F.2d at 933 (stating that insurance contract evidences agreement to spread risk; by enacting statute invalidating written arbitration clauses in insurance, Kansas legislature had limited enforceability of parties' agreement to spread risk); Cont'l Ins. Co. v. Equity Residential Props. Trust, 565 S.E.2d 603, 605 (Ga. Ct. App. 2002) (stating that Georgia Code §§ 9-9-2(c)(3) "has the effect of transferring or spreading risk by preserving the possibility of a jury verdict (as opposed to compelled arbitration) to resolve the claim."); Cox v. Woodmen of World Ins. Co., 556 S.E.2d 397, 401-02 (S.C. Ct. App. 2001) (excepting insurance contracts from arbitration statute, South Carolina legislature placed limits on the enforceability of an agreement to spread risk). Other courts hold to the contrary. *See, e.g.*, *Pacificare Behavioral Health of Cal., Inc.*, 113 Cal. Rptr. 2d at 152 (conceding that anti-arbitration statute does not spread risk); *Triton Lines, Inc.*, 707 F. Supp. at 279 (upholding the FAA against Texas anti-arbitration statute; method of resolving disputed claim is not business of insurance, since business of insurance focuses on underwriting and spreading of risk). Even apart from these decisions, the first factor does not prevent the conclusion that state insurance arbitration laws regulate the business of insurance. Courts have acknowledged the substantial questions surrounding the first factor and discount it accordingly. United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993); Owens v. Aetna Life & Cas. Co., 654 F.2d 218 (3d Cir. 1981); Proctor v. State Farm Mut. Auto. Ins. Co., 675 F.2d 308 (D.C. Cir. 1982). Most importantly, activities which the McCarran-Ferguson Act sought specifically to protect as the "business of insurance," such as cooperative ratemaking, do not directly transfer or spread risk.

60. *See, e.g.*, SEC v. Nat'l Sec., Inc., 393 U.S. 453, 460 (1969) (stating that "statutes aimed at protecting or regulating this relationship [between the insurance company and the policyholder], directly or indirectly, are laws governing the 'business of insurance.'").

process is an integral part of the policy relationship.[61] Third, the provisions at issue apply only to insurance, explicitly exempting insurance contracts from the application of pro-arbitration policies expressed in state statutes.[62]

Finally, the third Royal Drug-Pierno factor, that application of the federal statute will invalidate, impair, or supersede the state law, is satisfied. Enforcement of the FAA where state legislatures have made mandatory arbitration of insurance disputes unlawful, or have imposed limitations on the practice, invalidates or supersedes the state statute. Accordingly, state laws which limit or prohibit mandatory arbitration of insurance are valid and enforceable through inverse preemption of the FAA.

Decisional law generally accords with this analysis. Federal and state opinions agree that state statutes prohibiting or limiting insurance arbitration inversely preempt the FAA, preventing its application to insurance policies in the relevant states.[63] Courts have upheld provisions

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61. *See, e.g., Standard Sec. Life Ins. Co.*, 267 F.3d at 824 (stating that the statute regulates an integral part of the insurer-insured relationship by invalidating the mandatory policy term by allowing either party to compel arbitration, thus subjecting all policy disputes to possible jury trial); *Mut. Reinsurance Bureau*, 969 F.2d at 933 (explaining that the provision prohibiting enforcement of arbitration agreements in insurance contracts "directly regulates the relationship between the insurance company and its policyholder").

62. *See, e.g., Friday*, 939 P.2d at 872-73 (explaining that contracts of insurance were explicitly excluded from Kansas statute § 5-401 providing that the arbitration provisions were valid and enforceable); *Mut. Reinsurance Bureau*, 969 F.2d at 933-34 (explaining that contracts of insurance were explicitly excluded from Kansas statute § 5-401 providing that the arbitration provisions were valid and enforceable); *Cox*, 556 S.E.2d at 401 (stating that § 15-48-10(b)(4) provides that the South Carolina Arbitration Act, which favors arbitration, is not applicable to "any insured or beneficiary under any insurance policy or annuity contract").

63. *See, e.g., McKnight*, 358 F.3d at 858-59 (stating that Georgia Code § 9-9-2(c)(3) enacted by Georgia for the purpose of regulating the business of insurance, under the McCarran-Ferguson Act, inversely preempts the FAA; the statute affects the relationship between insurer and insured by substituting enforcement mechanism, transfering or spreading insured's risk by introducing possibility of jury verdicts, limiting enforceability of parties' agreement to spread risk, and is expressly limited to entities within insurance industry); *Standard Sec. Life Ins. Co.*, 267 F.3d at 824 (stating that Missouri code § 435.350 transfers or spreads risk by introducing the possibility of jury verdicts into the dispute resolution process; regulates an integral part of insurer-insured relationship by invalidating mandatory arbitration agreement, and subjects all policy disputes to possibility of jury trial; limited to entities within insurance industry because insurance is the only industry singled out for invalidation of arbitration clauses.); *Mut. Reinsurance Bureau*, 969 F.2d at 934 (applying Kansas law); Nat'l Home Ins. Co. v. King, 291 F. Supp. 2d 518, 529 (E.D. Ky. 2003) (utilizing test in United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993), where Supreme Court stated that any law with the "end, intention, or aim of adjusting, managing, or controlling the business of insurance" is a law "enacted for the purpose of

which prohibit arbitration in insurance or impose conditions on insurance arbitration against FAA challenges.[64]

Many states have utilized inverse preemptive powers under McCarran-Ferguson to regulate mandatory arbitration of insurance disputes. Almost a third of the states and two United States territories currently regulate arbitration of insurance disputes. These provisions generally appear in two types of state statutes.[65] First, some state arbitration acts provide, like the FAA, that arbitration agreements are valid, enforceable and irrevocable, but specifically exempt insurance contracts from the statute's scope.[66] Under

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regulating the business of insurance" under the McCarran-Ferguson Act); Am. Health and Life Ins. Co. v. Heyward, 272 F. Supp. 2d 578, 582-83 (D. S.C. 2003); *Friday*, 939 P.2d at 872-73; Cont'l Ins. Co. v. Equity Residential Props., 565 S.E.2d 603, 605 (Ga. Ct. App. 2002) (stating that Georgia Code § 9-9-2(c)(3) regulates the business of insurance within the meaning of the McCarran-Ferguson Act by transferring risk through the possibility of a jury verdict as opposed to an arbitration award, regulates the contract relationship of insured and insurer, and thus preempts the FAA); *Cox*, 556 S.E.2d at 401-02 (stating that the arbitration exception is an integral part of the policy relationship because it expressly invalidates policy provision and mandates methods for resolving disputes between insured and insurer, limits the enforceability of the agreement to spread risk; and is limited to entities within insurance industry); *PacifiCare Behavioral Health of Cal., Inc.*, 113 Cal. Rptr. 2d at 157 (explaining that because the statute directly regulates the words that HMO may use in its plan if it wants to include an enforceable arbitration clause, it regulates an integral part of the policy relationship); Pagarigan v. Super. Ct. of Los Angeles County, 126 Cal. Rptr. 2d 124, 130 (Cal. App. Dep't Super. Ct 2002); Imbler v. PacifiCare of Cal., Inc., 126 Cal. Rptr. 2d 715, 719-20 (Cal. App. Dep't Super. Ct. 2002); *Contra,* Erickson v. Aetna Health Plans of Cal., 84 Cal. Rptr. 2d 76, 78 (Cal. App. Dep't Super. Ct. 1999).

64. Courts have also rejected FAA challenges to state insolvency statutes which stay or consolidate all claims against an insolvent insurance company, precluding enforcement of arbitration agreements between the company and a claimant. *See, e.g.*, Davister Corp. v. United Republic Life Ins. Co., 152 F.3d 1277 (10th Cir. 1998); Stephens v. Am. Int'l Ins. Co., 66 F.3d 41 (2d Cir. 1995).

65. The Massachusetts and Louisiana laws are typical examples. Massachusetts' arbitration statute provides: "No company and no officer or agent thereof shall make, issue or deliver any policy of insurance or any annuity or pure endowment contract containing any condition, stipulation or agreement depriving the courts of the commonwealth of jurisdiction of actions against it . . . Any such condition, stipulation or agreement shall be void." MASS. GEN. LAWS ANN. ch. 175, § 22 (2005). Louisiana's prohibition appears in its insurance code. The statute provides: "A. No insurance contract delivered or issued for delivery in this state and covering subjects located, resident, or to be performed in this state or any group health and accident policy insuring a resident of this state, regardless of where made or delivered shall contain any condition, stipulation, or agreement: (2) Depriving the courts of this state of the jurisdiction of action against the insurer; B. Any such condition, stipulation, or agreement in violation of this Section shall be void." LA. REV. STAT. ANN. § 22:629 (2005).

66. States utilizing this form of regulation include: Arkansas, ARK. CODE ANN. § 16-108-201(b)(2) (2003), *see* IGF Ins. Co. v. Hat Creek P'ship 76 S.W.3d 859, 866 (Ark. 2002) (finding no inverse preemption because federal law specifically regulated insurance, but

these provisions, agreements to arbitrate insurance disputes are void, either through explicit statutory language or judicial interpretation. Second, some state insurance codes provide that insurance policies issued or delivered in the state may not contain any provision which deprives the state's courts of jurisdiction against the insurer.[67]

Most courts have concluded that both types of provisions regulate insurance under the McCarran-Ferguson Act, preempting the FAA. There is some precedent to the contrary. The Vermont Supreme Court ruled that its statute, which exempts insurance contracts from the Vermont Arbitration Act, does not regulate insurance.[68] The statute provides simply that the Arbitration Act "does not apply to . . . arbitration agreements contained in a contract of insurance."[69] According to this court, this

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assuming that § 16-108-201(b) "would ordinarily render the arbitration clause unenforceable"); Georgia, GA. CODE ANN. § 9-9-2(c)(3) (1998), *see Cont'l Ins. Co.*, 565 S.E.2d at 604 (holding that § 9-9-2(c)(3) regulates insurance by affecting transfer of risk through preservation of possible jury verdict and relationship between the company and policyholder); *see also Chi. Title Ins. Co.*, 358 F.3d at 858-59 (finding that § 9-9-2(c)(3) regulates insurance because it affects relationship between insurer and insured by invalidating chosen method of contract enforcement; transfers or spreads risk by making jury verdicts possible; and is expressly limited to insurance industry); Kansas, KAN. STAT. ANN. § 5-401(c)(1) (2003), *see Friday*, 939 P.2d at 869, 872-73 (finding that § 5-401(c)(1) regulates insurance and inversely preempts the FAA); Kentucky, KY. REV. STAT. ANN. § 417.050(2) (2004), *see Nat'l Home Ins. Co.*, 291 F. Supp. 2d at 530 (E.D. Ky. 2003) (finding that § 417.050(2) regulates insurance, preempting the FAA through the McCarran-Ferguson Act); *see also* Stephens v. Am. Int'l Ins. Co., 66 F.3d 41, 45 (2d Cir. 1995) (finding the anti-arbitration provision in the Kentucky statute regulating liquidation of insurance companies inversely preempts the FAA); Missouri, MO. ANN. STAT. § 435.350 (2004); Montana, MONT. CODE ANN. § 27-5-114 (2003); Nebraska, NEB. REV. STAT. § 25-2602.01(f)(4)(2002); Oklahoma, OKLA. STAT. ANN. tit. 15, § 802(A) (2004); South Carolina, S.C. CODE ANN. § 15-48-10(b)(4) (1976); South Dakota, S.D. CODIFIED LAWS § 21-25A-3 (2003); and Vermont, VT. STAT. ANN. tit. 12, § 5653(a) (2002).

67. The following states have such provisions: Hawaii, HAW. REV. STAT. ANN. § 431:10-221 (2003); Louisiana, LA. REV. STAT. ANN. § 22:629a (2004), *see* W. of England Ship Owners Mut. Ins. Ass'n (Luxembourg) v. Am. Marine Corp., 981 F.2d 749, 750 n.5 (5th Cir. 1993) (finding that pursuant to § 22:629a, Louisiana has preempted the FAA through the McCarran-Ferguson Act); Maine, ME. REV. STAT. ANN. tit. 24-A, § 2433 (2004); Massachusetts, MASS. GEN. LAWS ch. 175, §22 (2005); Virginia, VA. CODE ANN. § 38.2-312 (2002); Washington, WASH. REV. CODE ANN. § 48.18.200(1)(b) (2005); Puerto Rico, 26 P.R. LAWS ANN. § 1119 (1997); U.S. Virgin Islands, 22 V.I. CODE ANN. § 820 (1993) ("No insurance contract delivered or issued for delivery in this territory and covering subjects located, resident or to be performed in this territory, shall contain any condition, stipulation or agreement which (2) [D]eprives the courts of this territory of the jurisdiction of action against the insurer. (b) Any such condition, stipulation or agreement . . . shall be void, but such voiding shall not affect the validity of the other provisions of the contract.").

68. Little v. Allstate Ins. Co., 705 A.2d 538, 540 (Vt. 1997).

69. VT. STAT. ANN. tit. 12, § 5653(a) (2002).

provision simply leaves control over arbitration of insurance issues to Vermont common law.[70] The court held further that Vermont common law did not constitute "law" for purposes of inverse preemption under McCarran-Ferguson.[71] Other state statutes which simply exempt insurance agreements from the state Arbitration Act, like Vermont's, have been universally interpreted to prohibit arbitration of insurance claims and to inversely preempt the FAA.[72]

Other state statutes impose conditions or restrictions on arbitration agreements in insurance policies. Colorado's statute applies to medical services agreements, providing that such agreements must be voluntary and must satisfy various requirements as to content and form.[73] California's

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70. *Little*, 705 A.2d at 541.

71. *Id.*

72. Statutes in Arkansas, Kansas, Missouri, Montana, Nebraska, and South Carolina are very similar to Vermont's. Nebraska has not considered the issue of whether its statute, NEB. REV. STAT. § 25-2602.01, inversely preempts the FAA by prohibiting arbitration of insurance disputes. Other statutes have been construed to render arbitration agreements in insurance contracts unenforceable. IGF Ins. Co. v. Hat Creek P'ship, 76 S.W.3d 859, 866 (Ark. 2002) (finding no inverse preemption because Federal Crop Insurance Act specifically regulated insurance, but assuming that § 16-1108-201(b)(1) "would ordinarily render the arbitration clause unenforceable."); Friday v. Trinity Universal, 939 P.2d 869, 872-73 (Kan. 1997) (holding that § 5-401(c)(1) regulates insurance, inversely preempting the FAA); Mut. Reinsurance Bureau v. Great Plains Mut. Ins. Co., 969 F.2d 931, 934 (10th Cir. 1992) (holding that § 5-401(c)(1) regulates insurance, inversely preempting the FAA); Missouri, Standard Sec. Life Ins. Co. v. West, 127 F. Supp. 2d 1064, 1069 (W.D. Mo. 2000) (finding that § 435.350 regulates insurance because it only exempts insurance contracts inversely preempting the FAA); South Carolina, Am. Health & Life Ins. Co. v. Heyward, 272 F. Supp. 2d 578, 581-82 (D. S.C. 2003) (concluding that §15-48-10(b)(4) was enacted for the purposes of regulating the business of insurance and therefore, reverse preempts the FAA), Cox v. Woodmen of the World Ins. Co., 556 S.E.2d 397, 401-02 (S.C. Ct. App. 2001) (concluding that §15-48-10(b)(4) was enacted for the purposes of regulating the business of insurance and therefore, reverse preempts the FAA).

73. The statute requires inclusion of the following notice in medical services arbitration agreements: "It is understood that any claim of medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered or omitted, will be determined by submission to binding arbitration in accordance with the provisions of the 'Uniform Arbitration Act of 1975', part 2 of article 22 of title 13, Colorado Revised Statutes, and not by a lawsuit or resort to court process except as Colorado law provides for judicial review of arbitration proceedings. The patient has the right to seek legal counsel concerning this agreement, and has the right to rescind this agreement by written notice to the physician within ninety days after the agreement has been signed and executed by both parties unless said agreement was signed in contemplation of the patient being hospitalized, in which case the agreement may be rescinded by written notice to the physician within ninety days after release or discharge from the hospital or other health care institution. Both parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute

statute is similar[74] and also mandates specified procedures for the arbitration.[75] Rhode Island precludes arbitration agreements in life insurance policies;[76] Maryland similarly prohibits arbitration agreements in life or health insurance or annuity contracts.[77] In addition to its general prohibition of arbitration agreements in insurance policies, South Dakota also specifically precludes such agreements in life insurance policies.[78]

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decided in a court of law before a jury." COLO. REV. STAT. § 13-64-403(3) (2005). The statute also requires a 10 point, bold face type statement immediately above the signature lines, indicating that the parties are agreeing to utilize binding arbitration in lieu of the courts and outlining rescission rights. *Id.* § 13-64-403(4).

74. The statute provides that any health care service plan requiring binding arbitration must include, in understandable language, statements that the plan uses binding arbitration, including medical malpractice claims (if that is the plan's intent) and that such agreement entails a waiver of the right to trial by jury, using the wording provided in section 1295(a) the Code of Civil Procedure. CAL. HEALTH & SAFETY CODE § 1363.1 (2005). These statements must be contained in a separate contract provision and be prominently displayed on the enrollment forms signed by subscribers. *Id.* These disclosures must be displayed immediately above the signature lines provided for the representative of the group contracting with a health care service plan and for the individual enrolling in the health care service plan. *Id.* Section 1295 provides that arbitration agreements must be in the contract's first provision and use these words: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." CAL. CIV. PROC. CODE § 1295(a) (2005). Section 1295 additionally requires a notice in 10 point bold red type which reads: "Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of this contract." *Id.* § 1295(b).

75. The arbitration must be conducted by a neutral arbitrator; that requirement may not be waived. CAL. HEALTH & SAFETY CODE § 1373.19 (2005). The arbitrator must render a written decision indicating the prevailing party, the amount of any award and other relevant terms of the award, and the reasons for the award. *Id.* § 1373.21. Such decisions, including the name of the arbitrator or arbitrators, but excluding the names of the enrollee, the plan, witnesses, attorneys, providers, health plan employees, and health facilities, must be provided to the department and made available to the public upon request. *Id.*

76. "No life insurance company and no officer or insurance producer of the company shall make, issue, or deliver any policy or contract of insurance containing any condition, stipulation, or agreement depriving the courts of the state of jurisdiction of actions against it . . . ." R.I. GEN. LAWS § 27-4-13 (2005).

77. MD. CODE ANN., INS. § 12-209 (2005).

78. "No policy of life insurance shall be delivered or issued for delivery in this state if it contains any provision depriving the courts of this state of the jurisdiction of any action at law or in equity against the insurer." S.D. CODIFIED LAWS § 58-15-50 (2005).

Alabama's statutory configuration is unique. The states discussed above enforce arbitration agreements generally and specifically exempt insurance. To the contrary, Alabama's statute, section 8-1-41(3), prohibits enforcement of *all* pre-dispute arbitration agreements.[79] Policyholders have argued repeatedly and unsuccessfully that section 27-14-22 of the Insurance Code, which provides that insurance contracts for which application is made in Alabama are subject to the laws of Alabama,[80] incorporates Alabama's general anti-arbitration provision and transforms it into regulation of the business of insurance. Over strong and consistent dissents,[81] the Alabama Supreme Court has rejected this incorporation

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79. Ala. Code § 8-1-41, obligations which cannot be specifically enforced, provides in pertinent part: "The following obligations cannot be specifically enforced: . . . (3) An agreement to submit a controversy to arbitration." ALA. CODE § 8-1-41(3) (2005). Alabama has never enacted any variant of the Uniform Arbitration Act.

80. Ala. Code § 27-14-22 provides in full: "All contracts of insurance, the application for which is taken within this state, shall be deemed to have been made within this state and subject to the laws thereof." ALA. CODE § 27-14-22 (2005).

81. *See* Am. Bankers Ins. Co. v. Crawford, 757 So. 2d 1125, 1138 (Ala. 1999) (Houston, J., dissenting). It may be appropriate to consider section 27-14-22, which incorporates section 8-1-41(3), as the relevant statute for purposes of inverse preemption under the McCarran-Ferguson Act. Justice Houston in his dissent in *American Bankers v. Crawford*, joined by Justices Cook and Johnstone, argued that section 27-14-22, which incorporates section 8-1-41(3), satisfies the three factors of the inverse preemption: (1) the FAA is not specifically related to insurance; (2) section 27-14-22, which incorporates Alabama's anti-arbitration law, was enacted for the purpose of regulating insurance; and (3) application of the FAA would "invalidate, impair, or supersede" Alabama's statutory bar against specific enforcement of arbitration agreements. *Id.* at 1138. The Alabama Supreme Court's disagreement centers on the second requirement: the majority analyzes the general anti-arbitration statute, standing alone; the dissenters analyze section 27-14-22, which requires state insurance policies to conform to state law, and which, in their view, incorporates the anti-arbitration statute. *Id.* From a common sense perspective, a provision subjecting insurance policies applied for in Alabama to Alabama law regulates insurance, as do the state laws thereby incorporated. That section 27-14-22 includes state law generally and not just section 8-1-41(3) does not change this conclusion; neither does the fact that section 8-1-41(3) standing alone applies to contracts generally and not just to insurance contracts. As incorporated into section 27-14-22, section 8-1-41(3) regulates insurance; given the operation of the FAA, it can regulate *only* insurance. The McCarran-Ferguson factors also suggest, although perhaps less strongly, that section 27-14-22 and section 8-1-41(3) in combination regulate the business of insurance. The first factor asks whether the practice transfers or distributes risk. Some courts have found that restricting insurance arbitration transfers or distributes risk within the meaning of the McCarran-Ferguson Act. United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993); Owens v. Aetna Life & Cas. Co., 654 F.2d 218 (3d Cir. 1981); Proctor v. State Farm Mut. Auto. Ins. Co., 675 F.2d 308 (D.C. Cir. 1982). Even if such restrictions are found not to transfer or distribute risk, however, commentators have discounted this factor as excluding even cooperative ratemaking, which is central to the business of insurance and motivated the enactment of the McCarran-Ferguson Act. *See, e.g.*, ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW

argument, holding in *American Bankers Insurance Co. v. Crawford*[82] and subsequent cases[83] that the general anti-arbitration statute does not regulate the business of insurance as required for inverse preemption of the FAA. Specifically, Alabama courts hold that the general anti-arbitration statute does not have the effect of transferring or spreading a policyholder's risk, has "no bearing on the more essential aspects of the insurer-insured relationship," and is not limited to entities within the insurance industry.[84] Federal district courts in Alabama are in accord.[85]

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§ 21(d)(1) (3d ed. 2002). The second factor in the McCarran-Ferguson Act business of insurance test, whether the practice is an integral part of the policy relationship between the insurance company and the policyholder, is plainly satisfied. Section 27-14-22 affects the policy relationship between the insurance company and the policyholder by regulating the content and enforcement of the policy generally and specifically by prohibiting arbitration of policy disputes through section 8-1-41(3). The third criterion is whether the practice is limited to entities in the insurance industry. Alabama's prohibition on enforcement of pre-dispute arbitration agreements in section 8-1-41(3) was not intended to apply only to insurance entities. The state legislature applied the rule to all arbitration agreements, including those contained in insurance policies; section 27-14-22 simply reinforced that prohibition with respect to insurance. It is only by virtue of the FAA's preemptive effect that section 8-1-41(3) does not apply to all arbitration agreements, and only through the possibility of the McCarran-Ferguson Act's inverse preemptive effects, that it may apply solely to the insurance industry's arbitration.

82. 757 So. 2d 1125 (1999).

83. Subsequent cases have adhered to the analysis in *Crawford*. *See, e.g.*, S. United Fire Ins. Co. v. Preyer, 792 So. 2d 1092 (Ala. 2001) (Justices Houston, England, Cook, and Johnstone, dissenting); S. United Fire Ins. Co. v. Pierce, 775 So. 2d 194 (Ala. 2000) (Justices Houston, England, Cook, and Johnstone, dissenting). Although Justice Houston has dissented repeatedly on this issue, he joined the majority in Celtic Life Ins. Co. v. McLendon, 814 So. 2d 222 (Ala. 2001) (Houston, J. concurring specially). Justice Houston stated, "[T]his Court has soundly rejected the position I took in *American Bankers Insurance Co. of Florida v. Crawford*. Although I still think that I am right and the majority is wrong on this issue, there comes a time when one must follow stare decisis. That time has come." *Id.* at 226-27.

84. *See, e.g.*, Am. Bankers Ins. Co. v. Crawford, 757 So. 2d 1125 (Ala. 1999).

85. *See* Bullock v. United Benefit Life Ins. Co., 165 F. Supp. 2d 1259 (M.D. Ala. 2001); Woodmen of the World Life Ins. Soc'y v. White, 35 F. Supp. 2d 1349 (M.D. Ala. 1999); *see also* Spurlock v. Life Ins. Co. of Va., No. Civ.A.98-D-222-N, 2000 WL 1785300 (M.D. Ala. Oct. 31, 2000). *Woodmen* relies on the 1997 dissenting opinion of Justice Maddox, in which he concluded that § 8-1-41(3) did not specifically regulate insurance and so did not reverse preempt the FAA through McCarran-Ferguson. Justice Maddox's opinion did not, however, consider the implications of § 27-14-22. The court in Woodmen rejected the idea that incorporation of § 8-1-41(3) into the insurance code through § 27-14-22 changed the result. The court noted that the parties cited no cases in which an incorporation provision preempted the FAA through the McCarran-Ferguson Act, and distinguished cases in which a statute favoring arbitration specifically exempted insurance. The lack of precedent proves nothing; there are no cases simply because no other jurisdiction prevents enforcement of pre-dispute arbitration clauses.

Of course, the Alabama state legislature could eliminate these interpretive difficulties through the simple expedient of enacting a specific provision prohibiting the use of mandatory pre-dispute arbitration in insurance contracts.[86] The Alabama Department of Insurance could accomplish the same result through regulation to the same effect,[87] and has in fact attempted to restrict insurance arbitration as detailed in the next section.

B. REGULATORY LIMITATION OF ARBITRATION IN INSURANCE

States may also use the inverse preemptive effects of the McCarran-Ferguson Act through regulatory prohibition or limitation of insurance arbitration. First, traditional administrative law recognizes that regulations promulgated in accordance with an agency's statutorily delegated power have the force of law. The authority of insurance commissioners to promulgate regulations derives from legislative enactments. Second, the language of the McCarran-Ferguson Act suggests that properly promulgated administrative regulations are law for its purposes. The Act's statement of purpose declares "that the continued regulation and taxation by the several states of the business of insurance is in the public interest"[88] and section 1012(a) of the Act speaks broadly of the "laws of the several States which relate to the regulation or taxation" of the business of insurance.[89] Both provisions suggest an intent to include both statutory and regulatory law. The phrase in section 1012(b), "law *enacted* by any State,"[90] appears not to have been intended to limit the preemptive effects of the McCarran-Ferguson Act to enacted statutory law, but was meant to include promulgated administrative regulations as well.[91] Third, the

86. The Alabama legislature's posture with respect to pre-dispute arbitration has remained constant. *See, e.g.*, ALA. CODE § 6-5-485 (1975) (enacted in 1975, permitting post-dispute arbitration in Medical Liability Actions); ALA. CODE § 6-5-575 (1988) (enacted in 1988, permitting same in Legal Service Liability Actions). *See also* statutes cited *supra* note 81; Ex parte Dan Tucker Auto Sales, Inc., 718 So. 2d 33, 41 (Ala. 1998) (Lyons, J., concurring). Under the reverse preemption of the McCarran-Ferguson Act, 15 U.S.C. § 1011 et seq., state autonomy over matters of insurance is permitted.

87. The Alabama Department of Insurance has instead imposed limitations on the scope and content of arbitration agreements in insurance policies. *See infra* text accompanying notes 134-42.

88. 15 U.S.C. § 1011 (2005).

89. 15 U.S.C. § 1012(a) (2005).

90. 15 U.S.C. § 1012(b) (2005) (emphasis added).

91. The phrase is potentially limiting based on the common legal usage of the word "enact." In common legal usage, legislators *enact* statutes, whereas administrators *promulgate* regulations.

legislative record demonstrates Congress's intent to extend McCarran-Ferguson preemption to regulations. Reports on the bill refer repeatedly to state regulation.[92] The House and Senate reports similarly refer to regulation; and their analyses of section 1012(b) do not use the term "enactment."[93] Additionally, an exchange between two of the Senate managers of the bill indicates an intent to include regulations.[94] Traditional administrative law recognizes that regulations promulgated in accordance with an agency's statutorily delegated power have the force of law. The authority of insurance commissioners to promulgate regulations derives from legislative enactments.[95] Case law also indicates that administrative law is law for purposes of the McCarran-Ferguson Act.[96]

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92. S. Rep. No. 79-20 (1945); H.R. Rep. No. 79-143 (1945).

93. S. Rep. No. 79-20 (1945); H.R. Rep. No. 79-143 (1945).

94. In response to a statement by Senator Pat McCarran, Senator Joseph C. O'Mahoney said, "I believe the Senator from Michigan went a little further than was his intention when he said that if the States have *legislated* certain things will happen. The bill says if the States have regulated." 91 Cong. Rec. 1443 (1945) (emphasis added).

95. The National Association of Insurance Commissioners ("NAIC") Model Laws, used by many states as a model for the state insurance code, includes many such authorizations. *See, e.g.*, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES, PROP. AND CAS. INS., 9A. Regulatory Jurisdiction ("The insurance commissioner is authorized after due notice and hearing to promulgate such regulations as may be necessary to carry out the provisions of this Act"); NAIC MODEL LAWS, REGULATIONS AND GUIDELINES, GROUP PERS. LINES PROP. AND CAS. INS., AGENTS/BROKERS/PRODUCERS: PRODUCER LICENSING MODEL ACT, 16. Regulations ("The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].")

96. Administrative rules are "law" within the meaning of McCarran-Ferguson. *See, e.g.*, Doe v. Norwest Bank Minnesota, N.A., 107 F.3d 1297, 1307 (8th Cir. 1997) (application of RICO to insurance fraud preempted by McCarran-Ferguson as impairment of Minnesota's administrative remedial system under which no private cause of action exists; regulation occurs through Commissioner's pursuit of fines and injunctive relief); Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 563 (7th Cir. 1999) (direct conflict of federal and state law is not required to trigger McCarran-Ferguson Act reverse preemption; it is sufficient if interpretation of federal law would interfere with a state's administrative regime). Some courts have interpreted the McCarran-Ferguson Act's preemption provision fairly broadly to include city ordinances. *See* City of Charleston v. Gov't Employees Ins. Co., 512 S.E.2d 504, 505 (S.C. 1999) (city ordinance authorizing annual license fee based on gross premiums collected on insurance policies written on property or risks located within city exempt from Commerce Clause scrutiny because it was enacted pursuant to state's delegation of authority).

1. Regulations

Like statutes, administrative regulations generally satisfy the test for inverse preemption derived from the McCarran-Ferguson Act. Regulations clearly satisfy the three requirements for inverse preemption as outlined in section 1012(b). First, the FAA does not "specifically [relate] to the business of insurance."[97] Second, application of the FAA would "impair" state regulatory requirements regarding arbitration of insurance disputes.[98] Third, the purpose of these state regulations is to "regulat[e] the business of insurance" within the meaning of the McCarran-Ferguson Act. From a common sense perspective, regulations promulgated by state Insurance Departments constitute a regulation of the business of insurance, controlling the content of policies and various aspects of the insurance relationship.

The judicially prescribed "business of insurance" factors also appear to be satisfied. Some courts have held that prohibitions on arbitration in insurance transfer and distribute risk by limiting the way in which disputed claims may be resolved under the first factor.[99] Also, regulatory

97. United States Dep't of the Treasury v. Fabe, 508 U.S. 491, 500-01 (1993).

98. The case of Humana Inc. v. Forsyth, 525 U.S. 299, 301 (1999) dealt with the question of whether impairment of a state law is sufficient under McCarran-Ferguson to create an inverse preemption. The Supreme Court held that when federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application. The Court's holding in *Forsyth* accords with its prior precedent. For example, Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 104 (1983), supports the Court's view that to "impair" a law is to hinder its operation or "frustrate [a] goal" of that law. The Court's standard also follows from SEC v. Nat'l Sec., Inc., 393 U.S. 453 (1969). In both *Forsyth* and *National Securities*, it was determined that the application of a federal law that did not "directly conflict with state regulation," did not "frustrate any declared state policy," or "interfere with a State's administrative regime."

99. *See, e.g.*, McKnight v. Chicago Title Ins. Co., 358 F.3d 854, 858 (11th Cir. 2004) (Georgia Code § 9- 9-2(c)(3) transfers or spreads insured's risk by introducing possibility of jury verdicts and by limiting enforceability of parties' agreement to spread risk); Standard Sec. Life Ins. Co. v. West, 267 F.3d 821, 824 (8th Cir. 2001) (statute transfers or spreads the risk by introducing the possibility of jury verdicts into the process for resolving disputed claims); Mut. Reinsurance Bureau v. Great Plains Mut. Ins. Co., 969 F.2d 931, 933 (10th Cir. 1992) (insurance contract evidences agreement to spread risk; by enacting statute invalidating written arbitration clauses in insurance, Kansas legislature had limited enforceability of parties' agreement to spread risk); Cont'l Ins. Co. v. Equity Residential Props. Trust, 565 S.E.2d 603, 605 (Ga. App. 2002) (Georgia Code § 9-9-2(c)(3) has the effect of transferring or spreading risk by preserving the possibility of a jury verdict (as opposed to compelled arbitration) to resolve the claim); Cox v. Woodmen of the World Ins. Co., 556 S.E.2d 397, 401-402 (S.C. App. 2001) (by excepting insurance contracts from

prohibition or limitation of arbitration is aimed at policy content and dispute resolution procedures that are integral to the policy relationship. Lastly, the regulations apply only to insurance, satisfying the third and final factor used to delineate the "business of insurance."[100]

At least one state insurance department has promulgated regulations which, independent of any statutory prohibition of arbitration, may inversely preempt the FAA. Utah statutes allow insurance policies to contain "permissible" arbitration agreements.[101] The Insurance Commissioner has promulgated rules to define what constitutes "permissible" arbitration agreements. The rules require disclosure of an arbitration provision in a policy to a prospective insured prior to formation of the contract.[102] The rules also prohibit policy forms that permit the

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arbitration statute, S.C. legislature placed limits on the enforceability of an agreement to spread risk).

Other courts hold to the contrary. *E.g.*, Smith v. Pacificare Behavioral Health of Cal., Inc., 113 Cal. Rptr.2d 140, 156 (Cal. App. 2001) (conceding that antiarbitration statute does not spread risk); Triton Lines, Inc. v. Steamship Mut. Underwriting Ass'n (Berm.), 707 F. Supp. 277, 279 (S.D. Tex. 1989) (upholding FAA against Texas antiarbitration statute; method of resolving disputed claim is not business of insurance, since business of insurance focuses on underwriting and spreading of risk).

Many courts have not addressed this issue. Even those that have addressed the issue acknowledge the substantial questions surrounding the first factor and discount it accordingly. United States Dep't of the Treasury v. Fabe, 508 U.S. 491 (1993); Owens v. Aetna Life & Cas. Co., 654 F.2d 218 (3d Cir. 1981); Proctor v. State Farm Mut. Auto. Ins. Co., 675 F.2d 308 (D.C. Cir. 1982). Courts have recognized that activities which the McCarran-Ferguson Act sought specifically to protect, such as cooperative ratemaking, do not directly transfer or spread risk.

100. *See supra* text accompanying notes 54-55.

101. *See* Utah Uniform Arbitration Act § 78a-31a-101 et seq. The Insurance Code specifically acknowledges that insurance policies may contain arbitration provisions. UTAH CODE ANN. § 31A-21-313(3)(c) (2003) provides, "An insurance policy may not: (c) provide that no action may be brought, subject to permissible arbitration provisions in contracts." UTAH CODE ANN. § 31A-21-314(2) (2003) similarly states, "No insurance policy subject to this chapter may contain any provision . . . (2) depriving Utah courts of jurisdiction over an action against the insurer, except as provided in permissible arbitration provisions[.]"

102. UTAH ADMIN. CODE R-590-122-4 (2005) defines the term "permissible arbitration provision" set out in UTAH CODE ANN. §§ 31A-21-313(3)(c) & 31A-21-314(2). The rule states that each application or binder must have a "prominent statement" informing the applicant of the arbitration provision. UTAH ADMIN. CODE R-590-122-4(5) 2005. The rule includes the following suggested wording:

> ANY MATTER IN DISPUTE BETWEEN YOU AND THE COMPANY MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF (THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR), A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE COMPANY. ANY DECISION REACHED

insurer to elect optional binding arbitration,[103] obligate the insured to pay more than 50% of fees required to begin arbitration,[104] or require the arbitration to be held farther from the insured's residence than "the nearest location of a State Court of General Jurisdiction."[105] Each of these requirements would be invalid under the FAA, save for the inverse preemption under the McCarran-Ferguson Act.

2. Guidance Documents

Whether state insurance department bulletins, policy statements, guidelines, opinion letters, and similar documents, in contrast to promulgated regulations, constitute "law" within the meaning of McCarran-Ferguson is less clear.[106] Administrative law has long distinguished "legislative rules," which constitute law, and "interpretive rules," which do not.[107] Legislative rules derive from an agency's delegated legislative power, conclusively granting rights and imposing obligations. Interpretive rules typically provide information to the public, such as an agency's construction of an existing regulation or a statement of

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BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES IF ALLOWED BY STATE LAW AND MAY BE ENTERED AS A JUDGEMENT IN ANY COURT OF PROPER JURISDICTION.

Id.

103. UTAH ADMIN. CODE R-590-122-4(4) (2005).

104. UTAH ADMIN. CODE R-590-122-4(8) (2005).

105. UTAH ADMIN. CODE R-590-122-4(9) (2005).

106. The National Association of Insurance Commissioners ("NAIC") provides model bulletins in addition to model laws and regulations. *See, e.g.*, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES, Retained Asset Accounts Sample Bulletin, 573-1 (1994). *See also* NAIC MODEL LAWS, REGULATIONS AND GUIDELINES, Prohibition on the Use of Discretionary Clauses Model Act, 42-1 (2002) ("In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act as a regulation or bulletin. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation or bulletin.").

107. *See, e.g.*, Skidmore v. Swift & Co., 164 U.S. 134, 140 (1944) ("We consider that the rulings, interpretations and opinions of the Administrator under this Act, while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.").

general agency policy.[108] Administrative law contemplates that agencies will issue both types of rules.[109] Legislative rules are adopted through rulemaking procedures, which allow for notice to the public and public participation in the process.[110] Interpretive rules need not follow established rulemaking procedures.[111]

Accordingly, any insurance department document or policy statement, regardless of its designation as a bulletin, guideline, letter, statement, or otherwise, is "state law" for purposes of inverse preemption if promulgated pursuant to legislatively delegated authority through prescribed rulemaking procedures. Such documents have the force of law in precisely the same way as do agency regulations designated as rules. Absent legislative authorization, any insurance department document not promulgated through prescribed rulemaking procedures cannot, standing on its own, have the force of law.[112]

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108. Christensen v. Harris County, 529 U.S. 576, 587 (2000) (distinguishing agency formal adjudications or notice-and-comment rulemaking, which have the force of law, from interpretive documents such as "opinion letters . . . policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law."); Guardian Fed. Sav. & Loan v. Fed. Sav. & Loan Ins. Corp., 589 F.2d 658, 664-65 (D.C. Cir.1978) (legislative rules have "the force of law"; interpretive rules are "merely a clarification or explanation of an existing statute or rule," "'issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers.'") (*quoting* U.S. Dep't of Justice, Att'y Gen.'s Manual on the Admin. Procedure Act 30 n. 3 (1947)).

109. Federal Administrative Procedure Act, 5 U.S.C. § 553 (2000); Model State Administrative Procedure Act § 3-108 (2000).

110. Federal Administrative Procedure Act, 5 U.S.C. § 553 (2000); Model State Administrative Procedure Act § 3-108 (2000).

111. The federal and many state Administrative Procedure Acts recognize that efficient conduct of an agency's responsibilities sometimes requires action without public participation through rulemaking procedures. The Federal Administrative Procedure Act exempts from rulemaking procedures "interpretative [sic] rules, general statements of policy, or rules of agency organization, procedure, or practice[.]" 5 U.S.C. § 553(b)(A) (2000). The Model State Administrative Procedure Act of 1981 includes a similar general exemption, as well as specific exceptions for rules relating to internal agency management, including budget and maintenance of agency property and facilities, and procedural guidelines or criteria where disclosure would facilitate violations, among others. MODEL STATE ADMIN. PROCEDURE ACT § 3-108 (1981). For these types of rules, the drafters found that the costs of compliance with rulemaking procedures outweighed the benefits. The Federal Administrative Procedure Act also permits issuance of rules without adherence to procedures where notice and public participation is "impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(3)(B) (2000). Similarly, under the Model State Administrative Procedure Act of 1961, an agency may adopt a rule without public procedures if warranted by an imminent peril to the public health, safety, or welfare. MODEL STATE ADMIN. PROCEDURE ACT § 3(b) (1961).

112. *See infra* California statutes n. 118.

A few state legislatures have explicitly considered the purpose and nature of various agency documents. The rule in each instance accords with the analysis above. The New Mexico Insurance Code defines a "bulletin" as, "a statement, inquiry, or order of broad or general interest or application that does not in itself create new law but which may require certain actions to be performed under existing law,"[113] and specifies that the superintendent may use bulletins to provide information concerning enforcement or administration of rules, to indicate his understanding of statutes or rules, and to clarify ambiguous terms or requirements of existing law.[114] Similarly, in New Jersey, the legislature permits the Insurance Commissioner to issue bulletins that interpret existing regulations.[115]

The judiciary has refused to enforce these interpretive documents. Even where a bulletin or other document exhibits a sufficient number of the basic characteristics of law, including wide, general, and uniform application to the regulated public, prospective operation, prescription of standards or directives not present in or clearly inferable from the enabling statute, or reflection of new agency policy,[116] it is not law unless promulgated in accordance with New Jersey's Administrative Procedure

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113. N. M. ADMIN. CODE § 13.1.2.7 (2001), *available at* WL 13.1.2 NMAC ("A bulletin is a statement, inquiry, or order of broad or general interest or application that does not in itself create new law but which may require certain actions to be performed under existing law.")

114. N.M. ADMIN. CODE § 13.1.2.8 (2001), *available at* WL 13.1.2 NMAC. This part of the Code provides:

> **A.** The superintendent may issue bulletins requiring any person or company subject to regulation by the department: **(1)** to comply with requests from the superintendent to provide information useful in the lawful enforcement or administration of any provision of a rule adopted by the department or of the Insurance Code; **(2)** to respond to an inquiry from the superintendent with respect to any transaction or matter within the scope of the superintendent's supervision; **(3)** to comply with an order requiring that certain actions be performed.
>
> **B.** The superintendent may issue bulletins: **(1)** indicating his understanding of the meaning of a statute or rule; **(2)** indicating his understanding of the applicability of a statute or rule; **(3)** providing an explanation of how a statute or rule is to be administered in practice; **(4)** in response to inquiries from insurers, insurance professionals or the public clarifying ambiguous terms or requirements of existing law.

Id.

115. N.J. STAT. ANN. § 26:2J-43e (1996) states, "The Commissioner of Insurance may issue bulletins which are interpretive of existing regulations consistent with statutory provisions, with respect to any type of contract or evidence of coverage form that may be certified pursuant to section 26 of this act."

116. Metromedia, Inc. v. Dir., Div. of Taxation, 478 A.2d 742, 751 (N.J. 1984).

Act.[117] This is also the general rule in California, however, in particular instances, the California legislature has authorized the Commissioner to promulgate rules, which have the force of law, by adoption of a bulletin.[118]

State court judges have also addressed the issue of the status of bulletins, other documents, and general policy statements where no legislative guidance exists. A recent Kansas Supreme Court case[119] held that requirements on stop-loss insurance[120] in a department bulletin were

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117. Coalition for Quality Health Care v. N.J. Dep't of Banking and Ins., 791 A.2d 1085, 1099-102 (N.J. Super. Ct. App. Div. 2002).

118. *See, e.g.*, CAL. INS. CODE § 922.8 (2005) (bulletin providing requirements for allowance of reinsurance as an asset or deduction from liability; issuance and promulgation; adoption of regulations superseding bulletin requirements); CAL. INS. CODE § 1212(i) (2005) (insurance futures contracts; call and put options; purchase and sale) ("The commissioner shall issue a bulletin by June 30, 1994, setting forth the accounting, reporting, and valuation practices and procedures for insurance futures contracts."); CAL. INS. CODE §§ 10163.2(h)(6), (7) (2005) (calculation of adjusted premiums and present values; nonforfeiture interest (requiring use of mortality tables either promulgated by regulation or issued by bulletin)); CAL. INS. CODE § 10489.2 (2005) (minimum standard (requiring valuation of life insurance policies using mortality tables either promulgated by regulation or issued by bulletin)); CAL. INS. CODE § 10489.94 (2005) (commissioner's bulletin; contents; authority; legislative intent) ("The Commissioner may issue a bulletin to provide tables of select mortality factors and rules for their use, rules concerning a minimum standard for the valuation of plans with nonlevel premiums of benefits, and rules concerning a minimum standard for the valuation of plans with secondary guarantees. The bulletin authorized by this subdivision shall have the same force and effect, and may be enforced by the commissioner to the same extent and degree, as regulations issued by the commissioner. The commissioner shall adopt regulations that shall supersede the bulletin authorized by this section no later than December 31, 2002."); CAL. INS. CODE § 10506.3 (2005) (modified guaranteed annuities; administrative regulations; nonforfeiture values provisions application; group annuities exemption; retroactivity; bulletin (providing that insurance commissioner issue bulletin, which would supersede regulations)) ("The bulletin authorized by this section shall have the same force and effect, and may be enforced by the commissioner to the same extent and degree, as the regulations superseded by it until the time that the commissioner may make additional or amended regulations.").

119. Am. Trust Adm'rs, Inc. v. Sebelius, 44 P.3d 1253, 1259-60 (Kan. 2002) (insurance Commissioner's bulletin addressed to insurance companies writing stop loss or excess loss insurance constituted "rule or regulation" since agency did not exercise discretion in its application, it was generally applicable to regulated public, and the agency treated the bulletin as having the effect of law; bulletin void for failure to comply with requirement of filing and publication under KAN. STAT. ANN. §§ 77-415(4), 77-425).

120. Stop-loss insurance is a type of excess insurance generally sold to an employer with a self-funded group benefit plan in order to provide protection against catastrophic losses. A stop-loss policy reimburses the employer when its payment of benefits on behalf of an individual participant, or on behalf of the entire group, exceed specified threshold amounts. According to the Kansas Supreme Court's interpretation of Kansas law, the Insurance Commissioner was authorized to regulate stop-loss insurance. *American Trust Adm'rs, Inc.*, 44 P.3d at 1257-59. The Commissioner set minimum thresholds for individual

unenforceable, since the bulletin had not been promulgated in accordance with legislatively-imposed state agency procedures.[121] Other state courts agree.[122] The Florida Attorney General reached a similar conclusion concerning an Insurance Department bulletin related to life and health insurance; the bulletin constituted law only if promulgated in accordance with the state's Administrative Procedure Act.[123] More generally, the Fifth Circuit decided recently that an insurance department's "regulatory policy" is not "state law" for purposes of the McCarran-Ferguson Act.[124] Following the reasoning of that decision, the Western District Court of

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participants and for aggregate claims in a Bulletin and Addendum, Insurance Department Bulletins 1993-12 and 1993-12 (Addendum), and refused to approve a stop-loss policy with a threshold of zero. Such a policy is not an excess policy designed to protect a self-funded plan against catastrophic losses; functionally it is an ordinary primary insurance policy. The distinction is important because insurance purchased by an employee benefit plan is subject to state regulation; self-funded plans are not. ERISA governs self-funded plans, preempting state insurance regulation. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985) ("Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance -- so-called 'insured plans' -- are directly affected by state laws that regulate the insurance industry."). Most courts have held that the purchase of a true stop-loss policy does not change the character of a self-funded employee benefit, leaving ERISA preemption intact and state insurance regulation inapplicable. *See, e.g.*, Brown v. Granatelli, 897 F.2d 1351, 1354 (5th Cir. 1990); United Food & Commercial Workers v. Pacyga, 801 F.2d 1157, 1161-62 (9th Cir. 1986); Moore v. Provident Life and Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986); Hutchinson v. Benton Casing Serv., Inc., 619 F. Supp. 831 (S.D. Miss. 1985). *See also* Gen. Split Corp. v. Mitchell, 523 F. Supp. 427 (E.D. Wis. 1981); St. Paul Elec. Workers Welfare Fund v. Markman, 490 F. Supp. 931 (D. Minn. 1980).

Some courts have ruled differently. *See, e.g.*, Michigan United Food & Commercial v. Baerwaldt, 767 F.2d 308, 310 (6th Cir. 1985) (employee benefit plan administered by insurance company which provided stop-loss insurance was an insured plan subject to state insurance regulation); Simmons v. Prudential Ins. Co., 641 F. Supp. 675, 680 (D. Colo. 1986) (same).

121. Am. Trust Adm'rs, Inc. v. Sebelius, 44 P.3d 1253 (Kan. 2002) (holding that bulletin not enforceable since it did not comply with requirement of filing and publication under KAN. STAT. ANN. §§ 77-415(4), 77-425).

122. In other states, the judiciary has rejected interpretations of the Insurance Commissioner contained in Bulletins, indicating that these Bulletins are not law. *See, e.g.*, Thevenin v. Liberty Mut. Ins. Co., No. 254286, 2001 WL 890774 (Mass. Mun. Ct. Boston A.D. 2001); Bailey v. Progressive County Mut. Ins. Co., 78 S.W.3d 708 (Tex. Ct. App. 2002).

123. Op. Fla. Att'y Gen. 075-12 (Jan. 28, 1975) (*available at* http://myfloridalegal.com/ago.nsf/Opinions/02F5ED9CFAD672C1852566B70053F578) (bulletins issued by Department of Insurance are rules within Florida's Administrative Procedure Act, Fla. Stat. ch. 120.52 (2005), and to be effective, must be adopted in accordance with statutory rulemaking procedures).

124. Am. Heritage Life Ins. Co. v. Orr, 294 F.3d 702 (5th Cir. 2002) (rejecting arguments that an insurance department's regulatory policy or an attorney general's opinion is "state law" triggering inverse preemption of the FAA under the McCarran-Ferguson Act).

Missouri concluded that a general statement of policy by regulatory officials cannot trigger inverse preemption under the McCarran-Ferguson Act.[125]

Other legislative and regulatory statements utilize language which suggests that bulletins have the effect of law, regardless of the process by which they are issued. In Missouri, for example, a statute dealing with premium payments for title insurance speaks of "violations" of "general insurance statutes, regulations or bulletins."[126] A bulletin which may be violated would seem to have the force of law. Further, the inclusion of bulletins in a list also including statutes and regulations suggests a legislative view that bulletins have the same legal status as statutes and regulations. Similarly, the Pennsylvania Insurance Department Bulletin proposed a "formal repeal" of outdated bulletins "no longer necessary for the proper regulation of the insurance industry in Pennsylvania." These statements suggest the Department views such bulletins as having the force of law, since the term "repeal" is typically used in connection with statutes, and since the latter portion of the quoted material suggests the bulletins in fact regulate insurance.[127]

A number of state insurance departments have issued bulletins or guidelines concerning arbitration. Some of these are clearly interpretive rules which do not constitute state law and which cannot themselves inversely preempt the FAA. For example, the Acting Commissioner of Insurance in Louisiana issued Directive 173[128] in 2003 to clarify

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125. Thrivent Fin. for Lutherans v. Lakin, 322 F. Supp. 2d 1017, 1024 (W.D. Mo. 2004) ("Although the McCarran-Ferguson Act provides that state *laws* regulating the business of insurance are not preempted by federal law in some circumstances, the McCarran-Ferguson Act does not insulate a State's regulatory stance or opinion from preemption.") (citing *Orr*, 294 F.3d at 702).

126. MO. REV. STAT. § 381.032 (2002).

127. 26 Pa. Bull. 3496, Insurance Department, Repeal of Outdated Bulletins, Notices and Statements of Policy, Notice No. 1996-10 (1996), *available at* Lexsee 26 Pa. Bull. 3496. However, descriptions of the functions of Bulletins proposed for repeal suggest otherwise, indicating that these Bulletins "provide[d] guidance in advance of the promulgation of a regulation", "announced a change in the law or Insurance Department practice," or "related to statutes that subsequently were repealed or modified."

128. La. Directive 173, Re: Policy Forms, Binding Arbitration and/or Appraisal Provisions (Jan. 15, 2003). *See generally* Liberty Mut. Ins. Co. v. Louisiana Ins. Rating Comm'n, 696 So. 2d 1021 (La. Ct. App. 1997) (bulletin issued by Louisiana Insurance Rating Commission directing that insurers file wrap-up rates for approval was "rule" rather than mere investigatory order or interpretive directive, and could only be issued in accordance with rulemaking requirements of Administrative Procedure Act ("LAPA"); bulletin had general applicability to all insurers issuing wrap-up insurance programs, contained substantive criteria used in approval of programs).

Louisiana's prohibition against insurance policy provisions which deprive the state's courts of jurisdiction.[129] The Directive states that legislative restrictions on binding arbitration apply to group policies covering a Louisiana resident. It notifies insurers that the Commissioner will not approve policy forms which include a mandatory arbitration provision, and that insurers later discovered to have included such provisions will be subject to sanctions. It is the Louisiana legislature's prohibition of insurance arbitration, and not the Commissioner's interpretive rule, which inversely preempts the FAA.

South Dakota Insurance Bulletin 98-5[130] is another example of an interpretive rule. It cites the South Dakota statute which exempts insurance policies from the general law regarding arbitration.[131] The Commissioner's Bulletin notifies insurers of this provision, provides examples of prohibited provisions, and clarifies that it does not prohibit appraisals in the underwriting or claims processes. The Virginia Insurance Commissioner's Administrative Letter 1998-12 is similar, setting out the state's statutory prohibition on arbitration in insurance contracts[132] and providing guidance for compliance.[133] In each case, the statute rather than the interpretive rule has inverse preemptive effect.

Other state bulletins addressing arbitration in insurance are apparently intended to have the effect of law. The inverse preemptive effect of these documents depends on whether they were promulgated in accordance with required rulemaking procedures and pursuant to the agency's authority. Alabama's Bulletin, Approval of Arbitration Agreements: Departmental Guidelines and Requirements, enumerates various requirements which must be satisfied before the Commissioner will approve insurance policies containing binding arbitration agreements.[134] The Guidelines specify content and format, including typeface

129. LA. REV. STAT. ANN. § 22:629(A)(2). *See supra* note 65.

130. S.D. Bulletin 98-5 (May 22, 1998).

131. S.D. CODIFIED LAWS § 21-25A-3 (Michie 1987) ("This chapter shall not apply to insurance policies and every provision in any such policy requiring arbitration or restricting a party thereto or beneficiary thereof from enforcing his rights under by usual legal proceedings in ordinary tribunals or limiting the time to do so is void and unenforceable.").

132. VA. CODE ANN. § 38.2-312 (Michie 2002).

133. Va. Adm. Letter 1998-12 ("Arbitration clauses and appraisal conditions may be used in insurance contracts as long as they do not attempt to preclude jurisdiction of a dispute by a court in the Commonwealth of Virginia.").

134. AL Bulletin 3-5-98, Approval of Arbitration Agreements: Departmental Guidelines and Requirements (1998).

requirements, for both precontract disclosures[135] and the actual agreement.[136] The Guidelines are clearly more than interpretive rules, setting out substantive requirements which appear nowhere else in Alabama law. These guidelines are not law, and so cannot inversely preempt the FAA, for two reasons. First, the Guidelines apparently do not satisfy the procedural requirements for promulgation of rules in Alabama. The Alabama Insurance Code affords the Commissioner authority to make rules and regulations,[137] subject to public notice and hearing.[138] It does not appear that the required notification or hearings occurred.[139] Second, the Commissioner's statutory authority does not extend to promulgation of

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135. The application for any policy containing an arbitration provision must disclose the provision in at least 12 point type, capitalized and in bold print. Guidelines for Approval of Arbitration Provisions in Insurance Policies (on file with author). The application or a separate notice provided at the time of application must disclose that the policy contains a binding arbitration agreement; that the agreement means that disputes cannot be resolved by trial in a court of law and that there will be no judge or jury; that the arbitrator's decision is final and cannot be reviewed in court by a judge or jury. *Id.* This disclosure must be signed by the applicant. *Id.*

136. The arbitration provision itself must be in at least 12 point type, capitalized, and in bold print. Guidelines for Approval of Arbitration Provisions in Insurance Policies, copy on file with author. It must set forth or reference the rules which will govern the arbitration; state whether the arbitration award is subject to judicial review, and if so to what extent; provide that the insurer will pay the costs of arbitration (excluding the costs of an insured's representation); and specify that the arbitration will occur in the county of the policyholder's residence unless the parties agree otherwise. *Id.*

137. Alabama's Administrative Procedure Act excludes the Department of Insurance. ALA. CODE § 41-22-2 (2000) (setting out agency authority to prescribe rules and regulations) (providing that, "(e) All agencies whose rules or administrative decisions are subject to approval by the Supreme Court of Alabama and the Department of Insurance of the State of Alabama are exempted from the provisions of this chapter.") The Commissioner's authority to make rules and regulations appears in ALA. CODE § 27-2-17(a) (1998) ("The commissioner may make reasonable rules and regulations necessary for the effectuation of any provision of this title. No such rule or regulation shall extend, modify or conflict with any law of this state or the reasonable implications thereof.")

138. ALA. CODE §§ 27-2-17(b), (c) (1998) (subsection (b) requires a hearing in compliance with ALA. CODE § 27-2-29 (1998)); ALA. CODE § 27-2-29 (specifing notice of "not less than 10 days of the time, place and subject of the hearing, by publication in newspapers of general circulation for four weeks prior to the hearing.")

139. These Guidelines have been challenged for failure to comply with the statutory requirements. *See* Am. Gen. Life & Acc. Ins. Co. v. Smith, 4 F. Supp. 2d 1342, 1343-44 (M.D. Ala. 1998). The policyholder voluntarily dropped her state court action because her policy had lapsed. *Id.* However, the insurance company sought a ruling in federal district court. *Id.* The district court granted the policyholder's motion to dismiss, finding that the insurance company lacked standing since there was no longer a state court action and that the case was moot. *Id.*

rules or regulations which conflict with other state law.[140] The Guidelines violate Alabama Code section 8-1-41(3), which prohibits enforcement of all pre-dispute arbitration agreements, regardless of disclosure and other consumer-friendly characteristics.[141] The result is that any insurer whose policy form is disapproved for failure to comply with the Guidelines may successfully challenge their validity based on defective promulgation[142] or action outside the scope of the agency's authority, and the FAA will control.

Another failed departmental attempt to limit arbitration appears in a now-superseded Kansas Insurance Department Bulletin.[143] The Bulletin stated the Kansas Insurance Department's "belief," based on case law,[144] that the use of voluntary arbitration clauses in insurance contracts is permissible.[145] The Bulletin goes on to impose requirements for such clauses:

> If an insurance contract includes a provision for the arbitration of disputes, the language of the provision must clearly state that the procedure is voluntary and that both parties must mutually agree to the arbitration procedure. In addition, the language must clearly state whether the decision of the arbitrator is binding on the parties. The language stating that the arbitration procedure is voluntary and whether or not the decision of the arbitrator is binding must either be in bold print or underscored so that the insureds [sic] rights and responsibilities are highly visible.[146]

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140. ALA. CODE § 27-2-17(a) (1998) ("[N]o such rule or regulation . . . shall conflict with any law of this state.")

141. Any argument that ALA. CODE § 8-1-41(3) (2002) is not law should fail. Even though the FAA preempts ALA. CODE § 8-1-41(3) in virtually all instances (excluding only those instances in which the agreement does not "affect" interstate commerce), *see supra* text accompanying notes 9-18, there is still a scope of "local" operation for the provision. Furthermore, the scope of ALA. CODE § 8-1-41(3) could enlarge significantly if the United States Supreme Court reconsidered its interpretations of the FAA, for example, its application in state court, Southland. *See supra* text accompanying note 12.

142. ALA. CODE § 27-2-28(b) (1998) ("[T]he commissioner shall hold a hearing . . . upon written demand therefor by a person aggrieved by any act, threatened act or failure of the commissioner to act or by any report, rule, regulation or order of the commissioner"); ALA. CODE § 27-2-31, 32 (1998) (setting out procedures for the hearing and any appeal).

143. Kan. Ins. Dep't Bulletin 1998-3 (Feb. 3, 1998).

144. Referring to Friday v. Trinity Universal of Kan., 924 P.2d 1284 (Kan. Ct. App. 1996). Kan. Ins. Dep't Bulletin 1998-3 (1998).

145. Kan. Ins. Dep't Bulletin 1998-3 (1998).

146. *Id.*

These rules conflict with Kansas law, which provides:

> (b) Except as provided in subsection (c), a provision in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract. (c) The provisions of subsection (b) shall not apply to: (1) Contracts of insurance, except for those contracts between insurance companies, including reinsurance contracts . . . [147]

Accordingly, a subsequent Kansas Insurance Bulletin revoked the Department's earlier bulletin, finding upon subsequent review of *Friday* and of the Kansas statute that the Court approved only bilateral agreements to arbitrate an existing dispute.[148]

Agency policy statements concerning arbitration do not constitute "state law" for purposes of the McCarran-Ferguson Act. Courts have considered this issue in a few instances. In *Thrivent Financial for Lutherans v. Lakin*, the court concluded that Missouri's statutory prohibition on arbitration in insurance did not apply to fraternal benefit societies under Missouri law, which exempted such societies from all Missouri insurance laws.[149] Consequently, statements by the defendant Scott Lakin, director of the Missouri Department of Insurance, that the prohibition applied to fraternal benefit societies constituted only "a policy or opinion of defendant (not a state law)",[150] and could not inversely preempt the FAA.[151] Similarly, in *American Heritage Life Insurance v. Orr*, the court assumed that the McCarran-Ferguson Act barred application of the FAA to insurance contracts "only in the context of a *state statute* evincing the same, not mere policy statements of state officials or administrative rule interpretations of governmental entities."[152] The

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147. KAN. STAT. ANN. § 5-401 (2001). *See* discussion *supra* text accompanying notes 143-45.

148. Kan. Ins. Dep't Bulletin 2004-1 (March 3, 2004).

149. Thrivent Fin. for Lutherans v. Lakin, 322 F. Supp. 2d 1017 (W.D. Mo. 2004). Missouri's Fraternal Code exempts fraternal benefit societies from Missouri insurance law, except Chapters 378 (the Fraternal Code), 374 and 375, and any laws later enacted that are "expressly designated as applicable to fraternals." *Id.* at 1023. The prohibition on arbitration in insurance appears in Chapter 435. *Id.*

150. *Id.* at 1024.

151. *Id.*

152. Am. Heritage Life Ins. Co. v. Orr, 294 F.3d 702, 708 (5th Cir. 2002) (providing that where no Mississippi statute barred arbitration of insurance disputes, McCarran-Ferguson Act would not apply).

plaintiff's argument failed for two reasons. First, administrative policy is not the functional equivalent of state law within the meaning of the McCarran-Ferguson Act.[153] Second, the Commissioner of Insurance lacked authority to promulgate regulations because no Mississippi statute addressed the issue.[154]

3. Judicial Limitations on Arbitration in Insurance

It is unclear whether decisional law may inversely preempt the FAA through the McCarran-Ferguson Act. Decisional law is not "enacted" within the meaning of §1012(b) of the McCarran-Ferguson Act, either directly or pursuant to delegated authority. The legislative history of the McCarran-Ferguson Act does not stretch so far as to justify a different conclusion. Legislative materials include multiple references to state statutes, legislation, and regulation but no references to decisional law.[155] The now-familiar concept of judicial action as a means of regulating insurance developed much later.[156]

Very few courts have raised the issue. The Vermont Supreme Court concluded that state decisional law did not regulate insurance for purposes of inverse preemption,[157] the Fifth Circuit Court of Appeals in dicta suggested the opposite,[158] and the federal district court in the Southern District of Florida acknowledged the issue but did not decide it.[159] In

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153. *Id.* at 708-09.

154. *Id.* at 709.

155. This omission is not surprising since the McCarran-Ferguson Act predates the United States Supreme Court's preemption decisions addressing this question.

156. The seminal articles were Judge Keeton's. *See* Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970); Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions: Part Two*, 83 HARV. L. REV. 1281 (1970). Professor Abraham's work has also been influential. *See* Kenneth S. Abraham, *Interpretation or Regulation? Gaunt v. John Hancock Mutual Life Insurance Company*, 2 NEV. L.J. 312 (2002); Kenneth S. Abraham, *The Expectations Principle as a Regulative Ideal*, 5 CONN. INS. L.J. 59 (1998); Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981).

157. Little v. Allstate Ins. Co., 705 A.2d 538, 540 (Vt. 1997) (referring to Preziose v. Lumbermen's Mutual Cas. Co., 568 A.2d 397, 398-99 (Vt. 1989)).

158. Dehoyos v. Allstate Corp., 345 F.3d 290, 299 (5th Cir. 2003) (the court noted that there could be no inverse preemption absent a state law, and quoted the district court, "[D]efendants have not drawn the court's attention to any law, regulation, or *decision* in Texas or Florida requiring . . . [or] condoning the credit-scoring practice at issue here.") (emphasis added).

159. Mayard-Paul v. Mega Life & Health Ins. Co., No. 01CV3488, 2001 WL 1711519, at *3 (S.D. Fla. Dec. 21, 2001) (the court "need not reach the issue of whether

determining that state common law did not regulate insurance, the Vermont Supreme Court first reached the conclusion that the Vermont Arbitration Act's exemption of insurance policies[160] did not regulate insurance under the McCarran-Ferguson Act[161] but simply left issues relating to insurance arbitration to the common law. Second, the Vermont Supreme Court concluded that the general common law rule making arbitration agreements revocable up to the time of award was not a state law regulating the business of insurance for purposes of inverse preemption under the McCarran-Ferguson Act.[162]

The resolution of this question depends on close questions of statutory interpretation which the courts have not yet addressed and which cannot be discerned with any confidence from precedent. Although the United States Supreme Court's analysis of various express preemption provisions indicates the common law often constitutes state "law," preemption decisions have been highly dependent on the language and legislative history of the particular statute involved. It is unlikely that the McCarran-Ferguson Act will be found to permit inverse preemption of the FAA through decisional law. Although the language of the statute is open-ended in some circumstances, the central preemption clause provides: "No act of Congress shall be construed to invalidate, impair, or supersede any law *enacted* by any State for the purpose of regulating the business of insurance."[163] As the Supreme Court has recognized in a different context, "an enactment is the product of legislation, not adjudication."[164] Additionally, the text and legislative history of the McCarran-Ferguson Act

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McCarran-Ferguson operates to inversely preempt the FAA if it invalidates a state's case law, as opposed to statutory law.").

160. VT. STAT. ANN. tit. 12, § 5653(a) (2002).

161. Presumably because the Arbitration Act provides only that it does not apply to insurance contracts, without indicating the impact of the exemption. Some state statutes specifically provide further that arbitration agreements in insurance contracts are void. Several states have statutes structured like Vermont's; each of them which has considered the issue concluded that the statute renders such an agreement unenforceable. *See supra* text accompanying notes 68-71.

162. The court in *Little* reached the surprising conclusion that the Vermont statute which exempted insurance contracts from the Vermont Arbitration Act did not regulate insurance for purposes of inverse preemption under the McCarran-Ferguson Act. The effect of the statute is simply to permit state common law to control the arbitration of insurance disputes, and state common law did not constitute "law" under the McCarran-Ferguson Act. *See supra* text accompanying notes 68-71.

163. McCarran-Ferguson Act , 15 U.S.C. § 1012(b) (2005).

164. Branch v. Smith, 538 U.S. 254, 264 (2003) (determining that redistricting plan proposed by Mississippi State Chancery Court was not "enacted" within the meaning of the Voting Rights Act, 42 U.S.C. § 1973c).

indicate that it contemplated legislative action.[165] An argument for inverse preemption by case law based on the similarity of the language of McCarran-Ferguson and ERISA's saving clause, and the Supreme Court's ruling that California's common law notice-prejudice rule regulates insurance under ERISA's savings clause,[166] is also likely to fail. The language of the statutes is similar: ERISA saves from preemption "any law of any State which regulates insurance"; McCarran-Ferguson makes supreme "the laws of the several States which relate to the regulation or taxation of [the business of insurance]." However, in recent years, the Supreme Court has focused on the differences rather than the similarities between ERISA and McCarran-Ferguson, retreating from its use of the McCarran-Ferguson factors to determine whether a law was saved under ERISA § 144(b)(2)(A).[167]

CONCLUSION

Many decry the increasing prevalence of arbitration provisions in consumer contracts, but recognize that the FAA prevents general remedial action at the state level. However, a limited, specific remedy is possible: states may avoid the constraints of the FAA for insurance policies through inverse preemption under the McCarran-Ferguson Act. A number of state legislatures have done so by preventing mandatory insurance arbitration or by imposing significant limitations on the practice. State regulators, and possibly state judges, also have the power to take remedial action. State insurance regulators may clearly prevent or impose limits on arbitration through certain types of regulations, and judges may also have the power to do so through case law. Regulators have used their power under the McCarran-Ferguson Act sparingly, and inverse preemption of federal law through decisional law is as yet unexplored.

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165. The final clauses of § 1012(b) and the General Statement of the House Judiciary Committee, H.R. No. 143, February 13, 1945, contemplated that state legislatures would act during their 1945, 1946, and 1947 sessions to enact legislation to preclude federal intervention into state insurance regulation.

166. UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368-69 (1999) (California's common law notice-prejudice rule regulated insurance for purposes of ERISA's savings clause, § 1144(b)(2)(A)).

167. Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 339-40 (2003) (rejecting use of McCarran-Ferguson factors to determine whether state law "regulates insurance" under § 1144(b)(2)(A)).

THE POLITICS OF INFERTILITY: RECOGNIZING COVERAGE EXCLUSIONS AS DISCRIMINATION

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INTRODUCTION

Jane is infertile. When she sought treatment for her condition, she discovered that the health insurance provided through her work covered some treatments, but excluded surgical impregnation procedures such as the in vitro *fertilization procedure recommended by her doctor. Jane's infertility is recognized as a disability under federal law, and all of the excluded procedures are performed on women only.*

Infertility affects approximately ten percent of the reproductive-age population in the United States, and strikes people of every race, ethnicity and socio-economic level.[1] It is recognized by the medical community as a

1. *See generally* American Society for Reproductive Medicine, *Frequently Asked Questions About Infertility*, *at* http://www.asrm.org/Patients/faqs.html (last visited Aug. 21, 2004) [hereinafter ASRM, *Frequently Asked Questions*]; *See generally* RESOLVE, The National Infertility Association, *Coverage for Infertility*, *available at* http://www.resolve.org/main/national/advocacy/insurance/facts/coverage.jsp?name=advocacy &tag=insurance (last visited Apr. 9, 2005) [hereinafter RESOLVE, *Coverage for Infertility*] (According to the National Center for Health Statistics, approximately 5.4 million couples experience infertility every year); Elizabeth Hervey Stephen & Anjani Chandra, *Use of Infertility Services in the United States: 1995*, 32 FAM. PLANNING PERSP. 132 (May/June 2000) (surveyed population of fertility-impaired women similar to general population of women in terms of education, income, race and ethnicity). *But see* U.S CONG., OFFICE OF TECH. ASSESSMENT, INFERTILITY: MEDICAL AND SOCIAL CHOICES, OTA-

disease, one with devastating physical, psychological, and financial effects.[2] Nonetheless, comprehensive coverage of infertility treatments under employer-sponsored plans – where, like Jane, most Americans get health insurance[3] – appears to be the exception rather than the rule.[4] Can Jane sue for disability discrimination, sex discrimination, or both? While the answer – "it depends" – should not be surprising to anyone who has survived even a semester of law school, the facts upon which the answer depends are increasingly surprising. Why is Jane infertile? If she went ahead with the uncovered treatment, was it successful? Is Jane's plan insured or funded by her employer? When was the exclusion established? Does the plan treat male infertility more frequently than female infertility? And is Jane married? Underlying these factual and doctrinal issues is the deeper question, should Jane be able to state a claim of discrimination? In other words, why should the exclusion of treatments for infertility such as in Jane's plan be recognized as sex discrimination, disability discrimination, or both? This Article seeks to explore these questions.

In the last few years, the federal courts have issued important decisions under Title VII of the Civil Rights Act of 1964[5] ("Title VII") including the Pregnancy Discrimination Act,[6] ("PDA") and the Americans with Disabilities Act of 1990[7] ("ADA") regarding insurance coverage of treatments or conditions associated with sex and disability. Notably, the Supreme Court held in the 1998 case *Bragdon v. Abbott*[8] that reproduction is a major life activity within the meaning of the ADA. Many lawyers,

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BA-358 (Washington D.C. U.S. Government Printing Office, May 1988) *available at* http://www.wws.princeton.edu/cgi-bin/byteserv.pr1/~ota/disk2/1988/8822/8822.PDF (noting that one and one-half times more married African-American women are infertile than married white women) [hereinafter INFERTILITY].

2. *See infra* notes 14-33 and accompanying text.

3. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 2001, *available at* www.census.gov/hhes/hlthins/hlthin01/hlth01asc.html (last visited Apr. 9, 2004) (In 2001 62.6% of workers and their families were covered by employer-sponsored health plans.); RUSSELL C. COILE, JR., FUTURESCAN, A FORECAST OF HEALTHCARE TRENDS 2002-2006 11 (2002) ("Employer-sponsored health insurance covers approximately 165 million, or 65 percent of working Americans.").

4. Amicus Curiae Brief of the American Society for Reproductive Medicine at 11-12, Saks v. Franklin Covey, 316 F.3d 337 (2d Cir. 2003), available at 2001 WL 34113555 (C.A.2) [hereinafter ASRM Amicus Brief]; *see also* Shorge Sato, *A Little Bit Disabled: Infertility and the Americans with Disabilities Act*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 189, 197 (2001).

5. 42 U.S.C. § 2000e (1964).

6. 42 U.S.C. § 2000e(k) (1978).

7. 42 U.S.C. §§ 12101-12213 (Supp. V 1993).

8. 524 U.S. 624, 641-42 (1998)

activists and scholars thought that coverage for infertility treatment would follow soon after *Bragdon.*[9] However, in 2003, in the first major case applying *Bragdon* to health benefits, *Saks v. Franklin Covey*,[10] the Second Circuit held that an employer's health plan could exclude coverage for infertility procedures performed on women only without violating Title VII or the ADA.

The decision in *Saks* was a disappointment to many, particularly after the successful use of Title VII to challenge a health plan exclusion of prescription contraceptives in *Erickson v. Bartell Drug Company*[11] in 2001. But *Saks* did not shut the door on using Title VII or the ADA to challenge an employer's exclusion of infertility treatment from its plan. Although the ADA has received more scholarly attention in this context,[12] the decisions of the trial and appellate court illustrate the relative weakness of the ADA as a tool to challenge discrimination in the content of employer health plans because of its "equal access" test, which requires only facial neutrality, and its broad "safe harbor" provision. The decisions also illustrate that Title VII can offer significant advantages over the ADA for purposes of challenging the exclusion of infertility treatment because a facially neutral policy that simply permits equal access to the same set of benefits for male and female employees is not sufficient. Instead, employers providing coverage must provide equally comprehensive coverage for both sexes, and the additional cost of offering non-discriminatory benefits, if any, is not a defense. Although the court in *Saks* concluded that the employer's plan could lawfully exclude coverage for infertility procedures performed on women only without violating Title VII or the ADA, this Article explains how other courts could analyze claims under Title VII differently, and

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9. *See* Jane Gross, *The Fight to Cover Infertility; Suit Says Employer's Refusal to Pay is Form of Bias*, N.Y. TIMES, Dec. 7, 1998, at B1 (reporting opinions of Mark G. Sokoloff, Ms. Saks's attorney, and an anonymous EEOC official regarding the impact of *Bragdon* on employer health plan exclusion of infertility treatment); Sato, *supra* note 4, at 189-90 ("Many thought mandatory insurance coverage for infertility was a "slam dunk" after *Bradgon* held that reproduction was a major life activity as defined by the ADA.")

10. 316 F.3d 337, 345-46 (2d Cir. 2003) [hereinafter Saks II].

11. 141 F. Supp. 1266, 1277 (W.D.Wash. 2001).

12. *See, e.g.,* Kimberly Horvath, *Does Bragdon v. Abbott Provide the Missing Link for Infertile Couples Seeking Protection Under the ADA?*, 2 DEPAUL J. HEALTH CARE L. 819, 829 (1997-1999); John E. Estes, *Employee Benefits or Employer "Subterfuge": The Americans with Disabilities Act's Prohibition Against Discrimination in Health Plans*, 12 N.Y.L. SCH. J. HUM. RTS. 85 (1994); Dion A. Sullivan, *ERISA, the ADA, and AIDS: Fixing Self-Insured Health Plans with Carparts*, 7 MD. J. CONTEMP LEGAL ISSUES 423, 436 (1996); Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers Under the ADA and ERISA*, 35 TORT & INS. L. J. 117 (1999).

provides a roadmap of alternative legal and factual analyses for Title VII and ADA claims that could be successfully adopted in other cases.

Of course, notwithstanding the ability of a plaintiff to state cognizable claims under civil rights laws, requiring plans to provide comprehensive (or at least non-discriminatory) coverage of treatments for infertility is a controversial issue. Opponents of legislative or judicially mandated infertility coverage commonly argue that reproduction is simply a "lifestyle choice," and that increased coverage will further increase rising health care costs. When examined critically, however, these arguments fail to justify the pattern of exclusions. Indeed, infertility is still seen as a "woman's issue," it is not a "lifestyle choice," and the costs of comprehensive coverage for treatment of infertility (in particular coverage of *in vitro* fertilization) appear overstated. Moreover, appropriately comprehensive coverage of treatment for infertility may lead to better, more humane and cost-effective treatment.

In support of these conclusions, Part I of this Article provides a brief overview of the disease of infertility, medical treatments of infertility, and the cost of such treatments. Part II provides an overview of the important but limited protections under federal and state law against discrimination in benefits focusing on Title VII, the ADA and the Employee Retirement Income Security Act of 1974[13] ("ERISA"). Against this backdrop, Part III closely examines the decisions of the trial and appellate courts in *Saks,* and the rejection of plaintiff's challenges to the exclusion of certain infertility treatments under the ADA, Title VII, PDA and state law. Part IV provides a roadmap of alternative legal and factual analyses for Title VII and ADA claims that could be successfully pursued by future plaintiffs. Finally, Part V critically examines the policy arguments commonly raised in opposition to coverage, including reproduction as a "lifestyle choice" and the fear of increased health care costs, and concludes that public policy strongly supports comprehensive coverage of infertility.

I. THE PROBLEM OF INFERTILITY

Infertility is defined by the medical community as "a disease or condition of the reproductive system often diagnosed after a couple has had one year of unprotected, well-timed intercourse, or if the woman has suffered from multiple miscarriages."[14] The American Society of

13. 29 U.S.C. §§ 1001-1461 (2002).

14. RESOLVE, The National Infertility Association, *Frequently Asked Questions About Infertility, at* http://www.resolve.org/main/national/trying/whatis/faq.jsp?name=&tage=whatis

Reproductive Medicine ("ASRM") estimates that infertility affects approximately ten percent of the reproductive-age population in the United States, or over 6 million people.[15] The disease of infertility strikes people of every race, ethnicity and socio-economic level,[16] and more than one million Americans seek treatment for infertility every year.[17]

The devastating emotional effects of the disease of infertility are well documented.[18] Facing the potential or actual loss of the ability to conceive or carry a child, people diagnosed with infertility experience grief, anguish, despair, and isolation. Many report that dealing with infertility is "the most upsetting experience of their lives."[19] Indeed, in one widely cited study, researchers found that women living with infertility experienced levels of depression comparable to patients living with terminal diseases like cancer.[20]

(last visited Apr. 9, 2005) [hereinafter RESOLVE, *Frequently Asked Questions*]. *See also* ASRM, *Frequently Asked Questions, supra* note 1 ("a disease of the reproductive system that impairs the body's ability to perform the basic function of reproduction"); MERCK RESEARCH LAB, MERCK MANUAL OF MEDICAL INFORMATION § 22, at ch. 254 (2d ed. 2003) *available at* http://www.merck.com/mmhe/sec22/ch254/ch245a.html (last visited Apr. 9, 2005) ("the inability of a couple to achieve a pregnancy after repeated intercourse without contraception for 1 year"). There is also secondary infertility, defined as the inability to become pregnant, or to carry a pregnancy to term after the birth of one or more biological children. RESOLVE reports that over three million Americans experience secondary infertility. RESOLVE: The National Infertility Association, *Secondary Infertility*, at http://www.resolve.org/main/national/treatment/diagnosis (last visited Apr. 4, 2005).

15. ASRM, *Frequently Asked Questions*, *supra* note 1. According to the National Center for Health Statistics, approximately 5.4 million couples experience infertility every year. RESOLVE, *Coverage for Infertility*, *supra* note 1.

16. *See* Horvath, *supra* note 12, at 820.

17. RESOLVE & DIANE ARONSON, RESOLVING INFERTILITY: UNDERSTANDING THE OPTIONS AND CHOOSING SOLUTIONS WHEN YOU WANT TO HAVE A BABY 3 (1999) [hereinafter RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS].

18. *See generally* ASRM, *Frequently Asked Questions*, *supra* note 1; Katherine T. Pratt, *Inconceivable? Deducting the Costs of Fertility Treatment*, 89 CORNELL L. REV. 1121, 1126-30 (2004) (summarizing reports and research regarding the extreme emotional distress caused by infertility). Moreover, the negative effects of infertility may be long-lasting. *See* Ann Lalos et al., *The Psychosocial Impact of Infertility Two Years After Completed Surgical Treatment*, 64 ACTA OBSTET. GYNECOL. SCAND. 599, 599 (1985) ("The negative emotional and social effects of infertility were pronounced both before and 2 years after the surgical treatment."); INFERTILITY *supra* note 1, at 119-35.

19. Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48, 50 (1985) (noting that 49% of women and 15% of men being treated for infertility described the experience with this language).

20. Alice D. Domar et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1161-62 (1992) (noting that the researchers were

A. MEDICAL TREATMENTS FOR INFERTILITY

The medical diagnosis "infertility" encompasses a wide range of causes and conditions. According to the ASRM, male factors and female factors each account for about a third of infertility cases, and a combination of male and female factors account for another ten percent of cases.[21] In the remaining cases – around twenty percent – the infertility is unexplained.[22] Male factors include no or low sperm production, blocked passage of sperm, problems with ejaculation, or immunological disorders that prevent the sperm from penetrating the egg.[23] Female factors include ovulation disorders, blocked fallopian tubes, or structural problems or disorders of the uterus or cervix.[24] In both cases, the causes may result from a variety of factors, including: congenital defects; hormonal imbalances; genetic disorders; environmental factors; or previous illness, infection or surgery. In addition, fertility rates for women gradually decline during the thirties, and sharply decline after the age of forty.[25] Male fertility rates also decline with age.[26]

Given the range of factors that may contribute to a diagnosis of infertility, infertility can be treated in a variety of ways.[27] Treatment can include: advice and information regarding the reproductive cycle and process; drug therapies such as clomiphene and gonadtropins to regulate ovulation and to return female or male hormones to normal levels;[28] surgery for treatment of female structural problems, such as laparoscopy to repair or remove blockages from the fallopian tubes,[29] or male structural problems such as varicocele surgery to correct varicose veins;[30] intrauterine

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not surprised to find that the "infertile women had higher depression scores than control women").

21. ASRM, *Frequently Asked Questions*, *supra* note 1.

22. *Id.*

23. *Id.*

24. *Id.*

25. *See* Horvath, *supra* note 12, at 821.

26. *Id.*

27. For a more detailed discussion of causes of infertility and treatment options, *see* INFERTILITY *supra* note 1, at 117-32.

28. Bonny Gilbert, *Infertility and the ADA: Health Insurance Coverage for Infertility Treatment*, 63 DEF. COUNS. J. 42 (1996).

29. *Id.* Other surgically correctable female structural problems include endometriosis, tubal blockage, the presence of fibroid tumors, DES, Asherman's Syndrome and Sdenomyosis. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

30. Gilbert, *supra* note 28. Other surgically correctable male structural problems and obstructions partially or totally block the flow of sperm, seminal fluid or both. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

insemination (also called artificial insemination); and assisted reproductive technologies such as *in vitro* fertilization (IVF).[31]

The vast majority of cases of infertility – 85 to 90 percent – are resolved with conventional medical treatment such as drugs or surgery.[32] For the small percentage of cases not resolved through these means, assisted reproductive technologies may be appropriate. Intrauterine insemination is a relatively simple, non-surgical procedure in which prepared sperm from a partner or donor is brought closer to the ova through insertion into the woman's uterus during her ovulatory phase.[33] IVF is a more complicated process in which the ova are removed from the woman's body by laproscopy, fertilized with semen from her partner or a donor, incubated in a laboratory dish until an embryo develops, and then transferred to the woman's uterus.[34]

B. THE COSTS OF INFERTILITY TREATMENTS

Given the range of treatments, the cost of medical treatment for infertility varies greatly.[35] For example, advice and information costs no more than a general office visit. The cost of clomiphene, a drug commonly prescribed to women to induce regular ovulation, may be $50 for one month.[36] Surgery to repair blocked fallopian tubes typically costs between $10,000 and $15,000, and surgery to repair varicocele typically

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31. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

32. ASRM, *Frequently Asked Questions*, *supra* note 1. *See also* Stephen & Chandra, *supra* note 1, at 134 (Of the surveyed women who received treatment for infertility, the most common services provided were advice, diagnostic tests, medical help to prevent miscarriage, and drugs to induce ovulation. Fewer than 13% used intrauterine insemination, and fewer than 2% used assisted reproductive technologies such as IVF).

33. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 17.

34. RESOLVE, The National Infertility Association, *Intrauterine Insemination*, *available at* http://www.resolve.org/main/national/treatment/options. Related assisted reproductive technologies include gamete intra fallopian transfer (GIFT), in which the retrieved ova are immediately combined with the sperm and inserted into the fallopian tube during the laprascopy, and zygote intra fallopian transfer (ZIFT), in which the fertilized ova is transferred into the fallopian tubes at the zygote, rather than the embryonic, stage of development. *Id.* at *Assisted Reproductive Technology* (ART), available at http://www.resolve.org/main/national/treatment/options.

35. *See* Pratt, *supra* note 18, at 1135 (discussing costs of various treatments).

36. RESOLVE, UNDERSTANDING YOUR TREATMENT OPTIONS, *supra* note 1 *available at* http://www.resovle.org/main/national/treatment/options/medications (based on estimate of $10 per pill, taken for five consecutive days); INFERTILITY *supra* note 1, at 141 (based on 1986 data, average monthly cost of clomiphene is $30).

costs $5,000 to $8,000.[37] Repeated surgeries may be required to resolve the infertility.[38]

The assisted reproductive technologies used in the small percentage of cases not resolved through drug therapy or surgeries also vary widely in cost. Intrauterine insemination is relatively inexpensive, usually costing "a few hundred dollars."[39] Estimates for IVF range from $8,000 to $10,000 per procedure,[40] and patients often undergo multiple procedures.[41] As these figures show, although IVF is commonly thought to be the "big ticket item" in the treatment of infertility, surgery is often as expensive, and in some cases is more expensive.[42] In fact, according to one widely-cited estimate, assisted reproductive technologies such as IVF "account for only three hundredths of one percent (0.03%) of U.S. healthcare costs." [43]

II. PROTECTIONS AGAINST DISCRIMINATION IN BENEFITS

If an employer[44] elects to offer a health care benefit plan to its employees, the content of coverage must comply with applicable federal

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37. Pratt, *supra* note 18; INFERTILITY *supra* note 1, at 142 (based on 1986 data, average total cost of tubal surgery is $7,118).

38. *See* Pratt, *supra* note 18, at 1137 ("where insurance covers tubal surgeries but not IVF, a woman with blocked fallopian tubes may have several tubal ligation surgeries to attempt to repair her tubes, instead of bypassing the tubes with IVF"); INFERTILITY *supra* note 1, at 143.

39. Pratt, *supra* note 18 at 1135; *See also* INFERTILITY *supra* note 1, at 141 (based on 1986 data, average cost of intrauterine insemination is $50 to $100).

40. P.J. Neuman et al., *The Cost of a Successful Delivery with In Vitro Fertilization*, 331 NEW ENG. J. OF MED. 239, 239-43 (1994) (calculating average cost of IVF as $8,000 per cycle); Adam Sonfield, *Drive for Insurance Coverage of Infertility Raises Questions of Equity, Cost,* 2 THE GUTTMACHER REPORT (Oct. 1999) *available at* http://www.guttmacher.org/pubs/tgr/02/5/gr020504.pdf (last visited Apr. 9, 2005) (IVF costs $10,000 per attempt); ASRM, *Frequently Asked Questions*, *supra* note 1 (the average cost of IVF in the U.S. is $12,400).

41. According to a report published by the CDC and ASRM, 32.8% ART cycles reported in 2001 resulted in a clinical pregnancy, and 82.2% of those pregnancies resulted in a live birth. *See* CENTER FOR DISEASE CONTROL, *2001 Assisted Reproduction Technology Success Rates: National Summary and Fertility Clinic Reports* (Dec. 2003) available at http://www.cdc.gov. *See also* INFERTILITY *supra* note 1, at 293 (reporting that based on 1986 data, 15-20% of IVF treatments performed by expert clinics resulted in a live birth).

42. *See* Bradley J. Van Voohris *et al., Cost Effectiveness of Infertility Treatments: A Cohort Study*, 67 FERTILITY & STERILITY 830, 835 (May 1997) (comparing total cost per delivery, IVF is more cost effective than surgery for women with blocked fallopian tubes).

43. ASRM, *Frequently Asked Questions*, *supra* note 1.

44. This Article refers to plans as sponsored by a single employer, although a plan may also be sponsored by an employee organization, or jointly by multiple employers or employee organizations under ERISA. *See* 29 USCS § 1002(B) (2005).

laws, including Title VII and the ADA.[45] Although the protections offered by civil rights law in this area are important, they are limited.[46] Nor, as scholars have noted,[47] are state law mandates requiring coverage of certain conditions or treatments likely to lead to uniform results because of the preemption provisions of ERISA.

A. TITLE VII AND SEX-BASED DISCRIMINATION

Title VII of the Civil Rights Act of 1964 prohibits employment practices that "discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex or national origin."[48] In 1978, the PDA amended Title VII to clarify that discrimination "because of sex" included discrimination "because of or on the basis of pregnancy, childbirth, or related medical conditions."[49]

Employment benefits include health care benefits.[50] If an employer elects to offer a health care benefit, it has a legal obligation to make sure that the plan does not discriminate based on sex-based characteristics and that it provides equally comprehensive coverage for both sexes.[51] Under

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45. *See, e.g.*, Equal Employment Opportunity Comm'n, DECISION ON COVERAGE OF CONTRACEPTION (Dec. 14, 2000), *available at* http://www.eeoc.gov/policy/docs/decision-contraception.html ("ERISA preempts certain *state* laws that regulate insurance but explicitly exempts federal law from preemption . . . [T]he fact that ERISA does not require health plans to 'provide specific benefits' does not mean that other statutes – namely Title VII – do not impose such requirements where necessary to avoid or correct discrimination.").

46. Other civil rights laws also apply to employer health plans. *See* Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes' Applicability to Health Insurance*, 23 CARDOZO L. REV. 1315, 1318 (2002) (characterizing the protections offered by federal law, including Title VII, the ADA, the Equal Pay Act, the ADEA and HIPAA, the area of health insurance as containing "significant gaps and loopholes").

47. *See, e.g., id.*; Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 491-92 (1998); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 352-61 (1997).

48. 42 U.S.C. § 2000e-2(a)(1) (2000).

49 Act of Oct. 31, 1978, Pub. L. 95-555, 92 Stat. 2076 (codified as amended at 42 U.S.C. § 2000e(k) (2000)).

50. Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 682 (1983); *See also* 29 C.F.R. § 1604.9 (2004) (prohibiting discrimination with regard to fringe benefits, including medical, hospital, accident, life insurance and retirement benefits, as compensation).

51. *Erickson*, 141 F. Supp. 2d at 1272 (citation omitted).

the PDA, an otherwise inclusive plan that singles out pregnancy-related benefits for exclusion is discriminatory.[52] The additional cost of offering non-discriminatory benefits, if any, is not a defense.[53]

A plaintiff may pursue a claim of discrimination under Title VII under either a theory of disparate treatment or of disparate impact.[54] A plaintiff alleging disparate treatment must show that her employer intentionally treated her differently than other employees because of her sex.[55] For example, an employee who alleges that her employer's plan paid infertility benefits for male employees, but not for female employees, states a claim of disparate treatment under Title VII.[56] The landmark case of *Erickson v. Bartell Drug Company,*[57] decided in 2001, provides another example. In that case, plaintiffs claimed that their employer's policy of excluding coverage for prescription contraception from an "otherwise comprehensive"[58] health plan constituted sex discrimination under Title VII. In granting plaintiffs' motion for summary judgment on their claim of disparate treatment, the Court held that Title VII requires employers to recognize the differences between the sexes and provide equally comprehensive health coverage, even if that means providing additional benefits to cover expenses incurred only by women.[59] Relying in part on

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52. *See Newport News*, 462 U.S. 669, 683-85.

53. Los Angeles Dep't. of Water & Power v. Manhart, 435 U.S. 702, 716-17 (1978).

54. *See* Int'l Bhd. Of Teamsters v. U.S., 431 U.S. 324, 335-36 n.15 (1977). A plaintiff alleging disparate treatment must show that her employer intentionally treated her differently than other employees because of her sex. *See, e.g.,* McDonnell Douglas Corp. v. Green, 411 U.S. 792 at 802-03 (1973) (discussing prima facie case of disparate treatment). A plaintiff alleging disparate treatment must show that a facially neutral employment practice "in fact fall[s] more harshly on one group than another and cannot be justified by business necessity," and need not prove discriminatory intent. *See Int'l Bhd. of Teamsters*, 431 U.S. at 335-36 n.15 (1977). There is also a third theory, sexual harassment, which includes both quid pro quo and hostile work environment sexual harassment. *See* Meritor Sav. Bank, FSB v. Vinson, 477 U.S. 57 (1986).

55. *See, e.g., McDonnell Douglas*, 411 U.S. at 792 (discussing prima facie case of disparate treatment).

56. Such a plaintiff may also state a claim under both the PDA and the ADA. *See* Bielicki v. City of Chicago, No. 97 C 1471, 1997 WL 260595, at *3 (N.D. Ill. May 8, 1977); *see also* Cooley v. Daimler Chrysler, 281 F. Supp. 2d 979, 988 (E.D. Mo. 2003) (denying motion to dismiss female plaintiff's action alleging that the exclusion of prescription contraceptives constituted disparate treatment under Title VII).

57. 141 F. Supp. 2d. 1266 (W.D. Wash. 2001).

58. The court noted that the plan excluded only a handful of products, including contraceptive devices, drugs prescribed for weight reduction, infertility drugs, smoking cessation drugs, dermatologicals for cosmetic purposes, growth hormones, and experimental drugs. *Id.* at 1268 n.1.

59. Of course, it has not been established that coverage of prescription contraceptives would represent a significant additional cost. Indeed, one widely cited figure states that it

the PDA,[60] the Court held that "[m]ale and female employees have different, sex-based disability and healthcare needs, and the law is no longer blind to the fact that only women can get pregnant, bear children, or use prescription contraception."[61] Indeed, the special or increased health care needs associated with a woman's unique sex-based characteristics must be met to the same extent, and on the same terms, as other healthcare needs.[62]

A plaintiff alleging disparate impact must show that a facially neutral employment practice "in fact fall[s] more harshly on one group than another and cannot be justified by business necessity," and need not prove discriminatory intent.[63] Some courts appear reluctant to rule on disparate impact claims in the context of health care coverage. For example, in *Erickson*, plaintiffs asserted claims of disparate treatment and disparate impact. The Court granted the employer's motion for summary judgment on the disparate treatment theory only, and did not address the disparate impact claim.[64]

B. THE ADA AND DISABILITY-BASED DISCRIMINATION

Over 25 years after the enactment of Title VII, the ADA was enacted to "provide clear, strong, consistent, [and] enforceable standards [for] ending discrimination against individuals with disabilities," and to bring such individuals into the economic and social mainstream of American life.[65] The ADA prohibits an employer from discriminating on the basis of

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only costs an employer $1.43 per employee per month to add full contraceptive benefits to a health plan. *See, e.g.,* James Trussell, *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH, 494 (Apr. 1995).

60. The Court did not base its holding solely on the PDA, however. It also held that "regardless of whether the prevention of pregnancy falls within the phrase 'pregnancy, childbirth, or related medical conditions,' Congress' decisive overruling of *General Electric Co. v. Gilbert* [in the PDA] . . . evidences an interpretation of Title VII which necessarily precludes the choices Bartell has made in this case." *Erickson*, 141 F. Supp. 2d at 1274.

61. *Id.* at 1271.

62. *Id.*

63. *See Int'l Bhd. of Teamsters*, 431 U.S. at 335-36 n.15.

64. *Erickson*, 141 F. Supp. 2d at 1277. Similarly, the Court in *Saks* acknowledged that Ms. Saks's allegation of disparate impact was properly raised, but that it failed on the facts as she did not show that female employees were more adversely affected by the exclusion of fertility treatments than male employees. *Saks II*, 316 F.3d at 347 n.5 (plaintiff's disparate impact claim fails because she did not show that female participants were more adversely affected by the exclusion of fertility treatments than male participants); *see also* Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 680 (8th Cir. 1996), *abrogated on other grounds by* Bragdon v. Abbott, 524 U.S. at 644.

disability against a qualified individual with a disability[66] in regard to fringe benefits including participation in an employer-sponsored health insurance plan.[67] Employers can be liable for disability-based discriminatory benefits they provide themselves, as well as benefits that they contract with third-parties (such as plan administrators and insurance companies) to provide.[68]

As with Title VII, an ADA plaintiff can pursue a claim of employment discrimination based on disparate treatment or disparate impact.[69] In the context of cases alleging discrimination in benefits, disparate treatment theory is more commonly used.[70] A plaintiff alleging disparate treatment in this context must show that she, a qualified individual with a disability, did not have equal access to benefits.[71]

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65. 42 U.S.C. §§ 12101(b) (2000). The ADA reaches beyond employment, and into public services, public transportation, public accommodations and telecommunications. *See* 42 U.S.C. § 2000e (2000).

66. *See infra,* notes 104-107 and accompanying text for a definition of "disability" within the meaning of the ADA; *see also* 42 U.S.C. § 12102(2) (2000).

67. *See* 29 C.F.R § 1630.4(f) (stating that an employer may not discriminate on the basis of disability with respect to "[f]ringe benefits available by virtue of employment, whether or not administered by the "employer]"); EQUAL EMPLOYMENT OPPORTUNITY COMM'N, EEOC INTERIM GUIDANCE ON APPLICATION OF ADA TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (June 8, 1993), *available at* http://www.eeoc.gov/policy/docs/health.html [hereinafter EEOC Interim Guidance] ("[e]mployee benefit plans, including health insurance plans provided by an employer to its employees, are a fringe benefit available by virtue of employment. Generally speaking, therefore, the ADA prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees"); Parker v. Metro Life Ins. Co., 121 F.3d 1006, 1014-15 (6th Cir. 1997) (citing these sources and collecting cases).

68. *See* 42 U.S.C. § 12112(b) (2000). *See also* Anderson v. Gus Mayer Boston Store, 924 F. Supp. 763, 781 (E.D. Tex. 1996); EEOC Interim Guidance, *supra* note 67.

69. *See* Raytheon Co. v. Hernandez, 540 U.S. 44, 55 (2003) (recognizing disparate treatment and disparate impact claims under the ADA). Disability-based harassment is also a cognizable claim. Flowers v. S. Reg'l Physicians Servs,, Inc., 286 F.3d 798 (5th Cir. 2002) (recognizing disability-based harassment claim under the ADA).

70. Bonnie Poitras Tucker, *Health Care and the Americans with Disabilities Act: Access to Health Care for Individuals with Hearing Impairments*, 37 HOUS. L. REV. 1101 (2000) ("In the context of insurance coverage, however, disparate impact analysis cannot be utilized."); Daniel A. Engel, *The ADA and Life, Health, and Disability Insurance: Where is the Liability?*, 33 TORT & INS. L. J. 227, 236 (1997) ("The ADA prohibits under a disparate impact analysis conduct that, although facially neutral, has an adverse discriminatory effect on employment. However, Section 501(c) eliminated to a large degree the disparate impact analysis as it relates to the setting of coverage under ERISA plans.").

71. *Saks II*, 316 F.3d at 343; *See also* EQUAL EMPLOYMENT OPPORTUNITY COMM'N, A TECHNICAL ASSISTANCE MANUAL ON THE EMPLOYMENT PROVISIONS (TITLE I) OF THE AMERICANS WITH DISABILITY ACT, § 7.9-7.12 (1992).

"Equal access" is measured in two ways. First, the challenged distinction must be based on a disability as defined by the ADA. According to the EEOC, a distinction is disability-based if it singles out a particular disability, a discrete group of disabilities or disability in general for different treatment.[72] However, courts have generally recognized that the ADA does not require an employer to offer health plan benefits that provide the same level of benefits for all disabilities.[73] For example, several courts have held that an employer may offer a disability insurance policy that caps benefits for mental, but not physical, disabilities without running afoul of the ADA.[74]

Second, even if the distinction is disability-based, it may still be permissible if it falls within the ADA's "safe harbor" clause. Specifically, this clause provides that the ADA shall not be construed to prohibit or restrict "establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law . . . or that [are] not subject to State laws that regulate insurance."[75] As this language suggests and the regulations make clear:

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72. EEOC Interim Guidance, *supra* note 67.

73. Although an employer may draw disability-based distinctions in coverage, it may not simply deny coverage based on a disability. *Anderson*, 924 F. Supp. at 781. An employee of a small business was diagnosed with AIDS, a disability within the meaning of the ADA. When his condition was revealed to his employer's group health insurer, the premiums were raised and the employer sought a different group insurer. The new insurer excluded individuals with AIDS from participation in their plans. The court found "that if an employer switches to a group health insurer that categorically denies coverage to an employee with a disability because of that disability (here, AIDS), the employer has violated the ADA because it has not provided equal access to insurance for disabled and non-disabled employees.

74. *See Parker*, 121 F.3d at 1008; Ford v. Schering-Plough Corp., 145 F.3d 601 (3rd Cir. 1998); Kimber v. Thiokol Corp., 196 F.3d 1092, 1101 (10th Cir. 1999); Lewis v. Kmart, 180 F.3d 166 (4th Cir. 1999); *but see* Johnson v. K-Mart, 273 F.3d 1056 (11th Cir. 2001).

75 Specifically, the statute provides that the ADA shall not be construed to prohibit or restrict the following:

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

> the ADA is not intended to disrupt the current regulatory structure for self-insured employers or disrupt the current nature of insurance underwriting, or current insurance industry practices in sales underwriting, pricing, administrative and other services, claims and similar insurance-related activities based on classifications of risks as regulated by the states.[76]

As this section suggests, the funding of the plan makes a difference. Bona fide,[77] ERISA-regulated insured plans with disability-based distinctions will be protected by the safe harbor if the plan's sponsor can show that the distinction is actuarially justified, and is based on permissible classification of risks. Plans can also be self-funded, meaning that the employer assumes all or part of the risk of paying for the benefits instead of purchasing a health care coverage policy from an insurance company.[78] In contrast to insured plans, self-funded plans will be upheld—whether or not they are based on sound actuarial analyses—unless the distinctions can be shown to be subterfuge for discrimination.[79]

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(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

42 U.S.C. § 12201(c) (2000); 29 C.F.R. §1630.16(f) (2004).

76. 29 C.F.R. 1630.16(f).

77. Under the Age Discrimination in Employee Act ("ADEA"), a "bona fide" plan has been defined as one that exists and pays benefits. *See, e.g.*, United Air Lines v. McMann, 434 U.S. 192, 194 (1977); Pub. Employees Ret. Sys. v. Betts, 492 U.S. 158, 161 (1989). Several courts have adopted that definition for purposes of the ADA, as well. *See, e.g.* Fitts v. Fed. Nat'l Mortg. Ass'n, 236 F.3d 1, 3 (D.C.C. 2001); EEOC v. Aramark Corp., 208 F.3d 266, 269 (D.C.C. 2000); Piquard v. City of East Peoria, 887 F. Supp. 1106 (C.D.Ill. 1995).

78. *See* 27 AM. JUR. 2d *Employment Relationship* § 109 (2002); The Kaiser Family Foundation, *Employer Health Benefits 2003 Annual Survey*, 127 *available at* http://www.kff.org/insurance/upload/20672_1.pdf (last visited Apr. 9, 2005); Employee Benefits Research Institute, *EBRI Health Benefits Databook* 91 (1999) (comparing self-funded and insured plans). Self-funded plans are sometimes referred to as "self-insured" plans, although there is no insurance policy involved. A plan can also be partially self-funded, meaning that the employer bears the risk up to some stop-loss threshold, after which an insurer bears or shares the risk for additional claims. Gail A. Jensen & Jon R. Gabel, *The Erosion of Purchased Insurance*, 25 INQUIRY 328, 329 (1988) ("Jensen & Gabel, *The Erosion of Purchased Insurance*").

79. 42 U.S.C. § 12201(c) ("Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter I and III of this chapter."); Jensen & Gabel, *The Erosion of Purchased Insurance* at 329; *see also Saks II,* 316 F.3d at 341; Leonard v. Israel Discount Bank of N.Y., 199 F.3d 99, 104 (2d Cir. 1999); Henzel v. Del. Otsego Corp., 285 F. Supp. 2d 271, 279 (N.D.N.Y. 2003).

C. ERISA PREEMPTION AND STATE LAW MANDATES

ERISA was intended to encourage the formation of pension and welfare benefits plans, and to protect employees' rights within such plans by "establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts."[80] Although aimed primarily at pension benefits, ERISA also regulates employer-sponsored welfare benefit plans, such as health benefits.[81]

In recent terms, the Supreme Court has repeatedly turned its attention toward ERISA and the scope of its preemption provisions.[82] Although, generally, ERISA does not require that any employer provide a health care benefit plan, nor does it govern the content of a health care benefit plan in the event an employer elects to offer one,[83] the structure and interpretation

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80. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987) (quoting 29 U.S.C. § 1001(b)); *see also* Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) (quoting 29 U.S.C. § 1001(b)).

81. 29 U.S.C. § 1002 (2000); 29 U.S.C. § 1001.

82. *See, e.g., Davila*, 542 U.S. 200 (Plaintiffs' causes of action under Texas Health Care Liability Act completely preempted by ERISA § 502); Kentucky Ass'n of Health Plans Inc. v. Miller, 538 U.S. 329 (2003) (Kentucky's "any willing provider law" not preempted by ERISA); Rush Prudential HMO Inc. v. Moran, 536 U.S. 335 (2002) (Illinois law requiring independent medical review of benefit denials based on medical necessity considerations not preempted by ERISA); Egelhoff v. Egelhoff, 532 U.S. 141 (2001) (Washington law automatically revoking designation of spouse of beneficiary upon divorce preempted by ERISA); UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999) (California's notice-prejudice rule not preempted by ERISA). The Court also decided Pegram v. Herdrich, 530 U.S. 211 (2000), in which it held that mixed eligibility-treatment decisions by HMOS are not fiduciary acts within the meaning of ERISA. *Pegram* has been cited for its distinction between eligibility and treatment decisions in preemption cases involving medical malpractice and negligence claims against managed care organizations. *See, e.g.* Cicio v. Vytra Healthcare, 321 F.3d 83, 100-05 (2d Cir. 2003); Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 272 (3d Cir. 2001).

83. *See* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 668 (1995) (noting that ERISA does not require employer to provide any given set of minimum benefits); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983) (noting that "ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits."). There have been specific amendments to ERISA aimed at requiring coverage for specific conditions or treatments. For example, ERISA has been amended to require that health care benefit plans include coverage for post-delivery hospital stays, *see* 29 U.S.C. § 1185 (2000), and to require coverage for certain post-mastectomy treatment and care, including reconstruction, *see* 29 U.S.C. § 1185b (2000). Similarly, ERISA could be amended to provide coverage for infertility treatments to some degree, or to treat such coverage equitably in light of other covered treatments and conditions. Indeed, The Family Building Act of 2003 introduced in the House of Representatives in September of last year, would require all health plans –

of ERISA's express preemption provisions[84] created increasingly inconsistent results for the content of ERISA-regulated health care plans.

1. State Laws that "Relate to" a Plan are Preempted

In an attempt to create uniform administration of employee benefit plans,[85] ERISA contains a broad preemption clause that preempts state law insofar as it "relates to" employee benefit plans, and ERISA provides the exclusive remedial scheme for claims relating to employee benefit plans.[86] Although initially given an expansive interpretation,[87] the Supreme Court narrowed the reach of the preemption clause in a 1995 case, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, in which it held that a state law relates to an ERISA plan if it specifically refers to ERISA plans, mandates employee benefits structures or their

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including ERISA-regulated plans – that cover obstetrical benefits to cover infertility treatments as well. H.R. 3014, 108th Cong. (2003). The Act would also amend ERISA so that it would not preempt state laws that provide greater infertility-related benefits, thus ensuring that self-funded plans would be required to provide the coverage under either state or federal law. H.R. 3014 (2003) (proposed amendment at Sec. Sec 714(a), incorporating amendment to Public Health Service Act, including preemption section, by reference)). To date, attempts to enact the Act into law have failed. For an analysis of these and other similar targeted reforms of ERISA in health care reform, see Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 506 (1998).

84. This article focuses on ERISA's express preemption provisions in Section 514. ERISA also provides for complete preemption under Section 502(a) with respect to claims for benefits due under a plan, to enforce rights under a plan, or to clarify future rights under the terms of a plan, 29 U.S.C. § 1132(a)(1)(B) (2000). *See Travelers*, 514 U.S. at 654. For examples of conflict preemption analysis under ERISA, see *Davila*, 542 U.S. 200 (Plaintiffs' causes of action under Texas Health Care Liability Act completely preempted because they duplicate, supplement or supplant ERISA's list of exclusive remedies); Boggs v. Boggs, 520 U.S. 833, 874 (1997) (Louisiana community property law that allowed the spouse of a participant to designate a beneficiary of ERISA-regulated survivor annuity preempted under traditional conflict preemption analysis because it directly conflicted with ERISA's anti-alienation protections).

85. *See, e.g., Aetna*, 542 U.S. 200 (2004) ("the purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *Travelers*, 514 U.S. at 657 ("the basic thrust of the preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans").

86. ERISA § 502; 29 U.S.C. § 1132 (2000). Specifically, the "preemption clause" provides "[e]xcept as provided in [the savings clause]. . .[ERISA shall] supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514; 29 U.S.C. § 1144 (2000).

87. *See, e.g., Pilot Life Ins. Co.*, 481 U.S. 41, 47 (1987) (a state law relates to an employee benefit plan for purposes of ERISA preemption if it has a connection with or reference to such a plan).

administration, or provides alternative enforcement mechanisms for ERISA rights.[88]

At least fifteen states have enacted some type of infertility insurance coverage law requiring insurers to offer or to cover certain infertility treatments.[89] In the context of an action for health plan benefits, such state law mandates would be preempted (at least initially) by ERISA's broad preemption clause because they "relate to" a benefit plan.

2. State Laws that "Regulate Insurance" are Saved

The second part of ERISA's preemption analysis, the "savings clause," saves specific state laws regulating insurance, banking and securities law from preemption.[90] In order to escape preemption, the state law must be "specifically directed toward" insurance, and not simply a law of general application that has some bearing upon insurers.[91] In defining the regulation of insurance for the purpose of this clause, courts traditionally applied a "common sense view," and then looked to three factors developed under the McCarran-Ferguson Act:[92] (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the

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88. 514 U.S. 645, 668 (1995) (holding that a New York law requiring hospitals to collect surcharge from patients covered by a commercial insurer but not from patients covered by a Blue Cross/Blue Shield plan was not preempted by ERISA because the law did not "relate to" employee benefit plans within the meaning of ERISA's preemption clause).

89. A state law mandating offer of coverage requires insurance companies to offer a policy with infertility coverage, but does not require employers to select or pay for such coverage. A state law mandating coverage requires insurance companies to include infertility coverage in every policy offered. *Compare* CONN. GEN. STAT. § 38a-536 (1989) (requires health insurance organizations to offer coverage for the medically necessary expenses of the diagnosis and treatment of infertility, including IVF) *with* ARK. CODE. ANN. §§ 23-85-137, 23-86-118 (1987) (requires health insurance companies to cover the expenses of IVF procedures). *See* National Conference of State Legislatures, *50 States Summary of Legislation Related To Insurance Coverage for Infertility Therapy*, June 2004 (summarizes state infertility insurance coverage laws) *available at* http://www.ncsl.org/programs/health/50infert.htm.

90. Employee Retirement Income Security Act, 29 U.S.C. § 1144(b)(2)(A) (2002).

91. *Miller*, 538 U.S. at 334 (collected case law).

92. 15 U.S.C. § 1012(b). As noted in *Rush Prudential*, "The McCarran-Ferguson Act requires that the business of insurance be subject to state regulation, and, subject to certain exceptions mandates that "[n]o Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance ...." 536 U.S. 355, 366 n.4 (2002).

insurance industry.[93] For example, in the 1986 case *Metropolitan Life v. Massachusetts,* the Supreme Court held that a Massachusetts statute mandating minimum mental health care benefits in health insurance policies was a statute regulating insurance, and therefore was saved from preemption.[94]

In a 2003 case, *Kentucky Association of Health Plans v. Miller*,[95] a unanimous Supreme Court made a "clean break" from the McCarran-Ferguson Act factors, and held that a state law "regulates insurance" for purposes of ERISA if it: (1) is "specifically directed toward entities engaged in insurance"; and (2) substantially affects the risk pooling arrangement between the insurer and the insured.[96] This new test broadened the reach of the savings clause, and will likely save more state laws directed at insurance and insurance practices from preemption.[97] Although the results of the Court's holding in *Miller* in this respect remain to be seen, in the context of an ERISA benefits-due action, state laws mandating benefits will continue to be saved from preemption under this clause as state laws regulating insurance.[98]

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93. *See, e.g.,* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 743 (1985) (citing Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982)); *Rush Prudential*, 536 U.S. 365, 373.

94. 471 U.S. 724, 758 (1985).

95. 538 U.S. at 324.

96. *Id.* at 343.

97. The Supreme Court in *Miller* broadened the reach of the savings clause, and may save more state laws directed at insurance and insurance practices from preemption. Specifically, the Court held that "entities engaged in insurance" includes insurers, self-funded plans, and parties providing administrative services to self-funded plans. *Id.* at 337 n.1. The Court explained, "ERISA's savings clause does not require that a state law regulate 'insurance *companies*' or even '*the business of insurance*' to be saved from preemption; it need only be a 'law . . . which regulates *insurance*,' and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan." *Id.* With regard to the second requirement, the Court found that the state law merely had to substantially affect the risk pooling arrangement, and did not have to actually spread risk or change the terms of the insurance policy. *Id.* at 338. On the facts, the Court found that Kentucky's law met the first requirement because it was directed at HMOs in their capacities as both insurers and administrative service providers. *Id.* at 337 n.1. The Court found that the second requirement was met because Kentucky's law "substantially affected the bargain between insurers and insureds . . . [b]y expanding the number of providers from whom an insured may receive health services." *Id.* at 338.

98. *See, e.g.,* Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (Massachusetts law mandating coverage of certain mental health benefits saved from ERISA preemption under savings clause); *see also* Macro v. Indep. Health Ass'n, 180 F. Supp.2d 427, 436 (W.D.N.Y. 2001) (New York law prohibiting insurers from denying

3. The Exception for Self-Funded Plans

The third and final part of ERISA's preemption analysis is the "deemer clause," which provides that self-funded employee welfare plans cannot be deemed insurance plans for purposes of preemption analysis.[99] Because self-funded plans cannot be deemed insurance plans, specific state laws directed at insurance generally are not saved with respect to self-funded plans, and self-funded plans have not been considered subject to specific state regulation.[100]

In the context of state laws mandating coverage of a certain treatment or condition, it is well documented that this exemption leads to dramatically different results because such laws apply to insured plans, but not to self-funded plans.[101]

III. THE FIRST APPLICATION OF *BRAGDON* TO BENEFITS

In the last few years, the federal courts have issued important civil rights decisions regarding insurance coverage of treatments or conditions associated with sex and disability.[102] The lower court's decision in *Saks*

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coverage for correctable medical conditions resulting in infertility or based on infertility saved from ERISA preemption under savings clause).

99. ERISA § 514(b)(2)(B); 29 U.S.C. § 1144(b)(2)(B).

100. *See id*; FMC Corp. v. Holliday, 498 U.S. 52, 63 (1990) (interpreting deemer clause broadly to exempt self-funded plan ERISA-regulated plans from state regulation and state law claims).

101. Of course, this effect is not limited to state laws mandating benefits. As authors have noted, the deemer clause exempts self-funded plans from a variety of other state laws, as well. Jon R. Gabel et al., *Marketwatch: Self-Insurance in Times of Growing and Retreating Managed Care*, HEALTH AFF. (Mar./Apr. 2003) [hereinafter *Self-Insurance*] (noting that the deemer clause exempts self-funded plans from a range of state law regulations including "state financial reserve requirements to minimize the risk of insolvency; state imposed premium taxes to finance state guaranty funds to pay claims of insolvent plans; state charges to finance high risk pools that provide coverage of uninsurable people; various consumer protection laws, or state insurance reforms intended to minimize harsh medical underwriting.") For a discussion of the regulation of self-insured plans, including stop-loss plans, *see generally* Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615 (1995); Kenneth M. Coughlin, *Filling the Gaps in Stop-Loss Insurance*, BUS. & HEALTH, Sept. 1992; Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 275-77 (1997); Dennis K. Schaeffer, *Insuring the Protection of ERISA Plan Participants: ERISA Preemption and the Federal Government's Duty To Regulate Self-Insured Health Plans*, 47 BUFF. L. REV. 1085, 1108 (1999).

102. *See, e.g., Saks II*, 316 F.3d 337 (2003); *Erickson*, 141 F. Supp. 2d 1266 (2001).

garnered attention because it was the first to apply the Supreme Court's decision in *Bragdon* recognizing reproduction as a major life activity under the ADA to infertility.[103] However, in *Saks* the Second Circuit held that an employer's health plan could lawfully exclude coverage for infertility procedures that were only performed on women without violating Title VII or the ADA. What happened?

A. THE *BRAGDON* DECISION

In contrast to Title VII's prohibition against discrimination "because of [...] sex" which protects both men and women,[104] the ADA protects only a narrowly defined group of individuals who meet the statutory definition of "disabled." "Disability" is defined as having: "a physical or mental impairment that substantially limits one or more major life activities"; or "a record of such impairment"; or "being regarded as having such an impairment regardless of whether the individual actually has the impairment."[105] A major life activity is "substantially limit[ed]" if the individual is unable to perform a major life activity that the average person in the general population can perform, or is significantly restricted as to the condition, manner, or duration under which he or she can perform the activity, as compared to the general population.[106] Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.[107]

In 1996 the Eight Circuit held in *Krauel v. Iowa Methodist Medical Center* that the ADA's list of major life activities should not be expanded.[108] In *Krauel*, an employee brought an action against her employer under both the ADA and the PDA challenging the exclusion of coverage for infertility treatment under the employer's health plan.[109] On appeal from summary judgment for the employer, the employee argued that her undisputed impairment of infertility affected the major life activities of reproduction and caring for others.[110] The Eighth Circuit agreed that the employee's infertility was a physical impairment that prevented her from

103. 524 U.S. 624 (1998).
104. *Newport News*, 462 U.S. at 682.
105. 42 U.S.C. § 12102(2).
106. 29 C.F.R.§ 1630.2(j).
107. 29 C.F.R. § 1630.2(i).
108. 95 F.3d 674, 677 (8th Cir. 1996).
109. *Id.* at 675.
110. *Id.* at 676-77.

becoming pregnant naturally.[111] It declined, however, to expand the non-exclusive list of major life activities, and thus held that the impairment did not substantially affect any recognized major life activity.[112]

Prior to *Krauel*, at least two district courts had found that reproduction was a major life activity within the meaning of the ADA.[113] Two years later and in a different context, the Supreme Court in *Bragdon v. Abbott*[114] settled the question and held that reproduction is major life activity. In *Bragdon*, an HIV-positive patient sued her dentist under the ADA for his refusal to treat her in his office. The Supreme Court first established that her HIV-positive status was an impairment that substantially limited her ability to reproduce because of the risk to her partner and child.[115] Rejecting the petitioner's arguments that medication may significantly lower the risk of transmission at birth, the Court noted, "[i]t cannot be said as a matter of law that an 8% risk of transmission a dread and fatal disease to one's child does not represent a substantial limitation on reproduction [...] The Act addresses substantial limitations on major life activities, not utter inabilities."[116] The Court then held that reproduction is a major life activity within the meaning of the ADA, because "[r]eproduction and the sexual dynamics surrounding it are central to the life process itself."[117]

B. APPLYING *BRAGDON* TO BENEFITS: THE *SAKS* DECISION

Many lawyers, activists and scholars thought that coverage for infertility treatment would follow soon after the Supreme Court's decision in *Bragdon* recognizing reproduction as a major life activity within the meaning of the ADA.[118] However, in the first major case applying

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111. *Id.* at 677.

112. *Id.* ("Although Krauel is unable to conceive without medical intervention, she has the ability to care for herself, perform manual tasks, walk, see, hear, speak, breathe, learn, and work. It is undisputed that her infertility in no way prevented her from performing her full job duties as a respiratory therapist.")

113. Erickson v. Bd. of Governors, 911 F. Supp. 316, 323 (N.D. Ill. 1995); Pacourek v. Inland Steel Co., 916 F. Supp. 797 (N.D. Ill. 1996); *but see* Zatarain v. WDSU-Television Inc., 881 F. Supp. 240, 243 (E.D.La. 1995).

114. 524 U.S. 624 (1998).

115. *Id.* at 639-40.

116. *Id.* at 641.

117. *Id.* at 638.

118. *See* Gross, *supra* note 9 (reporting opinions of Mark G. Sokoloff, Ms. Saks's attorney, and an anonymous EEOC official regarding the impact of *Bragdon* on employer health plan exclusion of infertility treatment); Sato, *supra* note 4 at 220 ("Many thought mandatory insurance coverage for infertility was a "slam dunk" after *Bradgon* held that reproduction was a major life activity as defined by the ADA.").

Bragdon to health benefits, *Saks*, the Second Circuit held that an employer's health plan could lawfully exclude coverage for infertility procedures performed solely on women without violating Title VII or the ADA.

1. The District Court Decision

Rochelle Saks's self-funded ERISA-regulated health plan (the "Plan") denied coverage for surgical impregnation procedures for infertility. The plan covered a variety of infertility products and procedures including "ovulation kits, oral fertility drugs, penile prosthetic implants (when certified by a physician to be medically necessary), and nearly all surgical infertility treatments."[119] The Plan excluded "surgical impregnation procedures, including artificial insemination, IVF or embryo and fetal implants," regardless of medical necessity.[120]

In the course of her treatment, Saks used several covered products and processes, and also underwent intrauterine insemination procedures and two cycles of IVF. She became pregnant three times during the course of treatment, but all three pregnancies ended in miscarriage. Her employer refused coverage of the intrauterine insemination and IVF procedures, as well as the related office visits and drug and monitoring expenses, on the basis that they were expressly excluded from coverage as surgical impregnation procedures.[121] After receiving a probable cause determination from the EEOC,[122] Saks filed an action against her employer in the United States District Court for the Southern District of New York, alleging that the Plan's exclusion of infertility treatments that can only be performed on women – artificial insemination, IVF, and *in utero*

119. *Saks II*, 316 F.3d at 341.

120. *Id.*

121. *Saks II*, 117 F. Supp. 2d at 322-23. Her employer, through a third-party administrator, initially also refused coverage for pregnancy and miscarriage-related expenses after her first miscarriage. Ms. Saks's internal appeal of that denial was successful. *Id.*

122. An employee alleging employment discrimination under the ADA must pursue an administrative claim with the EEOC prior to filing suit. 42 U.S.C. § 2000e-5(e). The EEOC may investigate the claim to determine whether there is "reasonable cause to believe that an unlawful employment practice has occurred or is occurring." 29 C.F.R. § 1601.24 (2003). If it finds reasonable cause and the matter cannot be resolved with the employer, the EEOC may issue a "determination that reasonable cause exists to believe that an unlawful employment practice has occurred or is occurring," which allows plaintiff to proceed with a lawsuit. *Id.* § 1601.21; *see also* § 1601.19.

insemination – violated Title VII, the PDA, the ADA and New York law.[123] The district court granted the employer's motion for summary judgment on all claims.

a. *The Title VII Claim*

The district court held that the Plan did not violate Title VII because men and women receive the same benefits and are subject to the same exclusions under the plan -- both men and women have "equal access" to certain types of infertility treatments, and neither men nor women may receive benefits for other types of infertility treatment. The district court explained, "[i]t is no answer to say that the excluded treatments can only be performed on women, because male employees can claim infertility-related benefits for treatment performed on their wives – and are, conversely, precluded from obtaining benefits for surgical impregnation of their wives."[124]

Similarly, the district court held that infertility is a "pregnancy related condition" covered by the PDA under *Int'l Union, UAW v. Johnson Controls*,[125] but that the Plan did not violate the PDA because it provides equal coverage for male and female employees who suffer from infertility.[126]

b. *The ADA Claim*

The district court held that although infertility is a disability within the meaning of the ADA under *Bragdon*, the plan's exclusion of certain infertility treatments performed on women only did not violate the ADA because the plan offered the same insurance coverage to fertile and infertile employees.

The court also found that the Plan was not covered by the ADA because it was a bona fide, ERISA-regulated and self-funded plan within the ADA's "safe harbor" provision described above. Finding that "[t]he only self-insured plans that fall outside the ADA's safe harbor are those that are used as a subterfuge to evade the purposes of the statute," the court held that because the exclusion for surgical impregnation procedures pre-

123. *Saks II*, 117 F. Supp.2d at 320. Ms. Saks's state law claims were for breach of contract and violation of New York Executive Law § 296 prohibiting discrimination in employment. *Id.*

124. *Saks II*, 117 F. Supp. 2d at 328.

125. 499 U.S. 187 (1991).

126. *Saks II*, 117 F. Supp. 2d at 329.

dated the effective date of the ADA, it could not be considered a subterfuge as a matter of law.[127]

c. *ERISA and the State Law Claims*

Ms. Saks also raised claims of breach of contract and violation of New York Human Rights law. The district court granted summary judgment on these state law claims as preempted by ERISA, notwithstanding the employer's failure to timely raise ERISA preemption as a defense in its answer.[128]

2. The Appellate Court Opinion

Ms. Saks appealed from the grant of summary judgment on all but the ADA claim. On appeal, the Second Circuit affirmed the decision of the district court, but on different grounds.

a. *The Title VII Claim*

The appellate court first clarified that the district court's use of the "equal access" standard under Title VII was incorrect. The issue was not equal access to a single set of benefits, but whether the set of benefits provided equitable coverage to women and men. In the words of the court, the "proper inquiry in reviewing a sex discrimination challenge to a health benefits plan is whether sex-specific conditions exist, and if so, whether exclusion of benefits for those conditions results in a plan that provides inferior coverage to one sex."[129]

Applying this standard, the appellate court found that "[a]lthough the surgical procedures are performed only on women, the need for the procedures may be traced to male, female, or couple infertility with equal frequency. Thus, surgical impregnation procedures may be recommended regardless of the gender of the ill patient."[130] Thus, the court reasoned,

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127. *Id.* at 327-38.

128. *Id.* at 330.

129. Saks v. Franklin Covey Co., 316 F.3d 344 (2nd Cir. 2003) (citing *Newport News*, 462 U.S. at 676). Although it found that the district court did not rely on it, the appellate court also rejected the "couple analysis" (a female-specific exclusion does not constitute sex discrimination so long as male and female employees and their respective partners received the same health benefits when considered as a couple), noting the court must focus on the male and female employees, not the benefits offered to the "couple." *Saks*, 316 F.3d at 344-45.

130. *Id.* at 347.

because exclusion of surgical implantation procedures disadvantages male and female employees equally, the plan does not discriminate on the basis of sex.

In contrast to the district court, the appellate court held that infertility is not a "pregnancy related condition" under the plain meaning of Title VII as modified by the PDA and *Johnson Controls*, which addresses "childbearing capacity," but not "fertility alone." It reasoned that for a condition to fall within the PDA's inclusion of "pregnancy . . . and related medical conditions"[131] as a sex-based characteristic, it must be unique to women. Infertility is a medical condition that afflicts men and women with equal frequency, and the exclusion of surgical implantation procedures disadvantages male and female employees equally. Thus, an infertility-based distinction is not a sex-based distinction prohibited by Title VII.

b. *ERISA and the State Law Claims*

The Second Circuit held that ERISA preemption in a benefits-due action is a waivable affirmative defense, and must be timely raised in the answer.[132] Notwithstanding the employer's failure to raise ERISA preemption in its answer, the court remanded the case to the district court to determine whether the defendant's motion for summary judgment should be construed as a motion to amend the answer, and, if so, to rule on that motion.[133]

IV. FUTURE CHALLENGES TO THE EXCLUSION OF INFERTILITY TREATMENT

The decision in *Saks II* was a disappointment to many, particularly after the successful use of Title VII to challenge a health plan exclusion in

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131. *Id.* at 345-46.

132. *Id.* at 349-50.

133. *Id.* at 350-51. The court held that although the defendant failed to raise the affirmative defense of ERISA preemption in its answer, "a district court may still entertain affirmative defenses at the summary judgment stage in the absence of undue prejudice to the plaintiff, bad faith or dilatory motive on the part of the defendant, futility, or undue delay of the proceedings," and that under "such circumstances, the district court may construe the motion for summary judgment as a motion to amend the defendant's answer." *Id.* It seems likely that if the district court construes the employer's motion for summary judgment as a request to amend its answer to raise ERISA preemption, then the remaining state law contract claim will be preempted. As of the time this Article was completed, no further action had been reported on the remanded case.

Erickson.[134] But *Saks II* did not shut the door on using Title VII to challenge an employer's exclusion of infertility treatment from its plan, as other courts could analyze claims under Title VII differently. In addition, *Saks* and other cases suggest that seemingly small changes in the facts could lead to different results under Title VII and the ADA. Returning to the example of Jane introduced at the beginning of this Article, this section outlines the types of challenges to the exclusion of infertility treatment that plaintiffs may pursue with success in the wake of *Saks II*.

A. TITLE VII CLAIMS

Title VII offers significant advantages over the ADA for purposes of challenging the exclusion of infertility treatment. As discussed in Section II.A. above, a facially neutral policy that simply permits equal access to the same set of benefits for male and female employees will not pass muster under Title VII. Instead, employers providing coverage must provide equally comprehensive coverage for both sexes, and the additional cost of offering non-discriminatory benefits, if any, is not a defense. [135]

1. Disparate Impact: Gender Patterns in Coverage

After receiving the insurance plan's decision to deny coverage, Jane spoke to some of her coworkers about the situation, and learned that several others had requested and received coverage of infertility treatments. The stories that she heard suggest that the plan covered treatment of infertility attributable to male factors more frequently than infertility attributable to female factors.

If true, does this matter? The Second Circuit's opinion in *Saks II* suggests that Jane could state a disparate impact claim based on her plan's claim history. It held that "the Plan's exclusion of surgical impregnation procedures does not provide male employees with more comprehensive coverage of infertility treatments than female employees because the surgical procedures in question are used to treat both male and female infertility."[136] However, it also noted:

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134. *Erickson*, 141 F. Supp. 2d at 1266.

135. *See supra* notes 48 to 64 and accompanying text.

136. *Saks II*, 316 F.3d at 347.

> Saks has not offered any evidence from which a reasonable jury could conclude that the surgical impregnation procedures required for the treatment of male infertility differ from those required for the treatment of female infertility, or, more importantly, that male infertility is more frequently treated by other (Plan-approved) means than is female infertility.[137]

Accordingly, a plaintiff who can show that her plan has covered treatment of male infertility more frequently than female infertility may state a claim under Title VII. Specifically, she may be able to show that her plan more frequently treats male factors such as no or low sperm production, blocked passage of sperm, problems with ejaculation, or immunological disorders that prevent the sperm from penetrating the egg, than female factors such as ovulation disorders, blocked fallopian tubes, or structural problems or disorders of the uterus or cervix.[138]

2. Disparate Impact: Women and Infertility

After receiving the insurance plan's decision to deny coverage, Jane's feelings of rage, grief and depression at the perceived loss of a chance to conceive, deliver and raise a child intensify. She joins a support group for people struggling with the disease of infertility. Of the fifteen members of the support group, only two are men.

Although the Second Circuit recognized that gender patterns in a plan's claim history could support a claim of disparate impact on women, it failed to recognize how a plan's failure to provide comprehensive coverage for treatment of infertility disparately impacts women.

As discussed in the first section of this Article, infertility is recognized by the medical community as a disease with devastating emotional effects. The Second Circuit found that the specific cause of infertility could be "traced to male, female, or couple infertility with equal frequency," and

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137. *Id.* at 347 n.5.

138. *See supra* notes 21 to 31 and accompanying text. *See also* Coverage of Reproductive Technologies Under Employer-Sponsored Health Care Plans: Proceedings of the 2004 Annual Meeting, Association of American Law Schools, Joint Program of Sections on Employee Benefits and Employment Discrimination, 8 EMPLOYEE RIGHTS & EMP. POL'Y J. 2, 8 (2004) (comments of Professor Helen L. Norton, noting the potential for this type of claim). Conversely, a male plaintiff may also state a claim if he can show his plan has covered treatment of female infertility more frequently than male infertility.

thus exclusion of surgical impregnation procedures performed on women disadvantaged male and female employees equally. What the Second Circuit did not consider is the significant evidence suggesting that the emotional and physical toll of infertility disproportionately affects women.[139]

One recent survey of the literature on gender differences in psychological reactions to infertility concluded that in comparison to infertile men, infertile women report: a higher degree of anxiety, depression, and loss of self-esteem; lower sexual and marital adjustment;

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139. *See, e.g.*, SUSAN LEWIS COOPER & ELLEN SARASOHN GLAZER, CHOOSING ASSISTED REPRODUCTION: SOCIAL, EMOTIONAL AND ETHICAL CONSIDERATIONS 18 (1998) ("The observation that women and men experience infertility in different ways is something that has long been known by infertile couples and their caregivers. . . [In studies] [w]omen have been found to experience significantly more psychological distress than do their partners, especially in the areas of depression, anxiety, cognitive disturbance and hostility."); Anna Hjelmstedt et al., *Gender Differences in Psychological Reactions to Infertility Among Couples Seeking IVF- and ICSI-Treatment*, 78 ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 42, 44-46 (1999) (noting the different psychological impact infertility has on women and men); John Wright et al., *Psychosocial Distress and Infertility: Men and Women Respond Differently*, 55 FERTILITY & STERILITY 100 (1991) ("Consistent with previous research, infertile women showed higher distress than their partners on a global measure of psychiatric symptoms and subscales of anxiety, depression, hostility, and cognitive disturbances, as well as on measured of stress and self-esteem."); Frank M. Andrews et al., *Stress from Infertility, Marriage Factors, and Subjective Well-Being of Wives and Husbands*, 32 J.HEALTH & SOC. BEHAV., 238, 238 (1991) (finding that "negative effects on life quality are stronger for wives than for husbands"); Christopher R. Newton et al., *Psychological Assessment and Follow-Up After In Vitro Fertilization: Assessing the Impact of Failure*, 54 FERTILITY & STERILITY 879, 879 (1990) (after a failed cycle of IVF, women and men showed significant increases in anxiety and depressive symptoms, and prevalence of mild and moderate depression increased substantially, particularly among women); Ellen W. Freeman et al., *Psychological Evaluation and Support in a Program of In Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48, 50 (1985) (noting that 49% of women and 15% of men being treatment for infertility described the experience as the "most upsetting experience in their lives"); Ann Lalos et al., *A Psychosocial Characterization of Infertile Couples for Surgical Treatment of the Female*, 4 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 83, 83 (1985) (a Swedish study finding that infertility has severe emotional and social effects, and that women openly admitted more symptoms such as grief, depression guilt, feelings of inferiority and isolation that their male partners). *But see* Robert D. Nachtigall et al., *The Effects of Gender-Specific Diagnosis on Men's and Women's Response to Infertility*, 57 FERTILITY & STERILITY 113, 113 (1992) (finding significant differences in the emotional response to infertility between women and men, and noting that men's response more closely approximates that of women if the infertility has been attributed to a male factor); Aila Collins et al., *Perceptions of Infertility and Treatment Stress in Females as Compared with Males entering In Vitro Fertilization Treatment*, 92 FERTILITY & STERILITY 350, 350 (1992) (although women reported more stress entering into IVF treatment, the men appeared to be as psychologically affected by infertility as women).

and more feelings of guilt, inferiority and isolation. [140] The authors also noted that "[t]he negative effects of infertility on quality of life have been shown to be stronger for infertile women compared to infertile men."[141] While there could be many reasons for the disparity in reactions to infertility between women and men,[142] the evidence certainly suggests that the disease of infertility, in particular its psychological effects, disproportionately affects women.

Women may also experience distinct and disparate health effects as a result of infertility. For example, according to the National Cancer Institute, women who have never been pregnant have a greater risk of developing endometrial[143] or ovarian cancer,[144] while women who have more than one child have a decreased risk of developing breast cancer.[145] Another recent study suggests that breast-feeding after childbirth may reduce a woman's risk of developing rheumatoid arthritis.[146]

Accordingly, if a plaintiff musters the literature to support her claim that infertility disproportionately affects women in terms of emotional health, physical health, or both, she could then argue that the exclusion of certain treatments for infertility has a disparate impact on female employees that should be recognized under Title VII.

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140. *See generally* Hjelmstedt et al., *supra* note 139 (reviewing the literature); *See also* Domar et al., *supra* note 20 (reporting that infertile women being treated by an infertility specialist experience twice the prevalence of depression than healthy women).

141. Hjelmstedt et al., *supra* note 139, at 42.

142. *Id.* (women may be more likely to report greater feelings of anxiety, men may have different coping mechanisms, etc.). *See also* Nachtigall et al., *supra* note 139 (finding significant differences in the emotional response to infertility between women and men, and noting that men's response more closely approximates that of women if the infertility has been attributed to a male factor).

143. National Cancer Institute, U.S. National Institutes of Health, *Ovarian Cancer (PDQ®): Prevention, available at* http://www.cancer.gov/cancertopics/pdq/prevention/ovarian/Patient/page2 (last visited Apr. 9, 2005).

144. National Cancer Institute, U.S. National Institutes of Health, *Endometrial Cancer (PDQ®): Prevention, available at* http://www.cancer.gov/cancertopics/pdq/prevention/ovarian/Patient/page2 (last visited Apr. 9, 2005).

145. National Cancer Institute, U.S. National Institutes of Health, *Pregnancy and Breast Cancer Risk, at* http://cis.nci.nih.gov/fact/3_77.htm (last visited Apr. 9, 2005).

146. Elizabeth W. Karlson et al., *Do Breast-feeding and other Reproductive Factors Influence Future Risk of Rheumatoid Arthritis?: Results from the Nurses' Health Study*, 50 ARTHRITIS & RHEUMATISM 3458, 3458-67 (2004) (finding that women who breastfeed have a lower risk of developing rheumatoid arthritis).

3. Employee's Marital Status

Jane is seeking treatment for infertility because she and her partner, Julia, wish to raise a child together. In the alternative, Jane is single and heterosexual, and wishes to have a child.

Regardless of her sexual orientation, does Jane's marital status affect the scope of her protection under Title VII? Jane may be able to state a disparate impact claim based on the lingering "couple analysis." The appellate court in *Saks II* found that because exclusion of surgical implantation procedures disadvantages male and female employees equally, the plan does not discriminate on the basis of sex.[147] In so holding, it explicitly rejected the lower court's "couple analysis," under which a female-specific exclusion would not constitute sex discrimination so long as male and female employees and their respective partners received the same health benefits when considered as a couple.[148] The appellate court explained that the lower court had misapplied the Supreme Court's holding in *Newport News:*

> The [Supreme Court], therefore, focused on whether male and female employees received equal coverage under their health benefits packages. It did not hold, as Franklin Covey seems to suggest, that an across-the-board female–specific exclusion would pass muster under Title VII or the ADA, so long as all couples received the same benefits.[149]

However, the appellate court appeared to endorse another form of "couple analysis" in evaluating the level of coverage for male and female employees: "in the instant case, we engaged in a couple analysis to the extent that we evaluate whether the exclusion of surgical impregnation procedures results in less comprehensive benefits for female employees."[150]

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147. *Saks II*, 316 F.3d at 347.

148. *Id.* at 344. As an illustration of the district court's analysis, imagine that the Jane introduced at the beginning of the Article has a coworker, John, who is married and seeking coverage of infertility treatment for himself, his wife, or both. Jane and John's plan excludes infertility treatments performed on women only. Under the district court's analysis, the plan is not discriminatory because both Jane and John are denied coverage of the same treatments performed on women -- Jane is denied coverage for treatments performed on herself, and John is denied coverage for treatments performed on his wife.

149. *Id.* at 344-45 (citations omitted).

150. *Id.* at 345 n.2 (citations omitted). As the focus is on the employee, the spouse-beneficiary may not have standing to raise a Title VII claim. *See generally* Nicol v.

The appellate court went on to hold that Franklin Covey's plan did not violate Title VII because it did not result in a less comprehensive benefit package for female employees.[151]

The problem with the Second Circuit's analysis is that it still assumes a couple. Indeed, the court even suggested how this "couple analysis" might be exploited:

> With respect to unmarried employees, the Plan would appear to cover only those infertility treatments that are required to treat the infertility of the employee, not the employee's partner, and that are performed directly on the employee himself or herself. Hence, in these circumstances, by excluding certain infertility treatments that are performed on women only, an argument can be made that the Plan denies coverage for a subset of infertility treatments available to unmarried female employees while covering all infertility treatments available to unmarried male employees.[152]

Therefore, it appears that an unmarried infertile female employee may have a viable PDA or Title VII claim because she could not access certain infertility treatments that are performed on women only, while an unmarried infertile male employee could access the unrestricted benefits available without any such exclusion.[153] This is a notable inversion of the heterosexual and marriage-based norms traditionally reflected in diagnosis, treatment and legal criteria for infertility treatment.[154]

Imagematrix, Inc., 773 F. Supp. 802 (E.D.Va. 1991); Niemeier v. Tri-State Fire Prot. Dist., No. 99C7391, 2000 U.S. Dist. LEXIS 12621 (N.D. Ill. Aug. 24, 2000). At least one court has allowed the employee to seek reimbursement for costs associated with treating the spouse-beneficiary. Cwiak v. Flint Ink Corp., 186 F.R.D. 494, 496 (N.D. Ill. 1999) (male employee has standing to pursue claims under the ADA and the PDA for employer health plans failure to cover expenses incurred in treatment of his wife's infertility).

151. *Saks II*, 316 F.3d at 349.

152. *Id.* at 347-48 n.6.

153. *Id.; see* ASRM Amicus Brief, *supra* note 4, at 11-12.

154. *See, e.g.*, Lisa C. Ikemoto, *The Infertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007, 1027-33 (1996) (discussing heterosexual and marriage-based norms in diagnosis and treatment criteria). There have been news reports that couples are marrying in order to secure health insurance benefits. *See* Daniel Costello, *Saying "I Do" for a Health Plan: With Medical Costs Rising, Gaining Access to Benefits is Becoming a Factor in Some Couples' Decisions to Wed*, L.A. TIMES, June 28, 2004, at F1. If unmarried female employees do in fact have a relatively stronger Title VII or PDA claim as suggested above, this could lead to the opposite result—divorcing to secure coverage for infertility treatment.

The Second Circuit's analysis also appears to assume that the employee and his or her spouse are both covered under the employee's health care plan. This may not be a sound assumption, as according to recent news reports, a few large employers are eliminating health care benefits for employees' spouses, or using financial penalties to discourage such coverage in order to lower overall health costs.[155]

B. ADA CLAIMS

The ADA appears to be less helpful than Title VII for purposes of challenging the exclusion of infertility treatment due to the less demanding "equal access" standard, the broad safe harbor provision, and a narrow definition of subterfuge.[156] Notwithstanding these issues, what if Saks appealed the ADA claim? At first blush, it appears that the result would be the same, as the district court used the accepted "equal access" standard to evaluate non-discriminatory benefits under the ADA.[157] However, comparison of *Saks* with other cases suggests that seemingly small changes in the facts could lead to different results under the ADA.

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155. Kris Hundley, *Companies Squeeze Spouses Out to Save Health Care Costs*, ST. PETERSBURG TIMES, Sept. 30, 2004, at 1A (reporting that employers such as Gannett, Verizon and Knight-Ridder recently have implemented such policies).

156. *See supra* notes 65 to 79 and accompanying text.

157. Ms. Saks could have brought a claim under Title III of the ADA, challenging the exclusion as discrimination in the public accommodation of health insurance. Title III of the ADA prohibits disability-based discrimination by private entities "in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation." 42 U.S.C. § 12182(a) (2004). A few Circuits have held that a provider of health insurance coverage can be liable as a "public accommodation" under this Title. *See* Castellano v. City of New York, 142 F.3d 58 (2d Cir. 1998); Conners v. Me. Med. Ctr., 42 F. Supp. 2d 34, 46 (D. Me. 1999); Rogers v. Dep't of Health and Envtl. Control, 985 F. Supp. 635, 637-38 (D.S.C. 1997). However, other circuits have found that Title III does not reach the content of privately-offered health insurance coverage. *See* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1115 (9th Cir. 2000); Ford v. Schering-Plough Corp., 145 F.3d 601, 612 (3d Cir. 1998); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1012 (6th Cir. 1997). Analysis of health insurance as a public accommodation is beyond the scope of this Article.

1. Standing and the Origin of the Condition

When Jane sought treatment for her condition, her doctor opined that her infertility was due to her age, rather than a specific illness or disease.

Does the cause of Jane's condition matter? In the *Krauel* case discussed above, the Eighth Circuit held that an exclusion of infertility treatment was not a disability–based distinction under the ADA because it applied to infertility due to all causes, and not just ADA-recognized impairments.[158] The court reasoned:

> [T]he Plan's infertility exclusion applies equally to all individuals, in that no one participating in the Plan receives coverage for treatment of infertility problems. For example, the Plan exclusion bars coverage for infertility caused by age, a condition which is not recognized as a disability under the ADA, and for infertility caused by ovarian cancer, which is defined as a disability under the ADA. Therefore, the District Court properly held that the Plan is not a disability-based distinction in violation of the ADA.[159]

Although *Krauel*'s rejection of reproduction as a major life activity was abrogated by the Supreme Court's ruling in *Bragdon*, it is not clear that *Krauel*'s emphasis on the origin of the infertility was similarly abrogated. Indeed, the lower court in *Saks I* noted that infertility arising from "natural aging process, rather than from some disease or defect, is not a 'disability' within the meaning of the ADA."[160]

Given the numerous and often interacting causes of infertility—including the fact that in approximately twenty percent of the cases the cause is never known[161]—proving a medical cause or origin may be a significant factual hurdle for the plaintiff.[162] For example, in the course of treatment of her infertility, Ms. Saks's doctors attributed the inability of Ms. Saks and her husband to conceive first to polycystic ovarian syndrome,

158. Krauel v. Iowa Methodist Med. Ctr., 95 F.3d 674, 677-78 (8th Cir. 1996).

159. *Id.* at 678.

160. *Saks I*, 117 F. Supp. 2d. at 326.

161. ASRM, *Frequently Asked Questions*, *supra* note 1.

162. Plaintiff has the burden of establishing standing under the ADA as an essential element of her claim. *See. e.g.*, Sutton v. United Air Lines, Inc., 527 U.S. 471, 494 (1999) (dismissing petitioner's complaint for failure to state a claim because they did not establish that they are actually disabled or "regarded as" disabled).

then unknown causes, and finally a hormonal imbalance and ovulatory disorder.[163] Although the medical origin of Ms. Saks's infertility was not challenged,[164] it is unclear if Ms. Saks could have marshaled the medical evidence to demonstrate that her infertility arose from a disease or physical defect if she had been required to do so.

A pair of pre-*Bragdon* cases provides some guidance on this issue. In *Zatarain v. WDSU-Television Inc.*,[165] an employee brought suit under the ADA claiming that her employer rejected reasonable accommodations to her work schedule to allow her to pursue infertility treatment. No specific medical cause for her infertility was established. Her employer argued, among other things, that her infertility was not an impairment because it was likely caused by her age (she was approaching 40) or job stress.[166] The court denied the summary judgment for the employer on that basis because the employee had offered expert testimony sufficient to support a finding that she suffered from a disorder of the reproductive system apart from age and stress.[167] In addition, in *Pacourek v. Inland Steel Company*,[168] the court outright rejected the requirement of medical cause. In that case, an employee brought suit under the ADA claiming that she was fired for taking time off for infertility treatment. The cause of her infertility was medically unexplained.[169] Her employer argued, among other things, that she lacked standing because unexplained infertility is not an impairment covered by the ADA. The district court rejected that argument and held that "it does not matter whether the infertility is explained or not. The ADA and regulations under it are simply devoid of any requirement that a physiological disorder or condition have a scientific name or known etiology."[170] Courts have also rejected the requirement of specific medical cause or impairment post-*Bragdon*. For example, in *LaPorta v. Wal-Mart Stores Inc.*,[171] the employee's physician stated that she was infertile, but could not identify a specific cause for her infertility. Her employer

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163. *Saks I*, 117 F. Supp. 2d at 321-22.

164. *Id.* at 320 n.1. Although for the purposes of its motion for summary judgment her employer did not dispute that her infertility was an impairment that substantially limited her ability to reproduce, the court noted, "it appears that certain issues regarding Saks' infertility and her need for chemical and/or surgical intervention to become pregnant would be disputed if this case were going to trial." *Id.*

165. Zatarain v. WDSU-Television, Inc., 881 F. Supp. 240 (E.D. La. 1995).

166. *Id.* at 243.

167. *Id.*

168. 916 F. Supp. 797 (N.D. Ill. 1996).

169. *Id.* at 799.

170. *Id.* at 801.

171. 163 F. Supp.2d 758 (W.D.Mich. 2001).

suggested that because it might arise from "a physiological problem of the [husband]" or "environmental factors and lifestyle habits," she had not demonstrated that she was disabled within the meaning of the ADA.[172] The district court rejected this argument, finding that a reasonable jury could find that the plaintiff was infertile based on the doctor's affidavit.

Therefore, a plaintiff may need to be prepared to demonstrate the origin or medical cause of the infertility in order to establish that it arises from an impairment recognized under the ADA, although lack of a medical basis to do so should not bar her claim.

2. Standing and Mitigation of the Condition

After Jane discovered that the health insurance provided through her work covered some treatments, but excluded surgical impregnation procedures, she went ahead with IVF and was able to conceive. She then sought reimbursement from the health plan.

Do successful results affect Jane's ability to seek reimbursement for infertility treatment? The defendants in *Saks* argued—albeit in a footnote—that infertility cannot be a disability within the meaning of the ADA because it is a correctable condition,[173] relying upon *Murphy v. United Parcel Service*[174] and *Sutton v. United Airlines.*[175]

Together with *Albertsons v. Kirkenburg,*[176] *Murphy* and *Sutton* comprise the Supreme Court's 1999 "*Sutton* trilogy" on standing. In each of these cases, the Court held that the ADA requires an individualized consideration of the plaintiff's undisputed impairment, taking into account any medical treatment, corrective devices and other mitigating measures.[177]

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172. *Id.* at 764 (quotations omitted). Although not reached in *LaPorta*, the question of whether an employee can state a claim if the source of the infertility is her partner (and therefore she has no identifiable impairment herself) is an interesting one. At least one court has allowed the employee to seek reimbursement for costs associated with treating the spouse-beneficiary. *See* Cwiak v. Flint Ink Corp., 186 F.R.D. 494, 496 (male employee has standing to pursue claims under the ADA and the PDA for employer health plan's failure to cover expenses incurred in treatment of his wife's infertility).

173. 117 F. Supp. 2d at 325.

174. 527 U.S. 516 (1999).

175. 527 U.S. 471 (1999).

176. 527 U.S. 555 (1999).

177. For a critique of the *Sutton* Trilogy see Elizabeth A. Pendo, *Substantially Limited Justice?: The Possibilities and Limits of a New Rawlsian Analysis of Disability-Based Discrimination,* 77 ST. JOHN'S L. REV. 225 (2003).

Following these cases, courts have found impairments such as diabetes,[178] asthma[179] and depression[180] to be correctable or amenable to mitigation, and therefore not disabilities within the meaning of the ADA in those cases.

The district court in *Saks*, however, rejected this argument as ill-advised as applied to infertility:

> [I]n the opinion of this Court, the Supreme Court did not intend to rule that no disease or organic defect can qualify as an ADA disability as long as some treatment can ameliorate its impact in some percentage of persons afflicted, however small that percentage may be. Indeed, I think it highly likely that courts will, over time, develop a spectrum of "disability" along which various diseases will fall, depending on some case-by-case analysis of their seriousness, their susceptibility to treatment, the rate at which treatment succeeds in curing them altogether or lessening their impact, and the impact of available treatments on the plaintiff at bar . . .. Whether the availability of draconian regiments that avoid the consequences of infertility in a small percentage of individuals places this particular impairment closer to the Murphy/Sutton end of the spectrum or the diabetes/cancer/kidney failure end could not possibly be determined on the present record. But the position espoused by defendants is not so self-evident (as demonstrated by the fact that they relegate this argument to a footnote) that I would dismiss on Murphy/Sutton grounds at this juncture.[181]

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178. Orr v. Wal-Mart Stores, Inc., 297 F.3d 720, *reh'g en banc denied* (8th Cir. 2002) (employee with diabetes not disabled -- and therefore could not prevail on his claim that he was unlawfully terminated for closing pharmacy to take lunch breaks for maintaining his health -- because diabetes currently corrected with medication).

179. Tangires v. Johns Hopkins Hosp., 79 F. Supp. 2d 587 (D. Md. 2000), *aff'd*, 230 F.3d 1354 (4th Cir. 2000) (Plaintiff's asthma found not substantially limiting because it was correctable by medication, even though plaintiff refused to take the medication. Plaintiff's doctor testified that her asthma was slow to clear because she refused to comply with his recommendations and was reluctant to take steroid drugs).

180. Krocka v. Chicago, 203 F.3d 507 (7th Cir. 2000) (upholding jury's finding that employee's depression was not substantially limiting because he exhibited no symptoms when taking medication and was able to perform his job adequately); Spades v. City of Walnut Ridge, 186 F.3d 897 (8th Cir. 1999) (employee's depression was being treated with medication that allowed him to function "without limitation").

181. *Saks I*, 117 F. Supp.2d at 325-26.

One year later, the Michigan district court in *LaPorta* reached a similar conclusion. In that case, plaintiff brought an action under the ADA, Title VII and state laws challenging her termination after her employer failed to accommodate her request for medical leave to receive treatment for infertility.[182] Her employer argued, among other things, that plaintiff lacked standing to bring the action because her infertility was not a disability within the meaning of the ADA. Relying upon the *Sutton* trilogy, defendant argued, "[P]laintiff's eventual success in becoming pregnant through artificial insemination in 1998 renders it 'impossible' to find that her condition of infertility substantially limited her in the major life activity of reproduction."[183] The court rejected defendant's argument: "[u]nlike the plaintiffs in *Sutton* and *Albertsons*, Ms. LaPorta is not asking the court to consider her situation in an uncorrected state. To the contrary, she points to the need for accommodation arising from the corrective measures themselves." [184] Thus, the court recognized that defendant's argument would create a painful "Catch-22" for the plaintiff—her infertility is an impairment that was ultimately correctable through expensive and intrusive treatment, but her employer can refuse to accommodate her requests for medical leave to pursue such treatment because the treatments were ultimately successful.[185]

The courts in both *La Porta* and *Saks* also recognized that a rule under which an impairment that is subject to any amelioration—no matter how onerous—would not qualify as a disability under the ADA was unwise, and in the case of infertility conflates the distinct concepts of infertility and sterility.[186] Such an approach is also directly contrary to the Supreme Court's decision in *Bragdon*, which notes that the ADA "addresses substantial limitation on major life activities, not utter inabilities."[187]

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182. 163 F. Supp. 2d at 760. As the *LaPorta* case illustrates, courts have found that infertile employees enjoy more ADA protection for requests for changes to work schedules, time off for treatment, and other "reasonable accommodations" in the workplace than for coverage of infertility treatments under their employer's health plan. *See, e.g.* Pacourek v. Inland Steel Co., Inc., 916 F. Supp. 797 (N.D. Ill 1996).

183. *Laporta*, 163 F. Supp. 2d at 765.

184. *Id.* at 766.

185. *Id.*; s*ee also* Pendo, *supra* note 177, at 261-62 (discussing the "Catch 22" created by the *Sutton* trilogy).

186. *LaPorta,* 163 F. Supp. 2d at 764 (recognizing that infertility as "a diminished ability to become pregnant by natural means," not the "complete inability to produce offspring.")

187. 524 U.S. at 639. The Court also explicitly noted, "[W]hen significant limitations result from the impairment, the definition is met even if the difficulties are not insurmountable." *Id.* at 639.

Indeed, other courts have found that impairments such as hearing loss,[188] epilepsy,[189] depression[190] and asthma[191] that can be corrected or mitigated may still constitute disabilities within the meaning of the ADA where the mitigation was not complete, or itself resulted in substantial limitation of a major life activity.

Accordingly, although it may continue to be raised by defendants, the fact that infertility can be treated, sometimes successfully, should not bar a plaintiff's challenge to the exclusion of infertility treatment under the ADA.

3. Self-Funded versus Insured Plans

Although Jane's insurance card bears the name of a well-known insurance company, she recently discovered that her health plan is self-funded. A Human Resources representative told her that this means her employer assumes all or part of the risk of paying for the benefits instead of purchasing a health care coverage policy from an insurance company.

Does the funding of her plan affect her protections under the ADA? As discussed in Section I.B. above, self-insured plans are exempted from state regulation as a result of ERISA's preemption analysis, and therefore are subject to only the most minimal antidiscrimination requirements under the ADA.[192]

A number of scholars analyzed the scope of ADA protection for participants in self-funded health plans in the early 1990s, particularly after the decision in *McGann v. H & H Music Co.*,[193] upholding under ERISA an employer's cap on health insurance benefits for the treatment of persons with AIDS.[194] Based on two early cases,[195] some scholars anticipated a

188. *See* Wilson v. Aetna Life & Cas. Co., 195 F. Supp. 2d 419, 428-29 (W.D.N.Y. 2002) (denying defendant's motion for summary judgment because plaintiff's hearing loss, although mitigated by hearing aids, was permanent and significantly below the average person's hearing, and plaintiff had difficulties using the hearing aids).

189. Otting v. J.C. Penney Co., 223 F.3d 704, 711 (8th Cir. 2000) (denying defendant's motion for summary judgment because despite mitigating effects of plaintiff's medication, plaintiff's epilepsy was not fully under control).

190. Maxwell v. GTE Wireless Serv. Corp., 121 F. Supp. 2d 649, 654 (N.D. Ohio 2000) (denying motion for summary judgment in part because of genuine issues of material fact as to whether employee's depression, even when treated with medication and counseling, interfered with the major life activities of working).

191. Saunders v. Baltimore County, 163 F. Supp. 2d 564, 568 (D. Md. 2001) (finding that employee's asthma was an impairment because he experiences severe asthma attacks despite medications and other treatments).

192. *See supra* notes 75-79 and accompanying text.

more protective role for the ADA in the context of employer-sponsored health insurance, even for self-funded plans.[196] Despite the relative optimism of these predictions, courts subsequently held that disability-based distinctions in bona fide, ERISA-regulated, self-funded plans will be upheld—whether or not they are based on sound actuarial analysis—unless the distinctions can be shown to be subterfuge for discrimination.[197]

Although it is not clear that employers choose self-funding solely to avoid state law mandates or the protections of the ADA,[198] it remains true

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193. 946 F.2d 401 (5th Cir. 1991).

194. *See* John A. English, *Self-insured Group Medical Plans: A Search for Protection of Benefits*, 22 CAP. U. L. REV. 749 (1993); Patrick Morgan, *Applicability of ADA Non-Discrimination Principles to Self-Insured Health Plans: Do "AIDS Caps" Violate the Law?*, 11 J. CONTEMP. HEALTH L. & POL'Y 221 (1994); Dion A. Sullivan, *ERISA, the ADA, and AIDS: Fixing Self-Insured Health Plans with Carparts*, 7 MD. J. CONTEMP. LEGAL ISSUES 423 (1996); Nancy R. Mansfield et al., *Insurance Caps on AIDS-Related Healthcare Costs: Will the ADA Fill the Gap Created by ERISA?*, 14 GA. ST. U. L. REV. 601 (1998).

195. Mason Tenders Dist. Council Welfare Fund v. Donahey, No. 93 CIV. 1154, 1993 WL 944580, at *7 (S.D.N.Y. Nov. 19, 1993) (opining that a self-funded plan's benefit cap for a specific disability would violate the ADA unless actuarially justified); Carparts Distribution Ctr. v. Auto. Wholesaler's Asso. of New England, 37 F.3d 12 (1st Cir. 1994) (trade association and trust administering health plan can be considered a public accommodation under Title III of ADA for purposes of challenging a cap on benefits for illnesses relating to AIDS). The EEOCs Interim Guidance also lent support to a broader interpretation of the ADA's protections with respect to employer health plans. EEOC Interim Guidance, *supra* note 67.

196. *See* Kevin Caster, *The Future of Self-Funded Health Plans*, 79 IOWA L. REV. 413 (1994) (ADA could provide meaningful protection for participants in self-funded plans if the courts reject the ADEA's definition of subterfuge); John E. Estes, *Employee Benefits or Employer "Subterfuge": The Americans with Disabilities Act's Prohibition Against Discrimination in Health Plans*, 12 N.Y.L. SCH. J. HUM. RTS. 85, 100 (1994) (employers should be required to show that cost justification itself is not a subterfuge for discrimination); Sullivan, *supra* note 195, at 423; Nancy R. Mansfield, *Evolving Limitations on Coverage for AIDS: Implications for Health Insurers and Employers Under the ADA and ERISA*, 35 TORT & INS. L. J. 117 n.85 (1999) (cases such as *Mason Tenders* and *Carparts* suggests that the ADA may eliminate ERISA's loophole for self-funded plans, so that insured and self-funded plans may have to provide sound actual support when singling out a disability for a post-claim cap.). Other early analyses were less optimistic. *See* English, *supra* note 195, at 764-66 (1993) (Because of safe harbor, the only ADA limit on self-funded plans is "subterfuge" which is not defined by the statute. If ADEA definition is used (*McMann*), this protection will be quite limited.); Morgan, *supra* note 195, at 251 (1994) (predicting the courts would reject the EEOC's assertion that the ADA's anti-discrimination and provision and risk classification principles apply to self-funded plans).

197. *See, e.g.*, *Saks I*, 117 F. Supp. 2d. 318, *aff'd* 316 F.3d 337, 341 (2d Cir. 2003); *Leonard*, 199 F.3d at 104; *Henzel*, 285 F. Supp. 2d at 279.

198. One survey indicates that employers choose self-funded health insurance benefits in order to avoid conflicts in insurance laws across the states. LeAnne DeFrancesco, *State Variation in Insurance Laws a Major Driver of Employers' Self-Insurance Decisions*,

that employees who participate in self-funded plans will continue to enjoy significantly less protection under the ADA than those who participate in insured plans. The same is not true for employees pursing a claim under Title VII, in which case the funding status of the health plan is not relevant. Indeed, the plan at issue in *Erickson* was self-funded. [199]

The exception for self-funded plans is increasingly significant. The number of self-funded plans has increased dramatically since ERISA's passage in 1974.[200] As of 2003, the majority of covered workers are in a plan that is completely or partially self-funded.[201] While large employers have always been the most likely to self-fund health benefit plans,[202] news reports indicate that the trend toward self-funding will spread to small and mid-size employers as the cost of health care continues to rise.[203] Moreover, like Jane, many employees may not be aware that their health plans are self-funded, as employers may contract with a traditional insurance carrier or other third-party administrator to administer the plan on a day-to-day basis.[204]

Findings Brief (Academy Health / Changes in Health Care Financing & Organization), Vol. VII, No. 1 Feb. 2004, *available at* http://www.hcfo.net/pdf/findings0204.pdf; *see also* MARTHA PRIDDY PATTERSON & DEREK LISTON, ANALYSIS OF THE NUMBER OF WORKERS COVERED BY SELF-INSURED HEALTH PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974–1993 AND 1995 (1996) (noting one advantage to a self-funded plan is health plan designs can be applied on a nation-wide basis; the employee does not have to change benefits when he or she changes job locations with the employer). In addition, there is some evidence that self-funded and insured plans cost similar amounts and provide similar benefits. Gabel et al., *supra* note 101.

199. 141 F. Supp. 2d. at 1268 n.1.

200. *See, e.g.*, Jensen & Gabel, *supra* note 78 (reporting that between 1981 and 1985, the percentage of employees in mid- to large-size firms covered by self-insurance grew from 25% to 42%). *See also* PATTERSON & LISTON, *supra* note 198, at 6 (noting that the percentage of workers enrolled in a fully or partially self-funded plan dropped from 60 to 51% between 1993 and 1995, due in part to the shift toward insured managed care plans, particularly by smaller employers. However "[a]s various types of managed care plans begin moving toward shifting financial risk to the employer, the trend toward increasing self-insurance, and the ERISA preemption of state laws afforded by self-insurance, may begin growing again.").

201. Kaiser Family Foundation, *supra* note 78, at 121-29 (reporting that in 2003, 52% of covered workers were in a plan that is completely or partially self-insured) *available at* http://www.kff.org/insurance/upload/20672_1.pdf (last visited Apr. 9, 2005).

202. *See id.* at 123-29. "The likelihood that an employer self-insures is highly related to the size of the firm. Ten percent of covered workers in all small firms (3-199 workers) are in self-insured plans, compared to 50% of workers in mid-size firms (200-999 workers) and 79% of workers in jumbo firms (5,000 or more workers)." *Id.* at 124.

203. *See* Christopher Windham, *Self-Insurance Plans Gain as Premiums Jump*, WALL ST. J., Dec. 30, 2003, at B2.

204. Jensen & Gabel, *supra* note 78.

Accordingly, a plaintiff using the ADA to challenge exclusions in her employer-sponsored plan will be in a significantly better position if her plan is insured, rather than self-funded.

4. Subterfuge and the Timing of the Exclusion

Jane looks through her old health insurance booklets, and discovers that her employer instituted the exclusion of surgical impregnation procedures in 1995. In the alternative, she discovers that her employer instituted the exclusion in 1985.

As discussed above, disability-based distinctions in bona fide, ERISA-regulated, self-funded plans will be upheld—whether or not they are based on sound actuarial analysis—unless the distinctions can be shown to be subterfuge for discrimination. What is a "subterfuge" for discrimination in this context, and does the date of the exclusion determine whether or not the exclusion is a subterfuge for discrimination?

In its 1993 Interim Guidance, the EEOC defined subterfuge as disability-based disparate treatment in an employee benefit plan that is not justified by "sound actuarial principles or related to actual or reasonably anticipated experience."[205] It specifically rejected the definition of subterfuge developed by the Supreme Court in *Public Employees Retirement System v. Betts*[206] under the Age Discrimination in Employment Act of 1967 ("ADEA"),[207] which held that a plan adopted prior to the enactment of the statute could not be a subterfuge to avoid the purposes of the statute.[208] It also rejected *Betts's* requirement that an ADEA plaintiff show the employer's specific intent to discriminate in a non-fringe aspect of the employment relationship as inapplicable to the ADA.[209]

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205. EEOC Interim Guidance, *supra* note 67.

206. 492 U.S. 158 (1989), *superseded by statute as stated in*, Gen. Dynamics Land Sys., Inc. v. Cline, 540 U.S. 581 (2004).

207. 29 U.S.C. § 621.

208. EEOC Interim Guidance, *supra* note 67, at 10.

209. *Id.* at 10. Indeed, several scholars argued that the courts would or should adopt the EEOC's definition of subterfuge. Caster, *supra* note 196 (ADA could provide meaningful protection for participants in self-funded plans if the courts reject the ADEA's definition of subterfuge); Estes, *supra* note 196 (the ADEA's narrow, intent-based definition of subterfuge should not apply to the ADA. Moreover, employers should be required to show that cost justification itself is not a subterfuge for discrimination); Sullivan, *supra* note 195; Mansfield, *supra* note 196 (although the Circuits are not in agreement, cases such as *Mason Tenders & Carparts* suggests that the ADA may eliminate ERISA's loophole for self-funded plans, so that insured and self-funded plans may have to provide sound actual support when singling out a disability for a post-claim cap.). Other early analyses were less

However, beginning in 1996, courts began to reject the EEOC's definition, and to adopt the *Betts* definition of subterfuge in ADA cases.[210] These cases define subterfuge as "a scheme, plan, stratagem, or artifice of evasion," that includes "a specific intent to circumvent or evade a statutory purpose."[211] Under this analysis, it does matter when the challenged exclusion was adopted, because exclusions adopted prior to 1992, the date Title I of the ADA became effective for employers with 25 or more employees,[212] cannot be considered a subterfuge to avoid the ADA's prohibition of disability-based discrimination.

Accordingly, it appears that only plaintiffs who can establish that at some point after 1992, their employers planned to exclude treatments for infertility with the specific intent to evade the ADA can demonstrate that the exclusion is a subterfuge for discrimination.

V. RECOGNIZING THE EXCLUSIONS AS DISCRIMINATION: THE POLICY CONTEXT

There is an old saw in political science that difficult conditions become problems only when people come to see them as amenable to human action. Until then, difficulties remain embedded in the realm of nature, accident, and fate – a realm where there is no choice about what happens to us. The conversion of difficulties into problems is said to be the sine qua non *of political rebellion, legal disputes, interest-group mobilization, and of moving policy problems onto the public agenda.*[213]

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optimistic. *See* English, *supra* note 195 (Because of safe harbor, the only ADA limit on self-funded plans is "subterfuge" which is not defined by the statute. If ADEA definition is used (*McMann*), this protection will be quite limited); Morgan, *supra* note 195, at 251 (predicting the courts would reject the EEOC's assertion that the ADA's anti-discrimination and provision and risk classification principles apply to self-funded plans).

210. *See, e.g., Aramark Corp.*, 208 F.3d. 266 (D.C. Cir. 2000); *Ford*, 145 F.3d 601 (3d Cir. 1998); *cert. denied*, 525 U.S. 1093 (1999); Modderno v. King, 82 F.3d 1059 (D.C. Cir. 1996), *cert. denied*, 519 U.S. 1094 (1997); *Leonard F*, 199 F.3d 99 (2d Cir. 1999); Conner v. Colony Lake Lure, No. 4:97CV01, 1997 WL 816511 (W.D.N.C. Sept. 4, 1997).

211. *Aramark Corp.*, 208 F.3d at 269 (citing *Betts*, 492 U.S. at 167 (quoting *McMann*, 434 U.S. at 203)).

212. The ADA was signed by President George Bush in 1990, but Title I did not become effective until July 26, 1992 for employers with 25 or more employees. 42 U.S.C.A. § 12101, S. Rep. No. 101-116, at 2 (1989).

213. Deborah Stone, *Causal Stories and the Formation of Policy Agendas*, 104 POL. SCI. Q. 281, 281 (1989).

Currently, comprehensive coverage of treatments for infertility appears to be the exception rather than the rule in employer plans,[214] and voluntary expansion of benefits in this area seem unlikely in the face of continued increases in group health insurance premiums.[215] The analysis above shows that some plaintiffs may be able to use claims of sex discrimination, disability discrimination, or both to secure equitable treatment of infertility. Equitable coverage is of course distinct from comprehensive coverage – under the former, an employer could lawfully exclude all treatment of infertility, or place limitations on coverage based on factors other than sex or disability. The deeper question is whether employers should be required to provide comprehensive infertility treatments. This section examines the public policy arguments for and against the comprehensive coverage of infertility treatment, and argues for the transformation of the "difficulty" of infertility exclusions into a "problem" that should be recognized under the law.

A. INFERTILITY IS STILL A "WOMAN'S PROBLEM"

Jane and her husband, John, finally revealed their shared struggle to have a child with their family. Although they explained that the infertility was due to low sperm production, both Jane and John's family members

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214. ASRM Amicus Brief, *supra* note 4, at 11-12; s*ee also* Sato, *supra* note 4, at 197-2000.

215. Vernon Smith et al., Kaiser Commission on Medicaid and the Uninsured, Medicaid Spending Growth, Results from 2002 Survey, at 3, 9 (Sept. 2002) *available at* http://www.kff.org/insurance/upload/13512_1.pdf (rates rose by 12.7% in 2002 -- the largest increase since 1990); Bradley C. Strunk et al., *Tracking Health Care Costs: Growth Accelerates Again in 2001*, *available at* http://content.healthaffairs.org/cgi/content/full/hltaff.w2.299v1/DCI ("premiums for employment-based insurance increased 12.7 percent from 2001 to 2002...the largest increase in premiums since 1990."). *See* Hewitt Association at http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2003/06-23-03.htm (forecasting average rate increases of 17.7% for 2004); Aon Spring 2003 Health Care Trend Survey, *at* http://www.aon.com/about/publications/pdf/issues/healthcaresurvey_29may03.pdf (forecasting average health plan rate increases of 15.7% to 17.2% for 2004); Press Release, Hewitt Health Assocs., HMO Rates Continue Double-Digit Increases, But Begin to Moderate (June 3, 2004), *available at* http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2004/06-03-04.htm (health insurers will seek premium increases for large employers averaging 13.7 percent in 2005); Aon Consulting, Aon Spring 2003 Health Care Trend Survey, *available at* http://www.aon.com/about/publications/pdf/issues/healthcaresurvey_29may03.pdf (health care plan costs will rise between 14.4 percent and 17.2 percent, depending upon type of plan and including of prescription drug coverage).

offered support, sympathy and treatment advice primarily to Jane, and saw the issue as one primarily affecting Jane.

As discussed above, the available evidence suggests that women experiencing the disease of infertility are disproportionately affected by its devastating psychological impact. Although infertility is medically defined as applying to a (heterosexual) couple, the emotional and health care burden falls more heavily on the woman. It is worth noting that all of the major cases dealing with reasonable accommodation of infertility treatment and coverage of infertility treatment have been brought by female plaintiffs.[216]

Moving from the patient's perspective to a societal one, infertility is still considered a "woman's problem" by many.[217] As the sponsor of a recent public opinion poll regarding infertility noted, "women are feeling the brunt of responsibility when it comes to infertility, even though our research shows a public awareness about the male's role in conception problems."[218] Even the Merck Manual, one of the most influential and widely-used medical reference texts, lists infertility under "Women's Health Issues."[219]

The resistance to coverage of infertility treatment can be seen as part of a larger pattern of resistance to coverage of treatments or conditions associated with sex or sexuality. Past and present debates over coverage of pregnancy, prescription contraception, and (to a lesser extent) Viagra, serve as a few examples. However, in the case of infertility treatment, the resistance to coverage appears profoundly gendered. As Professor Lisa Ikemoto has written, one popular narrative of infertility is female selfishness. Infertility is seen as the price women must pay for delaying

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216. *See, e.g.*, *Saks II*, 316 F.3d at 337; *Pacourek*, 916 F. Supp. at 797; *Erickson*, 911 F. Supp. at 316; *Zatarain*, 881 F. Supp. at 240; *Krauel*, 915 F. Supp. at 102.

217. Gilbert, *supra* note 28, at 1 (noting that infertility is "stereotypically thought of as a female problem").

218. Sigma-Tau Pharmaceuticals, Inc., *Gallup Survey Shows Communications/Perception Barriers Between Men and Women When Discussing Infertility* (May 26, 1999), *available at* http://www.gobleedit.com/sigmatau/proxeed/consumer/gendergap.html (last visited Apr. 9, 2005)

219. THE MERCK MANUAL OF MEDICAL INFORMATION - SECOND HOME EDITION, *available at* http://www.merck.com/mmhe/sec22.html (last visited Apr. 9, 2005).

motherhood for a career, for enjoying sexual freedom, or for exercising control over the reproductive process.[220]

While there is no doubt that infertility affects men, this suggests that infertility is still considered a "woman's problem," and lends support to the concept that exclusion of treatment for infertility can be seen as an issue of gender equality that should be cognizable under Title VII.

B. INFERTILITY IS NOT A "LIFESTYLE CHOICE"

After receiving the insurance plan's decision to deny coverage, Jane realizes that she cannot afford to pursue uncovered treatments. She experiences feelings of rage, grief and depression at the loss of a chance to conceive, deliver and raise a child. A well-meaning co-worker attempts to comfort her by saying that many young women today choose not to have children.

Some have argued that coverage of treatment to enable men and women to conceive, deliver and raise a child is not essential to a health care plan because reproduction is a choice. In the words of one commentator, "reproduction is a bodily function, but it is one the exercise of which is purely optional – a lifestyle choice."[221] Indeed, in rejecting reproduction as a major life activity, the lower court in *Krauel* characterized reproduction in these terms, noting that "[s]ome people choose not to have children, but all people care for themselves, perform manual tasks, walk, see, hear, speak, breathe, learn, and work, unless a handicap or illness prevents them from doing so."[222]

While is it true that some people choose not to have children, the desire to have children is pervasive in our society.[223] One widely-cited study

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220. Lisa C. Ikemoto, *The Infertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L. J. 1007, 1042-44 (1996). Race and class also play a role, as the "infertile" are defined as white, married, middle-class women who are less deserving of sympathy. *Id.* at 1009.

221. *See* Sonfield, *supra* note 40, at 5 ("Infertility treatment is sometimes lumped together with cosmetic surgery as a 'lifestyle' type procedure rather than considered 'serious medicine.'") (quoting Deborah Wachenheim of RESOLVE); *see also* Pratt, *supra* note 18, at 1124-25 (quoting an exchange among tax professors on the issue of the deductibility of infertility treatment costs).

222. *Krauel*, 915 F. Supp at 106 n.1.

223 As the Supreme Court recognized, "[r]eproduction and the sexual dynamics surrounding it are central to the life process itself." *Bragdon*, 524 U.S. at 638.

found that only two percent of married women are childless by choice.[224] Moreover, the loss of the chance to conceive, deliver and raise a child due to the disease of infertility is a real and devastating loss. As the court in *Pacourek* recognized:

> Many, if not most, people would consider having a child to be one of life's most significant moments and greatest achievements, and the inability to do so, one of life's greatest disappointments. Since time immemorial, people have procreated, not as a lifestyle choice, but as an integral part of life.[225]

The intense desire to conceive, carry, birth and raise a child is also evident from the plaintiffs' vigorous pursuit of treatment and coverage of treatment in cases like *Erickson v. Board of Governors, Zatarain, Krauel, Pacourek* and *Saks.*

Moreover, similar arguments could be made for sexual functioning, as a certain percentage of people throughout the ages and across cultures have chosen to abstain from sexual activity.[226] Therefore, medical treatments aimed at restoring sexual function could be viewed as non-essential because sexual activity is simply a "lifestyle choice." Interestingly, this argument was not widely raised with respect to Viagra, a drug developed for male sexual dysfunction.[227] Instead, when Viagra was introduced in 1998, insurance companies "responded enthusiastically by willingly covering the prescriptions, at least in part,"[228] and reports estimated that about half of the men taking Viagra received some form of insurance reimbursement.[229] The outrage over the perceived inequity of employer health plan coverage of Viagra was a strong motivating factor in the movement for coverage of prescription contraceptives exemplified by

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224. *See* Patricia Schroeder, *Infertility and the World Outside*, 49 FERTILITY & STERILITY 765 (1988) (article by Congresswoman Schroeder, D-Colo., citing figures from the National Center for Health Statistics (NCHS)).

225. *Pacourek*, 916 F. Supp at 804.

226. *See, e.g,,* ELIZABETH ABBOT, A HISTORY OF CELIBACY 426 (2001) (". . . for at least three thousand years in most parts of the world, celibacy has been far from uncommon and rarely considered unnatural. Billions of people have either chosen or been forced into celibacy for periods ranging from [a] few weeks [to a] lifetime").

227. *See* Pratt, *supra* note 18, at 1124-25.

228. Lisa A. Hayden, *Gender Discrimination within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 176 (1998-99).

229. *Id.* at 172; Debra Baker, *Viagra Spawns Birth Control Issue*, 84 A.B.A. J. 36 (1998).

Erickson.[230] The sense of outrage may be heightened by a recent study indicating that Viagra is increasingly prescribed to younger men without markers for erectile dysfunction.[231]

The characterization of childbearing as a lifestyle choice also resonates with the pernicious image of the woman who "chooses" career and sex over motherhood described previously. As the Supreme Court recognized in *Bragdon,* "[i]n the end, the disability definition does not turn on personal choice."[232] Although the Court made this statement in the context of the plaintiff's choice to run the risks of reproduction – transmission of HIV to partner and child, in that case – it resonates here, as well. In fact, unlike in *Bragdon*, where the desire to reproduce was not related to the activity at issue in the case (being treated in a dentist's office), in cases like *Saks* there is a tight link between the desire to reproduce and the underlying claim (seeking coverage of treatment to allow reproduction).

C. THE COST OF COMPREHENSIVE COVERAGE IS OVERSTATED

After receiving the insurance plan's decision to deny coverage, Jane speaks with the Human Resources representative at her workplace. He tells her that their employer simply can't afford to cover the excluded treatments, and that including expensive treatments like in vitro *fertilization would dramatically increase the premiums for everyone in the group.*

Employers and insurers have argued that increased coverage of treatments for infertility, in particular IVF, will dramatically increase health care costs and health insurance premiums: "[e]choing the traditional defense by the insurance industry against coverage mandates of all sorts, they argue that requiring employers to cover infertility treatment will force some employers to eliminate health benefits entirely and increase the already considerable number of uninsured Americans."[233]

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230. *See, e.g.*, Marc Kaufman, *More Health Plans Cover Birth Control,* WASHINGTON POST, June 14, 2004, at A02 ("[a]t the Time Viagra came out and was immediately covered, many health plans were still defining contraceptives as lifestyle drugs . . . [t]he outrage that women felt was enormous and, we think, really drove the movement towards contraceptive equity.") (quoting Sharon Camp, president of the Guttmacher Institute); *see also* Hayden, *supra* note 228; Sylvia Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363 (1998); Baker, *supra* note 229, at 36.

231. *See* T. Delate et al., *Patterns of Use of Sildenafil Among Commercially Insured Adults in the United States: 1988-2002*, 16 INT'L J. OF IMPOTENCE RESEARCH 313 (2004).

232. *Bragdon*, 524 U.S. at 641.

233. Sonfield, *supra* note 40, at 5.

This argument is unconvincing because there is evidence that the cost of including comprehensive coverage of infertility treatment is overstated. For example, one study examined all IVF treatments performed in the United States during 1995, and projected that coverage of those treatments would increase group premiums by $3.14 per employee per year.[234] Other studies have reported similar figures.[235] Notably, a study examining utilization rates in Massachusetts, a state with mandated comprehensive coverage of infertility treatments, estimated the cost of such additional comprehensive coverage as $2.49 per insured per year.[236] These studies suggest that the cost of comprehensive infertility coverage is comparable to the cost of covering full contraceptive benefits.[237]

This argument is also unconvincing because comprehensive coverage does not necessarily mean unlimited coverage. Because the devastating emotional impact of infertility may lead to unreasonable expectations on the part of the person or couple seeking treatment, some have suggested external controls which give priority to people with better chances for success based on medical criteria, limit the number of cycles covered, direct people to the facilities with the highest success rates based on clear and consistent data, or limit the number of embryos that can be transferred at a time to reduce high-risk, high-cost multiple births.[238] In addition, insurers could employ traditional methods of reducing the cost of coverage, such as negotiating discounts with providers, or charging higher co-payments for demonstrably more expensive procedures.[239]

In sum, although the data is not conclusive, the available evidence suggests that the cost argument is exaggerated. This does not suggest that coverage decisions should necessarily be made on the basis of cost-effectiveness alone.[240] Indeed, the emotional, medical and social impact of

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234. Collins et al., *An Estimate of the Cost of In Vitro Fertilization Services in the United States in 1995*, 64 FERTILITY & STERILITY 538 (1995).

235. *See* Hidlebaugh et al., *Cost of Assisted Reproductive Technologies for a Health Maintenance Organization*, 42 REPRODUCTIVE MED. 570, 570 (1997) (estimating the cost of including ART subject to preauthorization clinical criteria as $2.49 per year); Sonfield, *supra* note 40, at 5 (summarizing similar studies).

236. Hidlebaugh, *supra* note 235, at 570.

237. *See, e.g.*, Trussell, *supra* note 59, at 12 (noting widely cited estimate that it only costs an employer $1.43 per employee per month to add full contraceptive benefits to a health plan).

238. Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215, 1227-30 (1997).

239. *Id.* at 1230.

240. *Id.* at 1227. As Professor Peter J. Neumann has suggested, "[I]t may be more important to guarantee that every infertile couple has at least some access to IVF instead of simply maximizing the number of deliveries achieved for the dollars expended." *Id.*

infertility, particularly on women, raises issues of equity and prioritization that should also be considered. Nonetheless, given the popularity and power of the cost argument, its relative lack of support certainly bears closer scrutiny.

D. COMPREHENSIVE COVERAGE MAY LEAD TO A BETTER AND MORE COST-EFFECTIVE TREATMENT

Jane sees a new specialist and discovers that she has blocked fallopian tubes. Her doctor explains that he can either attempt to repair the damage to her fallopian tubes through one or more rounds of surgery, or he can bypass the damaged area with IVF. The surgeries are covered under her employer's health plan, but IVF is not. Jane opts for tubal repair surgery. Two years and several surgeries later, she is still unable to conceive.

The pattern of exclusions in plans such as the one in *Saks* may lead to inefficient, wasteful and needlessly invasive treatment of infertility. Covering certain medications and procedures can lead patients to rely on the covered or less expensive treatments even though they may not be the most effective. [241] For example, a patient with a plan that excludes IVF but not intrauterine insemination may opt to undergo the latter even though it is not effective for her particular infertility problem.[242]

Choosing treatment options based on coverage alone may also be significantly more expensive. For example, patients in a situation similar to Jane's have undergone repeated attempts at tubal repair surgery – a procedure that "can be twice as expensive as one attempt at IVF, is more invasive and is less effective for some patients." [243] Interestingly, "[s]tudies show that tubal surgeries drop by 50 percent when [assisted reproductive technologies such as IVF] are covered by insurance."[244]

There are human costs, as well. Surgery also requires significant recovery time, and a period of up to two years before success can be

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241. Pratt, *supra* note 18, at 1126-30.

242. *Id.*

243. Sonfield, *supra* note 40, at 5; *see also* Pratt, *supra* note 18, at 1126-30 ("[w]here insurance covers tubal surgeries, but not IVF, a woman with blocked fallopian tubes may have several tubal ligation surgeries to attempt to repair her tubes, instead of bypassing the tubes with IVF"); Bradley J. Van Voorhis et al., *Cost-Effectiveness of Infertility Treatments: A Cohort Study*, 67 FERTILITY & STERILITY 890 (1997) (finding that assisted reproductive technologies such as IVF were more cost-effective than surgery for women with blocked tubes).

244. Gilbert, *supra* note 28, at 44 (citations omitted).

measured.[245] In contrast, IVF can be performed on an outpatient basis, and success can be evaluated within two weeks.[246] In addition, one study suggests that women who undergo infertility-related surgery reported significantly higher levels of depression than women who did not undergo surgery.[247]

Overall, the evidence suggests that comprehensive coverage of treatments for infertility "can act to reduce incentives to seek inappropriate, and expensive, treatment."[248] In contrast, lack of comprehensive coverage for infertility treatments may lead patients to choose an inefficient, invasive, and potentially more expensive course of treatment.[249] Decisions that uphold selective exclusions, such as *Saks*, could make this bad situation even worse.[250]

CONCLUSION

In the context of employer health plans generally, the protections of afforded by civil rights laws such as Title VII and the ADA are important but limited, and state law mandates requiring coverage of certain conditions or treatments are unlikely to lead to uniform results because of ERISA preemption. In the case of employer plan coverage of infertility treatment, a seemingly reachable goal after *Bragdon*, *Saks* seems to have aggravated an already bad situation. Given the rising cost of health care coverage, it is likely that the exclusion of coverage for treatment of infertility under employer plans will continue to be an issue. Although Title VII offers advantages over the ADA for purposes of challenging the exclusion of

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245. *Id.* at 43.

246. *Id.* (citations omitted).

247. Domar, *supra* note 20, at 1162. The authors of that study opined that "the surgical experience itself may have led to feelings of discouragement due to physical discomfort, presence of a scar, loss of work, feeling mutilated, and decreased optimism as time passes." *Id.*

248. Sonfield, *supra* note 40, at 5.

249. The treatment may also be riskier if the woman chooses to transfer multiple embryos in a single cycle rather than bear the cost of multiple cycles. Assisted reproductive technologies such as IVF have raised concerns because they lead to significant increases in multiple birth rates, which are associated with serious health consequences for the mother and the children, as well as considerably increased cost. *See, e.g.*, Meredith A. Reynolds et al., *Does Insurance Coverage Decrease the Risk for Multiple Births Associated with Assisted Reproductive Technology?*, 80 FERTILITY & STERILITY 16 (2003). One recent study found that coverage of IVF effected embryo transfer decisions, although it was not clear that it reduces the incidence of multiple births or triplets or more. *Id.*

250. *See, e.g.*, Valerie Gutmann, *Assisted Reproductive Technologies: Failure to Cover Does Not Violate ADA, Title VII or PDA*, 31 J.L. MED. & ETHICS 314, 315-16 (2003).

infertility treatment, employers and health plans can continue to expect the types of challenges outlined in this Article to the exclusion of coverage for infertility treatment under both Title VII and the ADA.

In addition to factual and doctrinal support for claims under Title VII and the ADA for equitable and non-discriminatory treatment, there are strong public policy arguments supporting comprehensive coverage of treatments for infertility. Infertility is still seen as a "woman's issue" and the failure to conceive, carry and deliver a child cannot be characterized as "lifestyle choice." Moreover, there is evidence that the costs of comprehensive coverage for treatment of infertility are overstated, and that comprehensive coverage of treatment for infertility could lead to better, more humane, and more cost-effective treatment.

In their influential article, "The Emergence and Transformation of Disputes: Naming, Blaming and Claiming...," William L.F. Felstiner, Richard L. Abel and Austin Sarat observed that "[t]he individual's sense of entitlement to enjoy certain experiences and be free from others is a function of the prevailing ideology, of which law is simply a component."[251] Legal challenges in particular can be a "highly effective way of transforming ideology to create a sense of entitlement."[252] Many workers and their families affected by the disease of infertility are struggling to receive treatment in the absence of adequate insurance coverage. Bolstered by public policy arguments, legal challenges such as those outlined in this Article can support the transformation of their struggle from a cruel twist of personal fate into a cognizable, legitimate and successful civil rights claim.

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251. William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming and Claiming...*, 15 LAW & SOC'Y REV. 631, 643 (1980-81).

252. *Id.*

LAW, POLITICS, AND THE POLITICAL SAFEGUARDS OF FEDERALISM: THE CASE OF INSURANCE REGULATION AND THE COMMERCE CLAUSE, 1938-1948

Katherine M. Jones[*]

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INTRODUCTION

Federalism played a key role in the development of economic regulatory policy during the period 1938 to 1948, particularly in the area of insurance regulation. Scholars have tended to assume that by 1937, or at least by 1942 when the Supreme Court decided *Wickard v. Filburn*, issues concerning Congress's power over the economy had been resolved. In other words, the predominant view held that the change in the Supreme Court's constitutional jurisprudence that occurred during the New Deal's

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"Constitutional Revolution of 1937" resulted in an end to all judicially enforceable limits to Congressional power where commerce is implicated, even tangentially.[1] My research, however, suggests that federalism concerns continued to play an important role in shaping economic regulatory policy long after the Constitutional Revolution of 1937.

Throughout U.S. history, the insurance industry's relationship to both State and federal regulators has been unique. During the New Deal, national industries such as banking, securities, and telecommunications developed regulatory systems under which state and national regulation were exercised concurrently. Insurance, however, remained and currently remains the last major U.S. industry to be regulated primarily by individual states. Moreover, the United States is the only major industrialized nation that does not regulate insurance at the national level.[2]

Political Safeguards of Federalism

Legal scholars debate whether policing the boundaries of state and federal power is an appropriate job for the courts.[3] The notion of the "political safeguards of federalism" has been used to argue against the need for courts to enforce federalism limits on congressional legislation.[4] "Federalism" as used in this context refers to a situation where decisions

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1. Edwin Corwin, *The Passing of Dual Federalism*, 36 VA. L.REV. 1-24 (1950); Harry N. Scheiber, "New Deal," Encyclopedia of the American Constitution 335-339 (Leonard Levy, ed.), Supplement I 1992.

2. Jonathan R. Macy & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation*, 68 N.Y.U.L. REV. 13, 20 (April 1993).

3. *See, e.g.*, JOHN T. NOONAN, JR., NARROWING THE NATION'S POWER: THE SUPREME COURT SIDES WITH THE STATES (2002); Marci A. Hamilton, *Why Federalism Must Be Enforced: A Response to Professor Kramer*, 46 VILL. L. REV. 1069 (2001); Larry D. Kramer, *The Supreme Court 2000 Term Forward: We the Court*, 115 HARV. L. REV. 4 (2001). This article addresses federalism limits imposed by the courts on Congress's ability to legislate under the Commerce Clause. But the federalism debate also extends to other areas, such as the Eleventh Amendment, *see, e.g.*, Seminole Tribe v. Florida, 517 U.S. 44 (1996), and section 5 of the Fourteenth Amendment, *see, e.g.*, City of Boerne v. Flores, 521 U.S. 507 (1997).

4. *See, e.g.*, Jesse H. Choper, *The Scope of National Power Vis-à-Vis the States: The Dispensability of Judicial Review*, 86 YALE L.J. 1552 (1977); Herbert Wechsler, *The Political Safeguards of Federalism: The Role of the States in the Composition and Selection of the National Government*, 54 COLUM. L. REV. 543 (1954). Legal scholar Larry Kramer believes in political safeguards, but sees a different mechanism at work. *See* Larry Kramer, *Understanding Federalism*, 47 VAND. L. REV. 1485 (1994). *See also* Mark V. Tushnet, Why the Supreme Court Overruled *National League of Cities*, 47 VAND. L. REV. 1623 (1994).

are made by the "people of the states" expressing their will through state elections and state legislation, rather than by "the people of the United States" expressing their policy preferences through the national Congress.[5] According to Herbert Wechsler, when decisions are made by the people of the states, "the states [become] the strategic yardsticks for the measurement of interest and opinion, . . . [and] the separate geographical determinants of national as well as local politics."[6] His theory posits that the national government has "intrinsic sensitivity to any insular opinion that is dominant in a substantial number of the states."[7] In other words, decision-making by Congress does not tend to be expansionist in nature, increasing national power at the expense of the states. Rather, it is designed to take into account the states' desire to retain control over "subjects that dominant state interests wish preserved for state control."[8]

Almost twenty years ago, the Supreme Court accepted this view in *Garcia v. San Antonio Metropolitan Transit Authority, Inc.*[9] In *Garcia*, the Court stated it would no longer strike down federal statutes for intruding on "traditional functions" of state government because "the principal means chosen by the Framers to ensure the role of the States in the Federal system lies in the structure of the Federal Government itself."[10] The Court reasoned that:

The Framers chose to rely on a federal system in which special restraints on federal power over the States inhered principally in the workings of the National Government itself, rather than in discrete limitations on the objects of federal authority. State sovereign interests, then, are more properly protected by procedural safeguards inherent in the structure of the federal system than by judicially created limitations on federal power.[11]

By 1995, however, the Court had reversed itself and began to enforce limits on Congress's ability to legislate under the Commerce Clause. In *United States v. Lopez,*[12] the Court invalidated the Gun-Free School Zones Act holding that the activity it regulated was not within the scope of Congress's Commerce power. With this holding, the Court struck down a federal statute on commerce clause grounds for the first time since the New

5. Wechsler, *supra* note 4, at 546.
6. *Id.*
7. *Id.* at 547.
8. *Id.* at 548.
9. 469 U.S. 528 (1985).
10. *Id.* at 550.
11. *Id.* at 552.
12. 514 U.S. 549 (1995).

Deal.[13] Five years later in *United States v. Morrison*,[14] the Supreme Court reaffirmed its new approach to federalism when it struck down the civil remedy provision of the Violence Against Women Act,[15] holding it invalid under the Commerce Clause and outside of Congress's power under section five of the Fourteenth Amendment.[16] The majority in *Morrison* (and a concurrence in *Lopez*) suggested whether the regulated activity is a matter of "traditional state concern" as an important consideration for determining whether an activity is more appropriately handled at the state or national level.[17] In both *Lopez* and *Morrison*, the majority identified specific areas "where States historically have been sovereign" as examples of those deserving protection from federal encroachment.[18]

Justice Scalia, one of the judges who voted with the majority in those two cases, has explained why his reading of constitutional history has convinced him of the need for the Court to police the boundaries of state and federal power.[19] He argues that the Framers' original design to protect state prerogatives has been eroded by historical constitutional changes.[20] In his view, the increased size and power of the national government relative to the states now mandates that the Court step in to protect state prerogatives.[21] More specifically he argues: "[t]he vast expansion of the federal government in this century is attributable . . . to two constitutional amendments and three elements of judicial constitutional interpretation."[22] The constitutional amendments were the Seventeenth Amendment, which eliminated the direct election of senators by state legislators, and the

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13. Jesse H. Choper, *Taming Congress's Power Under the Commerce Clause: What Does the Near Future Portend?*, 55 ARK. L. REV. 731, 732 (2003).

14. 529 U.S. 598 (2000).

15. 42 U.S.C. § 13981 (2005).

16. *Morrison*, 592 U.S. at 627.

17. *Id.* at 611; *accord Lopez*, 514 U.S. at 580 (Kennedy J., concurring).

18. *Morrison*, 529 U.S. at 613; *accord Lopez*, 514 U.S. at 564. Jesse Choper has written that he sees the idea of dual federalism as "the driving force at the core of the Rehnquist Court's overall revival of judicially secured federalism, a process that had its contemporary roots in the notions of 'traditional aspects of state sovereignty' and 'integral operations in areas of traditional governmental functions'" Choper, *supra* note 13, at 754 (quoting Nat'l League of Cities v. Usery, 426 U.S. 833 (1976)).

19. *See generally* Antonin Scalia, *American Federalism and the Supreme Court*, *in* THE NEW FEDERALISM: STRUCTURES AND INFRASTRUCTURES, AMERICA AND EUROPEAN PERSPECTIVES 56, 57-81 (Kjell Ake Modeer ed. 2000). Justices Lewis Powell and Sandra Day O'Connor have voiced similar opinions based on formal constitutional amendments and extra constitutional developments, such as the emergence of a national two-party system. *See* Tushnet, *supra* note 4, at 1624.

20. *See generally* Scalia, *supra* note 19, at 57-81.

21. *Id.*

22. *Id.* at 57.

Sixteenth Amendment, which authorized the federal government to impose an income tax that Scalia argues, now allows the national government to spend money in almost any area.[23] The two other elements of judicial constitutional interpretation that have permitted the extensive expansion of federal powers in this century are the Supreme Court's broad reading of the Commerce Clause since the New Deal and its expansive construction of the Due Process Clause of the Fourteenth Amendment.[24] Other legal scholars have argued that the Supreme Court can never be an effective protector of state prerogatives for institutional reasons.[25]

The authors of the *Federalist Papers*, James Madison and Alexander Hamilton, however, described a more nuanced view of the operation of federalism as embodied in the Constitution. Madison described the national government as a "safeguard against domestic faction" and as an antidote to the tendency of the smaller state governments to respond to "factions" and in the process, oppress minorities.[26] Madison wrote: "By a faction, I understand a number of citizens, whether amounting to a majority or a minority of the whole, who are united and actuated by some common impulse of passion, or of interest, adverse to the rights of other citizens, or to the permanent and aggregate interests of the community."[27] He believed that the national government was the answer to the problems posed by faction because, "[e]xtend the sphere, and you take in a greater variety of parties and interests; you make it less probable that a majority of the whole will have a common motive to invade the rights of other citizens . . . ."[28] A second aspect of the Founders' thought on federalism has been noted by Professor Petty who writes: "The Federalist Papers clearly suggest that the Framers believed federalism would foster a vertical competition between

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23. *Id.* at 57-58.

24. *Id.* at 57-67. Justices Lewis Powell and Sandra Day O'Connor have voiced similar opinions based on formal constitutional amendments and extra constitutional developments, such as the emergence of a national two-party system. *See* Tushnet, *supra* note 4, at 1624.

25. They argue that the federal courts, including the Supreme Court, are a part of the national government. For this reason, they should be assumed to be inherently predisposed to grant Congress power at the expense of the states because any increase in Congressional power increases the power of the federal courts to decide questions arising under their federal question jurisdiction. *See* Frank B. Cross, *Realism About Federalism*, 74 N.Y.U. L. REV. 1304, 1318 (1999).

26. THE FEDERALIST NO. 10, at 41 (James Madison) (Everyman ed., 1996) ("[a]mong the numerous advantages promised by a well constructed Union, none deserves to be more accurately developed than its tendency to break and control the violence of faction.").

27. *Id.* at 42.

28. *Id.* at 47.

the states and the federal government for the people's 'affection.'"[29] Both of these concepts articulated in the *Federalist Papers* tend to suggest that the allocation of regulatory authority between the state and national governments is best treated as political question rather than a judicial one.

In order to evaluate the appropriate role of the courts in policing federalism, it is first necessary to determine what exactly federalism is as practiced in the United States, and whether it really matters.[30] In general, federalism connotes a system of government that combines the general (the national government) and constituent governments (the states) and distributes power among them in such a way as to protect the existence and authority of both.[31] While scholars can agree on its definition, there has been a dearth of historical and empirical research into the dynamics of federalism as it operates in concrete circumstances.[32]

Professor Larry Kramer has suggested that to understand federalism better:

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29. Todd E. Pettys, *Competing for the People's Affection: Federalism's Forgotten Marketplace*, 56 VAND. L. REV. 329, 332 (2003). According to Petty:

> Each time a government acts or refuses to act, it further develops its reputation among its constituents. If a government satisfactorily regulates a given matter, it can expect to earn an added measure of its citizens' affections . . . The more areas that a government regulates satisfactorily, the greater the affection it can expect to earn and thus the greater the responsibilities it can expect citizens to confer upon it. Because there are many areas in which the state and federal governments' legislative powers overlap, however, if one government regulates an activity in an unsatisfactory manner, the people may be able to shift responsibility to the other sovereign.

Id. at 333; *see also* THE FEDERALIST NO. 17 (Alexander Hamilton). Larry Kramer has also written about the role of state and federal politicians as rivals for the peoples' affection. *See* Larry Kramer, *Putting the Politics Back into the Political Safeguards of Federalism*, 100 COLUM. L. REV. 215, 268-69 (2000).

30. Many have argued that discussions of federalism often serve as a pretext for advocating particular policy outcomes. *See, e.g.*, Barry Friedman, *Valuing Federalism*, 82 MINN. L. REV. 317, 318-19 (1997); Jonathan R. Macey, *Federal Deference to Local Regulators and the Economic Theory of Regulation: Toward a Public-Choice Explanation of Federalism*, 76 VA. L. REV. 265, 265 (1990); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 907-08 (1994).

31. *See* DANIEL J. ELAZAR, AMERICAN FEDERALISM: A VIEW FROM THE STATES 2 (3d ed. 1984); *see also* Sally F. Goldfarb, *The Supreme Court, the Violence Against Women Act, and the Use and Abuse of Federalism*, 71 FORDHAM L. REV. 57, 59 (2002).

32. *But see generally* Frank B. Cross & Emerson H. Tiller, *The Three Faces of Federalism: An Empirical Assessment of Supreme Court Federalism Jurisprudence*, 73 S. CAL. L. REV. 741 (2000); Hamilton, *supra* note 3.

> We need a picture of the evolution of American federalism over time—a narrative account of conflicts that arose and how they were resolved, of shifts in power and what motivated them, of how different institutions adapted to changing circumstances and what the consequences of those adaptations were.[33]

Thus, scholars need to study federalism in "the context of dynamic political, economic, and social systems," because, "in the United States, the politics of issues are shaped by the special institutions and processes of the federal system."[34]

One of the few scholars to engage in this type of exercise advocated by Kramer has been Marci A. Hamilton. In her article, "Why Federalism Must Be Enforced: A Response to Professor Kramer," she argues that not only is the procedural safeguards theory wrong as a matter of constitutional history, "it is untrue as an empirical matter."[35] She argues that "[t]he crux of the political safeguards theory is empirical. This is a factual question: are states being overrun by the federal government or being subject to federal law without adequate recourse?"[36] While I disagree with her conclusion that there is no empirical support for the procedural safeguards theory, I believe that her methodological approach to the issue is a good one. Consequently, I have adopted a similar empirical approach. The following study is a search for empirical evidence to support or refute the presence of political safeguards of federalism. My historical research, however, provides evidence of state interests in fact being protected in Congress, in some cases, to a greater degree than they are protected by the Court.

Woodrow Wilson recognized at the turn of the century that "[t]he question of the relation of the states to the federal government is the cardinal question of our constitutional system" and that it could never "be settled by the opinion of any one generation, because it is a question of growth, and every successive stage of our political and economic development gives it a new aspect, makes it a new question."[37]

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33. Larry Kramer, *supra* note 4, at 1493.

34. Harry N. Scheiber, *Federalism and Legal Process: Historical and Contemporary Analysis of the American System*, 14 LAW & SOC'Y REV. 663, 664 (1980).

35. Hamilton, *supra* note 3, at 1071.

36. *Id.* at 1077.

37. WOODROW WILSON, CONSTITUTIONAL GOVERNMENT IN THE UNITED STATES 173 (1908).

This article attempts to more fully understand the ways in which the United States citizens and the judges, legislators, and other political actors of a particular decade, the ten years between 1938 and 1948, struggled to answer this "cardinal question of our Constitutional system."[38] Their times and the circumstances they faced differed from those of every generation that came both before and after them, and their solutions to the problems of government raised by federalism also differed. Moreover, the Americans of the early post-New Deal period, like all Americans, did not have the luxury of working with a clean slate. Layers of existing governmental policy had been built in previous decades reflecting various conflicting theories of federalism and varying social circumstances. And these governmental structures and precedents remained on the books, in the ideas held by elites about the proper role of the nation and the states, and in the existing structures of government. For example, the predominant intellectual framework governing federal/state relations, which included whether state and federal powers could ever be exercised concurrently, changed over time. Yet issues settled in earlier times were seldom reopened for wholesale reconsideration.

The study that follows presents a detailed case study of the insurance industry and efforts by the federal government to apply both the Commerce Clause and national antitrust laws to this industry. That this national industry continues to be state regulated, despite the existence of the commerce clause and of federal regulation of every other similar industry can be directly attributed to historical accident and to the continuing power of federalism principles in the United States. The effort to make insurance subject to the Sherman Act occurred soon after the Supreme Court had appeared to relinquish all judicially enforceable limits on Congress's power vis-à-vis the states in what is generally known as "the Constitutional Revolution of 1937." After 1937, cases such as *Wickard v. Filburn*[39] appeared to confirm the new breadth of the Commerce Clause and to ensconce it firmly within U.S. legal doctrine. Therefore it is surprising that the ultimate outcome of the Court's decision in 1944 in *United States v. South-Eastern Underwriters Association,*[40] which held that the business of insurance was engaged in interstate commerce, and Congress's reaction to that decision, should have been to leave essentially all regulation of this admittedly national industry to the states.

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38. *Id.*
39. 317 U.S. 111 (1942).
40. 322 U.S. 533 (1944).

In the end, the decision was made to entrust insurance regulation to individual state governments, despite a recognized need for some degree of uniformity in regulation of a national industry. This was true even though it was never credibly contended that Congress lacked the power to promulgate the rules necessary to satisfy this need. Nevertheless, the ultimate policy choice was made to deal with the need for uniformity through a complex regime of uniform state laws, rather than by federal regulation. The concept of uniform state laws was a progressive era innovation designed to deal with cases of incongruity between economic and formal political systems.[41] While business operated increasingly in both national and regional markets, the U.S. political system during the Progressive Era tended to place political authority within the states. In most regulatory areas, the New Deal ushered in national solutions to economic regulatory problems. But in the case of insurance, structural factors deriving from the federal system led Congress to opt for a Progressive Era solution to a post-New Deal problem.[42]

While any study of the political safeguards of federalism is necessarily time bound, the history of this controversy suggests that political safeguards of federalism do exist, but that it is not clear exactly what type of interests they protect.[43] The relevant caselaw is quite vague about the nature of the state interests that deserve protection from federal encroachment. Clearly, national commandeering of state officials is frowned upon by the Court. But the Court has also stressed at times that the state interests at risk constitute the "traditional functions" of state government.[44] In Professor Wechsler's view, the political safeguards of federalism operate to protect "subjects that dominant states' interests wish preserved for state control."[45] In my view, conceiving of the relevant protected interests in this way helps explain the anomaly of state regulation of insurance in a period following the creation of national regulatory bodies in areas of law previously regulated at the state level, such as securities, telecommunications and banking. This history of the regulation of insurance strongly indicates that the ability to continue to collect taxes from

41. William Graebner, *Federalism in the Progressive Era: A Structural Interpretation of Reform*, 64 J. AM. HIST. 331 (1977). "Occupying a middle ground, uniformity was the Progressive era's answer to the need for a political device that would take a variety of questions beyond the states but keep them from the national government." *Id.* at 345.

42. *Id.*

43. Professor Sally Goldfarb has queried, "To the extent that local government is predisposed to be accessible and responsive, the relevant question is, accessible and responsive to whom?" Goldfarb, *supra* note 29, at 106.

44. *Garcia*, 469 U.S. 528, 550 (1985).

45. Wechsler, *supra* note 4, at 55.

insurance companies was not only a "traditional function of government" but also an interest that "dominant states' interests wished preserved for state control."

A second type of state interest protected by the political safeguards of federalism at this time involved protection of the states' traditional authority over matters affecting race relations. It is precisely because history demonstrates that the protection of state's traditional authority over matters affecting race relations can be an interest that states care about protecting, that jurists such as Justice Scalia should be cognizant of the principle spelled out by Madison in Federalist No. 10 that national decision-making can operate as an antidote to the tendency of the smaller state governments to respond to "factions" and in the process, oppress minorities.[46]

Part II of this article takes an historical look at the development of commerce clause jurisprudence and the regulatory history of insurance. In particular it examines the history of preemption doctrine, the expansion of the commerce clause that occurred during the "Constitutional Revolution of 1937," the development of dormant commerce clause jurisprudence and the effects of these developments on conceptions of federalism. Part III provides an in-depth analysis of *United States v. South-Eastern Underwriters Association* and the various conceptions of federalism that collided in the course of that litigation. Part IV examines the legislative history of the McCarran-Ferguson Act in an attempt to determine the extent to which the actions of Congress reflected the interests of the states represented by its members. Part V attempts to analyze the role played in Congress of the political safeguards of federalism, as well as other possible factors such as political parties or relevant economic interests, that contributed to Congress's resolution of the federalism issues presented to it by the controversy over insurance regulation. Part VI concludes that as early as the immediate Post-New Deal period, federalism as both an active element in a dynamic political system and as a concept embedded in judicially-created doctrines such as preemption and *stare decisis* played a significant role in the development of regulatory policy by both Congress and the courts. In other words, this historical episode appears to confirm the actual historical operation of not only "political safeguards of federalism" in Congress, but also the existence of jurisprudential and legal doctrines that operate to protect state's previously sanctioned rights through preservation of the status quo. Some of the most important structural political factors relating to federalism that have influenced policy outcomes

46. THE FEDERALIST NO. 10 at 42 (James Madison) (Everyman ed. 1996).

in Congress have been the representation of state interests in Congress, the operation of the intergovernmental lobby, and the high percentage of officials in the federal government who began their political careers working in state government.

Of course, an examination of the political safeguards of federalism in action in a particular set of historical circumstances leaves many normative questions unanswered. The conclusion that there are such safeguards that sometime operate to protect state prerogatives in Congress does little to address the question of whether they offer sufficient protection of the right type. The degree of power that states "should" possess must be assessed before a means of protecting that power can be evaluated. The constitution does not specify what quantum of state power is desirable in our federal system, it merely requires that states continue to exist.[47] Perhaps an historical inquiry can assist in developing an answer to the normative question by presenting empirical evidence of the specific ways that the political power of states has influenced the political system in the past and pointing out the mechanisms through which legal doctrines such as *stare decisis* tend to perpetuate past political and economic accommodations.[48]

I. COMMERCE CLAUSE AND INSURANCE REGULATION

The political decision in the United States to regulate a powerful national industry at the state level presents a complex example of the dynamics governing the division of labor in a federal system. The continued state regulation of insurance throughout the twentieth century is an historical anomaly. While the Constitution grants Congress the power

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47. *See* Gregory P. Magarian, *Toward Politician Safeguards of Self-Determination*, 46 VILL. L. REV. 1219 (2001).

48. According to Mark Tushnet, it is important not only to protect state interests, but to protect them to an appropriate degree:

> It may be true, as Wechsler argued, that federalism principles need not be enforced by the courts as long as the interests of the states as states are adequately represented in the national political process. But, contrary to Wechsler, it may not be true today that those interests are represented adequately. And, judicial review is designed to deal with precisely those situations in which the interests constitutional principles are designed to protect are not adequately represented in the political process. Preserving state competence in the face of centralizing legal doctrine and the obvious failure of the structural guarantees on which Wechsler relied leads recurrently to a search for informal means by which state interests are protected. Those informal means, however, are not themselves embedded in the Constitution and are always vulnerable to drift and change.

Tushnet, *supra* note 4, at 1635-36.

"[t]o regulate Commerce . . . among the several States,"[49] the Supreme Court held that insurance is not commerce for purposes of the Commerce Clause.[50] The Court reversed itself on this issue in a highly controversial opinion in 1944.[51] Nevertheless, although there currently is no dispute that Congress has the power to regulate insurance, it has never done so, even to the extent of applying the generally applicable antitrust laws to the industry. Rather, in 1945, soon after the decision that insurance was interstate commerce, Congress declared in the McCarran-Ferguson Act "that the continued regulation and taxation by the several States of the business of insurance is in the public interest."[52] This article explores how federalism influenced Congress to choose to protect the states' regulatory power in this area when the Supreme Court did not do so.

In the nineteenth century when the need to regulate insurance first became apparent, state legislatures promulgated virtually all economic regulatory legislation, including corporate law. Early insurance regulation initially took the form of restrictive requirements included within company charters.[53] While common, such charter restrictions were rarely enforced because the penalty for violations was effectively limited to not allowing the company to do business in the state, an action that states had little incentive to take because it tended to deprive them of both jobs for their citizens and tax revenues.[54]

In the mid-nineteenth century at a time when it was subject to control only by state governments, the insurance industry began to organize itself into regional and national organizations with the goal of eliminating "excessive" competition. In furtherance of this goal, insurance companies operating in large cities formed private rating organizations to coordinate (and raise) the rates they charged. For example, shortly after the Civil War, companies in city-wide rating organizations formed the National Board of Fire Underwriters ("NBFU") for the purpose of establishing uniform

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49. U.S. CONST., art. I, § 8, cl. 3 (the "Commerce Clause").

50. Paul v. Virginia, 75 U.S. 168 (1869).

51. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944).

52. McCarran-Ferguson Act, 15 U.S.C. § 1011 (2000).

53. State legislatures typically included provisions within insurance companies' charters calling for such things as guidelines for minimum capitalization, investment restrictions, provisions for reserves, and periodic public financial reports. Most of the requirements were designed to ensure that the company remained solvent. Virtually no state regulated the collective activities of insurance companies or attempted to guard against their charging excessive rates.

54. *See* HARRY N. SCHIEBER, THE CONDITION OF AMERICAN FEDERALISM: AN HISTORIAN'S VIEW (Government Printing Office 1966).

national rates.[55] The NBFU also began to engage in political activities such as lobbying both state legislatures and Congress.[56] At the same time, insurance companies also joined together to form regional rate associations, such as the New England Insurance Exchange.[57] Insurance organizations engaging in such regional and national activities operated without any effective regulatory supervision. Often the multistate activities of these insurance associations were overtly anticompetitive and designed to promote uniform rates, leading certain policy-makers to advocate federal control of insurance, possibly by way of a constitutional amendment.[58]

In 1868 the insurance industry mounted a legal challenge to state regulation of insurance in *Paul v. Virginia.*[59] Attorneys for the insurance industry argued that as corporations, insurance companies were "citizens" under the constitution and thus entitled to the "privileges and immunities" of U.S. citizens under the Fourteenth Amendment.[60] Therefore, they argued, out-of-state or "foreign" corporations could not be subject to discriminatory legislation that was inapplicable to domestic insurance companies.[61] They also argued that the Virginia statute discriminated against interstate commerce in violation of the dormant commerce clause.[62] Ultimately, the U.S. Supreme Court upheld the constitutionality of state regulation of insurance companies against the charge that such regulation violated the Commerce Clause by holding that "insurance is not a transaction of commerce."[63] After the *Paul* case confirmed state authority

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55. GRANT, INSURANCE REFORM: CONSUMER ACTION IN THE PROGRESSIVE ERA 74-75 (1979).

56. *Id.*

57. Phillip L. Merkel, *Going National: The Life Insurance Industry's Campaign for Federal Regulation After the Civil War*, 65 BUS. HIST. REV. 528, 540 (1991).

58. *Id.* In 1868, proponents of federal regulation introduced bills in Congress to create a federal commissioner of insurance and in 1897 to declare that insurance companies doing business outside their state of incorporation were engaged in interstate commerce. *Id.* at 541. Neither bill passed, partly because many Congressmen read *Paul* to mean that Congress had no power to regulate insurance. *Id.* at 544-50.

59. 75 U.S. 168 (1869). The litigation was orchestrated by the New York City Association of Underwriters, but the National Board of Fire Underwriters provided financial support for the litigation. Merkel, *supra* note 57, at 540.

60. *See* Paul, 75 U.S. at 170.

61. *Id.*

62. *Id.*

63. *Id.* at 168. The statute at issue in *Paul* was not part of a comprehensive regulatory scheme, but rather a statute that required agents of out-of-state insurance companies (but not those chartered by the state) to obtain a license before selling insurance within the state. *Id.* at 169. Mr. Paul represented several New York fire insurance companies that requested that he violate the statute in order to bring a test case. *Id.* His subsequent appeal to the U.S. Supreme Court was financed by the NBFU. Justice Field devoted the bulk of the Court's

to regulate insurance, state insurance commissioners followed the insurance companies' example and formed a national association for cooperation among state regulators.[64] In 1871 the National Insurance Convention was formed to provide a forum in which state insurance officials could discuss common regulatory problems.[65] For the next 75 years, both Congress and the executive branch made no attempt to subject insurance to federal regulation, believing such regulation to be outside the federal government's constitutional power. In 1913, in *New York Life Insurance Company v. Deer Lodge County*, the Court further discouraged attempts at national control of insurance when it stated that if insurance were to be held to be commerce, it would render all existing state insurance regulations invalid under the doctrine of preemption.[66]

This view that state and federal regulatory responsibilities were necessarily mutually exclusive, was known as "dual federalism."[67] The classic judicial definition of dual federalism is found in *Tarble's Case*:

> There are within the territorial limits of each State two governments, restricted in their spheres of action, but independent of each other, and supreme within their

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opinion to the privileges and immunities clause argument. He held that for purposes of that clause a corporation was not a citizen because it possessed only the rights granted to it by the state in its corporate charter. *Id.* at 170. "The corporation being the mere creation of local law can have no legal existence beyond the limits of the sovereignty were created." *Id.* at 181.

64. KENNETH MEIER, THE POLITICAL ECONOMY OF REGULATION: THE CASE OF INSURANCE 53-54 (1988).

65. This organization later changed its name to the National Convention of Insurance Commissioners and then to the National Association of Insurance Commissioners. *Id.*

66. *See* New York Life Ins. Co. v Deer Lodge County, 231 U.S. 495 (1913).

67. DONALD H. HAIDER, WHEN GOVERNMENTS COME TO WASHINGTON: GOVERNORS, MAYORS AND INTERGOVERNMENTAL LOBBYING 20-21 (1974). A brief summary of the complex concept of dual federalism can be found in WILLIAM WIECEK, LIBERTY UNDER LAW 95 (1988):

> [The states were] the equals of the national government in the federal system; that each of these [state and federal] governments had a complete, independent structure within which to exercise its power and could not require the other to administer its laws; that the powers of each government were completely distinct and independent with each supreme in its own sphere; that the Tenth Amendment confirmed this structure and guaranteed that the national power would not be interpreted in such as way as to subvert the reserved sovereign jurisdiction of the States.

Id. (citing Michael Les Bendict, *Preserving Federalism: Reconstruction and the Waite Court*, SUP. CT. REV. 39, 42 (1978)).

> respective spheres. Each has its separate departments; each has its distinct laws, and each has its own tribunals for their enforcement. Neither government can intrude within the jurisdiction, or authorize any interference therein by its judicial officers with the action of the other. The two governments in each State stand in their respective spheres of action in the same independent relation to each other . . . that they would if their authority embraced different territories.[68]

As the U.S. economy continued to develop in the period leading up to World War I, insurance companies began conducting more interstate business and the number of critics of state regulation of insurance grew. In 1905, the state of New York's Armstrong Investigation of the life insurance industry uncovered sensational evidence of unethical industry practices.[69] In 1909 in response to these revelations, Kansas enacted the first comprehensive state rate-regulatory statute, and other states soon followed suit.[70] Nevertheless, most early state regulation aimed to ensure that insurance rates were "adequate" to prevent insurer insolvency rather than to protect policyholders from excessive rates.[71] In addition, virtually every state insurance commission was under funded. According to one Missouri Insurance Superintendent: "some [companies] kept but a few books of any kind, and these in so slovenly a manner that even the officers could tell nothing about the entries. The agents . . . wrote . . . specious and novel plans, and defrauded without fear of penalty."[72]

The Armstrong Committee particularly denounced the lobbying activities of the large insurance companies:

> Nothing disclosed by the investigation deserves more serious attention than the systematic efforts of the large insurance companies to control a large part of the legislation of the state. They have been organized into an offensive and defensive alliance to procure or prevent the passage of laws

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68. 80 U.S. 397 (1872).

69. DAVID LYNCH, THE CONCENTRATION OF ECONOMIC POWER 388 (1946).

70. The Supreme Court upheld this statute in *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389 (1914) on the basis that insurance was a business "affected with the public interest."

71. SANDRA B. MCCRAY, FEDERAL PREEMPTION OF STATE REGULATION OF INSURANCE: END OF A 200-YEAR ERA?, 23 PUBLIUS 23, 34 (1993).

72. *Id.*

> affecting not only insurance, but a great variety of important interests to which, through subsidiary companies or through the connections of their officers, they have become related. . . . Enormous sums have been expended in a surreptitious manner. Irregular accounts have been kept to conceal the payments for which proper vouchers have not been required. This course of conduct has created a widespread conviction that large portions of this money have been dishonestly used. . . . The pernicious activities of corporate agents in matters of legislation demand that the freedom of lobbying should be restricted. They have exposed its members to consequent assault. The legislature owes it to itself, so far as possible to stop the practice of the lavish expenditure of moneys ostensibly for services in connection with the support of or opposition to bills, and generally believed to be used for corrupt purposes.[73]

The national government made no concerted effort to regulate the activities of insurance companies and their associated organizations until late in the New Deal period, when Thurman Arnold became the head of the Antitrust Division of the Justice Department.[74] In fact, both the national Republican and Democratic platforms of 1940 contained planks in favor of the continued state regulation of insurance.[75] Thurman Arnold was prompted to take action when he received a large number of complaints from policyholders, independent companies and insurance agents of anticompetitive activities engaged in by the insurance industry.[76] In

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73. LYNCH, *supra* note 69, at 294.

74. SPENCER L. KIMBALL & BARBARA P. HEANEY, FEDERALISM AND INSURANCE REGULATION: BASIC SOURCE MATERIALS 18 (1995) "It is fair to observe that though regulation at the state level was becoming increasingly invasive and therefore was not always welcome, the only federal regulation likely to be applicable before the New Deal period would have been the Sherman and Clayton Acts." *Id.*

75. *See Bills to Affirm the Intent of Congress that the Regulation of Business of Insurance Remain within the Control of the Several States and that the Acts of July 2, 1890, and October 15, as Amended, Be Not Applicable to That Business, Joint Hearing Before the Subcomm. of the Comm. on the Judiciary,* 78th Cong. 1, 1st Sess. (1943) [hereinafter *Joint Hearings*]; Brief for Appellees at 27-28, United States v. South-Eastern Underwriters Ass'n, 323 U.S. 811 (1943) (No. 354).

76. *See* Memorandum from Frank H. Elmore, Jr., Special Assistant to Attorney General, to Thurman Arnold, Assistant Attorney General, Dept. of Justice (January 21, 1942) (on file with author) [hereinafter Elmore Memo]. A number of insurance agents and independent companies complained to the Department that rating bureaus attempted to fix rates and to control their activities through threats and coercion. For example, any agent

response to these activities, states such as Georgia and Alabama had passed anticompact laws. These laws generally proved ineffective, however, because no state was able to prevent insurance companies from retaliating against the out-of-state offices of uncooperative agents or independent companies.[77]

Arnold saw the need for the Justice Department to step in and address the problem on a national basis. And despite the Supreme Court's holding that insurance was not commerce, he saw no constitutional impediment to its doing so because his reading of subsequent Supreme Court cases interpreting the Commerce Clause expansively, such as *Wickard v. Filburn*, led him to believe that the Court would overturn *Paul v. Virginia* if given the opportunity.[78] His decision to bring suit was bolstered by a contemporaneous massive investigation into the state of the United States' economy which had uncovered significant abuses in the insurance industry, including price-fixing, that were not being controlled by state regulation.[79]

The actual trigger for the case came when the state of Missouri sued a coalition of fire insurance companies under a Missouri statute that prohibited insurance companies from combining to fix premiums for fire insurance. On December 22, 1941, Missouri Attorney General Roy McKittrick's office wrote to Arnold that Missouri had uncovered evidence that insurance companies responsible for selling the vast majority of stock fire insurance policies in the United States were "parties to the most vicious and powerful trust ever devised."[80] McKittrick believed that his office lacked the competence to prosecute such a nation-wide conspiracy and he requested that the U.S. Antitrust Division "take the necessary steps to dissolve this trust. . . ."[81] In fact, McKittrick had initially brought a *quo warranto* action against 134 stock fire-insurance companies under Missouri's anticompact law, which specifically prohibited combinations to fix premium rates for fire insurance.[82]

In 1942, the Justice Department filed suit against a regional insurance trade association and certain of its members in *United States v. South-*

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doing business with a company not affiliated with the bureau was requested to stop doing such business or risk being kicked out of the organization. *Id.*

77. *Id.* at 5.

78. *See* Memorandum from Thurman Arnold, Assistant Attorney General, to the Attorney General 2 (February 16, 1942) (on file with author) [hereinafter Arnold Memo]; *see also* Elmore Memo, *supra* note 76, at 7.

79. FINAL REPORT AND RECOMMENDATIONS OF THE TEMPORARY NATIONAL ECONOMIC COMMITTEE (Washington: U.S. Govt. Printing Office) (1941) [hereinafter TNEC].

80. Elmore Memo, *supra* note 76, at 7.

81. *Id.*

82. *Joint Hearings*, *supra* note 75, at 25.

Eastern Underwriters Association.[83] The Department lost the case at the district court level when the Court relied on *Paul v. Virginia* to hold that insurance was not commerce and therefore not subject to the federal antitrust laws. The Department then appealed the case to the Supreme Court in a conscious attempt to make new constitutional law and won.[84]

A. THE HISTORY OF PREEMPTION AND THE DORMANT COMMERCE CLAUSE

After losing the *South-Eastern Underwriters* case in district court, Thurman Arnold had concluded that it was the fear of possible federal preemption of state law that had influenced the Court in *Paul* to uphold state regulation by declaring that insurance was not commerce. Preemption is an area of the law with great theoretical and practical significance for federalism because the doctrine was designed to mediate conflicts between national and state substantive policies.[85] One argument against the existence of political safeguards is the obvious superiority of federal to state law under the Supremacy Clause. According to Marci Hamilton, "with each federal law, Congress holds the trump card of preemption . . . ."[86] History, however, demonstrates that over time, the actual operation of the doctrine of preemption in concrete situations has been far from predictable. A primary reason that the courts were, and historically had been, reluctant to apply federal law to the insurance industry was concern about the possible preemptive effect on state law of applying federal law to this area.

A primary issue in the *United States v. South-Eastern Underwriters* case was whether conceding federal power to regulate insurance would

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83. Memorandum from Assistant Attorney General Tom C. Clark, to the Attorney General 1 (June 22, 1943) (on file with author); 51 F. Supp 712 (N.D. Ga. 1943).

84. Memorandum from Attorney General Tom C. Clark, to Solicitor General Charles Fahy 5 (August 17, 1943) (on file with author).

85. *See* S. Candice Hoke, *Preemption Pathologies and Civic Republican Values*, 71 B.U. L. REV. 685, 687 (1991). According to Hoke, "Preemption is properly considered within the larger framework of federalism theory. A sound restructuring of preemption doctrine must be founded upon an understanding of the purposes served by a federal division of power, and of the structural features requisite to the effective achievement of those objectives." *Id.* at 701. She argues that use of federal preemption should be limited because "Federal preemption decisions impede the ability of those governmental bodies that are structured to be the most responsive to citizens' public values and ideas – state and local governments – and have concomitantly undermined citizens' rights to participate directly in governing themselves." *Id.* at 687.

86. Hamilton, *supra* note 3, at 1078.

have the effect of negating all pre-existing state law on the subject.[87] At the time the case was brought, the doctrine of federal preemption of state law had been in a state of flux for many years and was characterized by inconsistent Supreme Court decisions. However, Arnold was convinced that cases such as *Wickard v. Filburn* had definitively proven that activities such as the interstate business activities of insurance companies would now be considered to be commerce by the Supreme Court, should it be called upon to rule on the issue. Moreover, he believed that a recent antitrust case, *Parker v. Brown,*[88] had laid to rest traditional concerns over whether state and federal laws could operate concurrently.

Since the days of John Marshall, the U.S. Supreme Court had recognized that statutory primacy of national over state laws in areas that clearly involved interstate commerce. At the same time, however, the Court continued to grant the states a degree of independent ability to regulate certain commerce-related actions under their police powers, particularly in cases where Congress had not acted.[89] In the late nineteenth century, Congress complicated matters by creating federal regulatory agencies to control corporate behavior previously policed by state governments. This new form of regulation raised the issue of whether state and federal regulation could co-exist.[90] From approximately 1912 to 1920, the Supreme Court generally held that once Congress legislated in an area, the existence of federal legislation not only preempted conflicting state laws on the same subject, but also invalidated any and all laws governing that subject area, even those that were arguably consistent with the federal law. Such preemption, it held, occurred automatically – Congressional intent regarding the preemptive effect of the legislation was irrelevant.[91]

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87. *See* South-Eastern Underwriters Association, 322 U.S. at 533.

88. Parker v. Brown, 317 U.S. 341 (1943).

89. DAVID B. WALKER, THE REBIRTH OF FEDERALISM: SLOUCHING TOWARD WASHINGTON 68 (1995). One of the first tests used to determine whether federal action or its absence prevented state regulation of an area was the Cooley Doctrine. *See* Cooley v. Board of Wardens, 53 U.S. 299 (1851). *Cooley* held that states were free to regulate those aspects of interstate and foreign commerce so local in character as to demand diverse treatment, while Congress alone could regulate aspects of interstate commerce that required a uniform national rule for effective regulation.

90. *See* WALKER, *supra* note 89, at 69. The earliest preemption cases of this type considered whether railroad regulation by the newly formed Interstate Commerce Commission preempted preexisting state regulation of railroads. Courts have generally held that it did. *See* Southern Ry. Co. v. Reid, 222 U.S. 426, 435 (1913); *see also* Rock Island & Pac. Ry. Co. v. Hardwick Farmers Elevator Co., 226 U.S. 426, 435 (1913); N.Y. Cent. & Hudson River R.R. Co. v. Tonsellito, 244 U.S. 360 (1917).

91. Stephen Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767 (1994). But during this time, certain types of state regulation of commerce was sustained on the

This new doctrine of automatic, complete preemption of state law gained ascendancy during the period between the end of World War I and the beginning of the New Deal. With the increase in federal power recognized as granted by the Commerce Clause that accompanied the Constitutional Revolution of 1937, the Court found itself forced to modify this preemption doctrine. As the scope of Congress's power increased, many began to fear that if every act of national legislation resulted in the preemption of all state laws governing the same subject, the states would soon be stripped of any regulatory role.[92] Therefore, the Court gradually replaced this doctrine of automatic complete preemption with a rebuttable presumption against preemption, greatly increasing the regulatory space for concurrent federal and state regulatory power. Ultimately, in 1943 in *Parker v. Brown*, the Supreme Court went so far as to state that in the case of conflict, courts should balance the "competing demands of the state and national interests involved."[93]

The most intransigent constitutional issue arising from the shift in the New Deal Court's Commerce Clause jurisprudence thus proved to be whether and how to permit concurrent state and national legislative power over the same subject-matter area.[94] In *Kelly v. Washington*,[95] the Supreme summed up the doctrine of preemption as it existed in 1937. It began by noting that the states retain the authority to exercise a range of powers "appropriate to their territorial jurisdiction" even when the exercise of this power may affect interstate commerce:

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grounds that it only "incidentally" imposed on interstate commerce or constituted only an "indirection" burden on such commerce. *See, e.g.*, Merrick v. Halsey & Co., 242 U.S. 568 (1917). The Supreme Court upheld state securities regulations on those grounds.

92. Barry Cushman, *Formalism and Realism in Commerce Clause Jurisprudence*, 67 U.CHI. L. REV. 1089 (2000). According to Barry Cushman,

> were the growth of federal power not to obliterate state and local regulatory authority by implication, dormant commerce clause jurisprudence would have to be placed upon a new footing. It would have to be decoupled from its affirmative counterpart, to abandon the categories the two had shared, and regulatory authority of over such matters would have to become concurrent.

Id.

93. *Parker*, 317 U.S. at 345.

94. *See* Hartford Accidental & Indem. Co. v. Illinois, 298 U.S. 155 (1936). In *Hartford*, a federal statute designed to prevent infectious diseases in cattle was held not to preempt similar New York health and safety regulations; *see also* Mintz v. Balwin, 289 U.S. 346 (1933). This was the first case in which the Court's preemption determination turned on Congressional intent to preempt state law in a particular area, rather than on Congress's intention to exercise federal power over that subject area.

95. 302 U.S. 1 (1937).

And when Congress does exercise its paramount authority, it is obvious that Congress may determine how far its regulation shall go. Congress may circumscribe its regulation and occupy only a limited field. When it does so, state regulation outside that limited field and otherwise admissible is not forbidden or displaced. The principle is thoroughly established that the exercise by the state of its police power, which would be valid if not superceded by federal action, is superceded only where the repugnance or conflict is so "direct and positive" that the two acts cannot be reconciled or consistently stand together.[96]

While the standard could be articulated as a conflict that was "direct and positive," experience proved that determining whether an actual conflict existed posed a difficult question of statutory interpretation, particularly in cases involving the Sherman Act.

B. THE CONSTITUTIONAL REVOLUTION OF 1937 AND BEYOND

In the mid-1930s, Congress passed new economic regulatory legislation designed to deal with the crisis of the Great Depression. Much of this legislation was challenged as unconstitutional and these cases worked their way slowly through the court system.[97] Between 1937 and 1942, the Court began to uphold important aspects of the New Deal in a series of well-known decisions expanding the reach of Congress under the Commerce Clause. From this point on, the Court effectively ceased to enforce federalism-based limits on Congress's powers to legislate on economic regulatory issues.[98] Important decisions in this series included *NLRB v. Jones & Laughlin*,[99] *United States v. Darby*,[100] and *Wickard v.*

96. *Id.* at 10.

97. In 1935, the Supreme Court struck down an Act of Congress in *Panama Refining Co. v. Ryan*, 293 U.S. 388 (1935). When the price of oil collapsed during the Depression, the oil-producing states demanded that Congress limit production. The National Industrial Recovery Act of 1934 (NIRA) authorized the president to prohibit shipments in interstate commerce of petroleum produced in excess of quotas fixed by the states. In *Panama Refining*, the Court held the "hot oil" provision to be an unconstitutional delegation of legislative power to the president. *Id.* Within six weeks, Congress responded to the Court's decision in *Panama Refining* by completely banning the interstate transportation of hot oil. Abner J. Mikner and Jeff Bleich, *When Congress Overrules the Court*, 79 CAL. L. REV. 729, 737 (1991). Similarly, in *R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330 (1935), that same year the Court struck down a federal railroad retirement plan. Again Congress responded by creating a federal tax to induce states to provide unemployment insurance.

98. Kramer, *supra* note 4, at 1498.

99. 301 U.S. 1 (1937).

100. 312 U.S. 451 (1941).

Filburn.[101] Surprisingly, the increase in federal regulatory power at the expense of the State governments tended to be tied in certain Southern newspapers to the issue of race. One North Carolina reporter lamented after *Darby* that "'states' rights' were as dead as the gallant boys from North Carolina who fell on the scarred slopes of Gettsyburg . . . . Now the States, like the Negro in the Dred Scott decision, have no real rights which the Federal Government is bound to respect."[102] *Wickard v. Filburn*, decided in 1942, provided the most expansive interpretation of the commerce clause because it effectively disavowed any federalism limits on Congress's power to regulate even areas only tangentially related to commerce.[103] The Court stated that "today the 'commerce' of the Commerce Clause covers every kind of interstate communication or commercial intercourse and is not confined to the interstate movement of persons or commodities."[104]

In private correspondence, Justice Jackson disavowed any further role for the Court after *Wickard* due to a need to maintain dual federalist principles. Jackson wrote in a letter to then circuit Judge Sherman Minton:

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101. In *NLRB v. Jones & Laughlin*, 301 U.S. 1 (1937), the Court upheld a national labor regulation even though labor issues had traditionally been consider the province of the States. In doing so, it invalidated the "direct" versus "indirect" effects on interstate commerce test that had been previously used to separate areas of national and State authority. Under its new jurisprudence, the Court held that Congress's regulatory reach extended not only to interstate commerce itself, but also to any activity affecting interstate commerce. *Id.* In *Darby*, the Court also upheld a national labor regulation and announced that the Tenth Amendment "states but a truism that all is retained which has not been surrendered." 312 U.S. at 462. The press commentary on these cases was prolific, especially with respect to *Darby*. According to the Washington Post, "[t]he change that has been effected is scarcely less than it would have been if accomplished through a constitutional amendment." MASON, HARLAN FISKE STONE: PILLAR OF THE LAW 555 (Viking Press 1956). Other journalists felt that under *Darby*, the national government "emerged as a government of almost unlimited powers in the economic and social field." *Id.*

102. MASON, *supra* note 101, at 555 (quoting Constitutional Change, Asheville (N.C.) Citizen, Feb. 4, 1941). As Professor William Wiecek explains, the concept of states' rights the author refers to is a notion widely held by Southerners during Reconstruction. According to Wiecek, "[t]he concept of states' rights implied that states continued to possess elements of sovereignty that had not been conveyed to the federal government by the Constitution, and that the federal government had to respect these state sovereign powers." WIECEK, *supra* note 65, at 95.

103. The *Wickard* opinion, authored by recently appointed Supreme Court Justice Robert H. Jackson, upheld significant portions of the Second Agricultural Act. *Wickard*, 17 U.S. at 111.

104. *Wickard*, 317 U.S. at 121.

> In any case where Congress thinks there is an effect on interstate commerce, the Court will accept that judgment. All of the efforts to set up formulae to confine the commerce power have failed. When we admit that it is an economic matter, we pretty nearly admit that it is not a matter which courts may judge.[105]

While *Wickard* established broad regulatory powers in the agricultural field under the Commerce Clause, it did not deal with the issue of whether the existence of federal programs resulted in the preemption of a concurrent State program. Analytically, however, the *Wickard* decision created large problems for dormant commerce clause jurisprudence. Previously, State regulation of activities such as agriculture had been held to affect interstate commerce only "indirectly" and therefore were not held to violate the dormant commerce clause. Now those same activities had been held to affect interstate commerce in such a manner as to authorize congressional regulation.

A year later, in *Parker v. Brown*,[106] Chief Justice Stone addressed this issue when he considered whether an arguably anticompetitive California program for marketing raisins violated federal statutes including the Sherman Act. Relying on principles of federalism, Stone articulated the doctrine that federal antitrust laws were subject to supersession by State regulatory programs. He based his decision on his view that federalism requires the reconciliation of congressional supremacy with a degree of freedom of action for the States.[107] Justice Stone found that the Sherman Act was not generally intended to preempt activities specifically sanctioned by State legislation.[108]

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105. Cushman, *supra* note 92, at 1146.

106. 317 U.S. 341 (1943).

107. *See* FTC v. Ticor Title Ins. Co., 504 U.S. 621, 633 (1992). California's regulatory scheme encompassed all raisins grown in California, even though 90 to 95 percent of those raisins were subsequently shipped in interstate commerce. The California Agricultural Prorate Act authorized state officials to set up programs for the marketing of crops with the explicit goal of restricting competition among growers and maintaining high crop prices. Porter Brown, a raisin grower, challenged the act as a violation of the federal antitrust laws and a violation of the dormant commerce clause. Brown v. Parker, 39 F. Supp. 895 (S.D.Cal. 1941).

108. *Parker*, 317 U.S. at 350-51 ("We find nothing in the language of the Sherman Act or its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature. In a dual system of government in which . . . the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a states' control over its officers and agents is not lightly to be attributed to Congress.").

Justice Stone also concluded that the statute was not invalid under the dormant commerce clause even though he assumed that Congress could have acted under its commerce power to prohibit the State from interfering with interstate commerce in this way. In his view, when otherwise valid State regulation also operates as a regulation of commerce, "the reconciliation of the power thus granted with that reserved to the state is to be attained by the accommodation of the competing demands of the state and national interests involved."[109]

Thus *Parker* stands for the proposition that federal antitrust laws may be superseded by State regulatory programs. The rationale for this holding was the need to preserve principles of federalism by allowing for "freedom of action for the States."[110]

As *Parker* illustrates, the issues surrounding the application of the dormant commerce clause are very similar to those surrounding the issue of preemption. Both legal doctrines were developed in an attempt to "protect federalism and the national economy against state parochialism and exploitation."[111] Preemption prevents state encroachments on federal policies that have been affirmatively implemented by Congress through legislation. The dormant commerce clause deals with situations in which Congress has not acted. Its purpose is either to safeguard a presumed Congressional determination that the area remain free of regulation, or to protect one state from being exploited by a sister state that chooses to enact legislation that discriminates against commercial activity by that state.[112] According to one commentator, "[t]he dormant commerce clause has been regarded as a major federal intrusion into states' rights."[113]

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109. *Id.* at 362-63. The Court found that the state statute did not violate the commerce clause because the regulation affected the raisins before they entered the stream of commerce. The Court also found that the state program "was not aimed at nor did it discriminate against interstate commerce although it undoubtedly affected the commerce by increasing the interstate price of raisins and curtailing raisin shipments . . . ." *Id.* at 367.

110. *See Ticor*, 504 U.S. at 633.

111. Michael S. Greve, *Commerce and the Constitution*, FEDERALIST OUTLOOK, *1 (2001) *available at* http://www.aei.org/include/pub_print.asp?pubID=57 (last visited Apr.21, 2005).

112. In *Welton v. Missouri*, 91 U.S. 275 (1875), Justice Field struck down a state license requirement imposed solely on out-of-state peddlers, based on an inference of congressional intent derived from Congress's failure to act. He stated that "[t]he fact that Congress has not seen fit to prescribe any specific rules to govern inter-state commerce does not affection the question. Its inaction on this subject . . . is equivalent to a declaration that inter-State commerce shall be free and untrammeled." *Id.* at 282.

113. Frank B. Cross, *The Three Faces of Federalism: An Empirical Assessment of Supreme Court Federalism Jurisprudence*, 73 S. CAL. L. REV 741, 754 (2000).

In the period prior to the Court's decision in *United States v. South-Eastern Underwriters Association*, dormant commerce clause doctrine evolved significantly.[114] Before 1938, the Supreme Court tended to allow States to regulate interstate commerce if the impact of the challenged regulatory act affected interstate commerce "only indirectly, incidentally, or remotely." Should the Court find that a state regulation imposed a "direct" burden on interstate commerce, the Court would invalidate the rule under the dormant commerce clause.[115] Around 1938 the Court rejected the distinction between "direct" and "indirect" restraints on interstate commerce. The new primary rationale for the dormant commerce clause doctrine, that of preventing discrimination against out-of-state commercial interests, was set forth by Chief Justice Stone in 1938 in *South Carolina State Highway Department v. Barnwell Brothers, Inc.*[116] He stated that "when the regulation is of such a character that its burden falls principally upon those without the state, legislative action is not likely to be subjected to those political restraints which are normally exerted on legislation where it affects adversely some interests within the state."[117]

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114. The first Supreme Court case to mention the dormant commerce clause was *Wilson v. Black Bird Creek Marsh Co.*, 27 U.S. (2 Pet.) 245 (1829). In that case Delaware had authorized the building of a dam across a navigable creek and plaintiffs argued that this authorization conflicted with Congress's power to regulate interstate commerce. The Court found that the statue was valid because it was not "repugnant to the [national] power to regulate commerce in its dormant state . . . ." *Id.* at 252.

115. LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 6-4, at 324 (1978).

116. 303 U.S. 177 (1937).

117. *Id.* at 185 n.2. An additional rationale for the doctrine was articulated in *Welton v. Missouri*, 91 U.S. 275 (1876). In that case Justice Field declared a state license imposed only on out-of-state peddlers to be invalid because he interpreted the lack of congressional regulation of such commerce to be "equivalent to a declaration that inter-state commerce shall be free and untrammeled." *Id.* at 282. Thus Field interpreted congressional silence to infer that Congress intended the area to remain unregulated. For example, in *Edwards v. California*, 314 U.S. 160 (1941), the Supreme Court held unlawful a California statute designed to criminalize the act of transporting an indigent into the state during the Depression. The Court held the statute to be outside the scope of California's police powers even though the state argued that the huge influx of migrants into California in recent years had resulted in problems of "health, morals, and especially finance." *Id.* at 167. The Court stated that the commerce clause "established the immunity of interstate commerce from the control of the states respecting all those subjects . . . which are of such a nature as to demand that, if regulated at all, their regulation must be prescribed by a single authority." *Id.* at 168 (quoting Milk Control Bd. v. Eisenberg Farm Prods., 306 U.S. 346 (1939).

C. THE TNEC

As noted earlier, Arnold's decision to sue the insurance industry for antitrust violations in *United States v. South-Eastern Underwriters Association* was influenced not just by recent Supreme Court cases reinterpreting the Commerce Clause, but also by a contemporaneous political development know as the Temporary National Economic Committee ("TNEC"). The TNEC hearings demonstrated that courts were not the only forum in which issues such as federalism and preemption were being discussed, both with regard to the insurance industry and other industries. On April 29, 1938, President Roosevelt had called for an antimonopoly investigation.[118] This investigation, which proved to be the largest study ever conducted of the United States economy, continued for three years, from 1938 to 1941, and resulted in thirty-seven volumes of testimony consisting of 17,000 pages of information on the state of the U.S. economy. The TNEC's mandate was to analyze the causes, character and effects of the economic concentration on the economy.[119] President Roosevelt stressed that the purpose of the TNEC was not merely "trust-busting" but to protect and preserve private enterprise by correcting abuses.[120]

The TNEC was a hybrid organization composed of representatives of the Administration and both Houses of Congress and headed by Senator Joseph O'Mahoney of Wyoming, its Chairman.[121] According to a contemporaneous commentator, the committee members "were essentially from the Middle West and West . . .. Ten were Democrats of varying predilections and leanings, two were Republicans, at least three were conservatives, and four could properly be called New Dealers."[122]

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118. LYNCH, *supra* note 69, at 8.

119. Roosevelt declared, "the liberty of a democracy is not safe if the people tolerate the growth of private power to the point where it becomes stronger than their democratic state itself. . . ." S. Doc. No. 173, 75th Cong., 3rd Sess.

120. ALAN BRINKLEY, THE END OF REFORM NEW DEAL LIBERALS IN RECESSION AND WAR 110 (Vintage Books 1995).

121. LYNCH, *supra* note 69, at 40-50; ELLIS W. HAWKLEY, THE NEW DEAL AND THE PROBLEM OF MONOPOLY: A STUDY IN ECONOMIC AMBIVALENCE 415 (1966). The President's announcement of the investigation stressed that it was not to be limited to the traditional field of antitrust, but should also address nine additional topics. These were 1) improvement of antitrust procedure; 2) mergers and interlocking relationships; 3) financial controls; 4) investment trusts; 5) bank holding companies; 6) trade associations; 7) patent laws; 8) tax correctives; and 9) the desirability of establishing a federal Bureau of Industrial Economics. BRINKLEY, *supra* note 120, at 110.

122. Other Senators appointed to the Committee were Senator Borah of Idaho and Senator King of Texas. The western senators, O'Mahoney and Borah were well-know

During the hearings, the Committee examined the competitive conditions and business practices of the insurance industry, among others. Insurance industry officials feared that a major purpose of the TNEC hearings was to uncover abuses in the industry, and some expected that immediately after the TNEC issued its report, Congress was likely to introduce a bill calling for federal control over insurance. In fact, the committee did discover problems with state regulation of insurance when the Securities and Exchange Commission conducted a detailed study of the life insurance industry, which concluded that current levels of supervision by state authorities appeared to be inadequate.[123]

The TNEC revealed that state governments had difficulties regulating the insurance industry in part due to the size of the companies and the high level of concentration in the industry. The Committee found that the nation's largest life insurance company, the Metropolitan Life Insurance Company, was the nation's largest business concern.[124] Moreover, it found that the top five life insurance companies controlled more than half of the industry's resources. The life insurance industry also proved to be geographically clustered. Six of the largest companies were located in the New York/New Jersey area and owned 57 percent of all life insurance assets. Ten of the 25 largest companies had their home offices in New England and accounted for 17 percent of life insurance assets. The twenty-five largest companies accounted for 87 percent of total life insurance assets. In addition to those located in the Northeast, one large life

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opponents of unrestrained corporate power, a fact that was unsurprising given the lack of corporations headquartered in their respective states. Senator King, was better known as an anti-New Deal Democrat and proponent of states rights. Hatton W. Sumners a Democrat from Texas, B. Carroll Reece, an independent Republican from Tennessee, and Edward C. Eicher, a Democratic Congressman from Iowa, represented the House of Representatives on the Committee. The remaining committee members hailed from the administration and tended to be committed antimonopolists. These men included Thurman Arnold of the Justice Department, Herman Oliphant of the Treasury Department, Isador Lubin from the Department of Labor, Garland Ferguson of the FTC, and William O'Douglas, the Chairman of the SEC. Only Richard Patterson of the Commerce Department was regarded as sympathetic to business's distaste for antitrust restrictions. LYNCH, *supra* note 69, at 48.

123. TNEC, *supra* note 79, at 561, 567. Reasons for this included insecure and irregular tenure for supervising authorities, that insurance commissioners had to contend with low pay and inadequate staff and that extraneous responsibility interfered with their duties. As a result of this lax supervision, the Committee found that some of the largest companies' directors have sought and exploited their posts for personal gain at the expense of the interests of policyholders. *Id.* at Part 4, 1197, 1249, 1422, 1424, Part 13, pp. 65621, 6593; Part 28, pp. 14780-14782.

124. In 1937, it had assets of $5 billion, or the equivalent to 18 percent of the total assets held by life insurance companies. LYNCH, *supra* note 69, at 119.

insurance company was located in California, one in Wisconsin, two in Iowa, two in Pennsylvania, two in Ohio and one in Indiana.[125]

Thurman Arnold represented the Justice Department on the Committee and proved to be its most vigorous advocate of antitrust enforcement in the field of insurance. Arnold argued that the United States must choose between complete governmental control of business and effective regulation of private enterprise. In his view, antitrust enforcement was the best way to keep the government out of business.[126] When Arnold testified before the Committee, a colloquy occurred between him and Representative Sumners, the Vice Chairman of the TNEC, which illustrates the contours of the federalism debate. Sumners repeatedly spoke of the inappropriateness of federal action and the importance of moving "the power and the responsibility back toward the people."[127] He continued:

> What business is it of yours up here in Washington to tell my people down in Texas what to do? . . . There are people down in the State, they have a State legislature, they have their merchants and mercantile business. What business is it to Washington messing up with those people? . . . I would like to see you gentlemen of the Federal government stay out and let them take care of their mustard plaster.[128]

Arnold responded to Representative Sumners' comments by arguing that the quickest way to ensure Federal entry into the field of insurance would be to create "a twilight zone under the guise of protecting State's Rights, a zone where nobody could effectively act . . .."[129] This would create a situation that might suddenly require drastic Federal action.

> You do not increase State powers, nor do you increase popular confidence in State powers by telling the State governments: "Act and control this situation," when you know as a practical matter, they can't control it at all. So it seems to me that the real problem here is whether the States can control this thing. If they can't, then the quickest way to move the camel into the tent and get all the other camels

125. *Id.*
126. *Id.*
127. *Id.* at 322.
128. *Id.*
129. *Id.* at 44.

> in is to ignore it, pretend they are exercising State powers, and wake up . . . and find that we have got to take legislation and actions far more drastic than would have been necessary otherwise.[130]

In addition to life insurance, the TNEC conducted detailed investigations of other sectors of the insurance industry that revealed widespread abuses. State regulation often had proven ineffective at limiting these abuses due to the interstate character of the industry.[131] When the TNEC debated ways to improve the quality of insurance regulation, all participants assumed that the national government possessed the power to regulate the insurance industry. Even proponents of state regulation shared this view. The TNEC Final Report stated that it was possible to utilize Federal powers in ways that would strengthen the effectiveness of state regulation without moving to general federal regulation of insurance. "There are admittedly areas where State regulation is severely handicapped by reason of the interstate character of the insurance business."[132] Nevertheless, the report advocated using federal power to "plug the gaps . . . ."[133]

When the Committee ultimately made its recommendations for the insurance industry, one of its most important proposals was that antitrust prosecution be pursued more vigorously. SEC Commissioner Pike recommended both that the states undertake a program to strengthen the existing machinery for regulating and supervising life insurance, and that the federal government assist the states in these efforts by rendering advice, by disseminating information, and by exercising supervisory powers on its own account.[134]

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130. *Id.*

131. The most common unethical practices uncovered involved pressuring poor clients to subscribe to more insurance than they could afford. Insurance companies also routinely took steps to ensure that soon-to-be-paid-up policies lapsed before the company incurred any liability. Particular problems were found in the sale of industrial insurance policies, typically sold to people with low incomes. LYNCH, *supra* note 69, at 262. One agent testified at the hearings that 75 percent of the customers on his collection route were on relief and a second agent testified that at times as many as 100 percent of his clients were in arrears. *Id.* at 264. A TNEC investigation into the operations of the Monumental Life Insurance Company of Baltimore revealed that its managers engaged in extensive self-dealing and that the relevant state regulators took no action because they shared in the managers profits. *Id.* at 262-71 & 282-84.

132. *Id.* at 350.

133. *Id.*

134. *Id.* at 329-30. Commissioner Pike saw a role for the federal government in collecting and disseminating information. He proposed that a federal agency be created

Nevertheless, despite evidence that state regulation of insurance had often proven ineffective, the Committee did not recommend federal regulatory control. A partial explanation for this failure may lie in the lobbying activities of the insurance industry. According to one observer:

> [L]ong before the Committee had time to digest the testimony, a concerted broadside was unloosened prejudging its decisions and denouncing its presumed recommendations. Insurance company employees and policyholders were informed that their interests were being jeopardized: spontaneous policyholders meetings were held throughout the land, and the Congress was deluged with letters denouncing the plot and demanding protection. When the final report was eventually completed, the TNEC had little to propose . . . but to exhort the states to do a better job of regulating.[135]

The TNEC hearings convinced Arnold of the need for some degree of national control over the insurance industry. Consequently, Arnold decided to file suit in the *South-Eastern Underwriters Association* case. This decision triggered a vigorous public debate over the respective roles of the state and federal governments in regulating insurance and whether the Supreme Court's recent expansion of the commerce power applied to the insurance industry.

II. *UNITED STATES V. SOUTH-EASTERN UNDERWRITERS ASS'N*

After Missouri Attorney General McKittrick requested that the Justice Department open a federal antitrust investigation of the insurance industry, staff attorneys at the Department's Antitrust Division drafted a memorandum to Thurman Arnold analyzing the merits of taking action.[136]

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possessing visitorial powers over life insurance companies doing interstate business. This agency could be authorized to investigate particular companies when so requested by the insurance commissioners of two or more states. It could also require reasonable reports from insurance companies, assist state regulatory officers in their duties and keep state legislatures and Congress advised of conditions requiring legislative correction. He also recommended that Congress pass specific federal laws to prohibit insurance companies from selling policies either directly or indirectly in states in which they had not be authorized to do business and to restrain officers and directors of insurance companies from exploiting their positions for personal gain. *Id.*

135. *Id.* at 372.

136. *See generally* Elmore Memo, *supra* note 76.

The primary impediment to an antitrust investigation was the holding in *Paul* that insurance was not "commerce."[137] Nevertheless, the staff memo urged Arnold not to be dissuaded from taking action by this case which it explained as a decision aimed at upholding the validity of state regulation of insurance, a question separate from that of federal authority. According to the memo "the insurance companies have repeatedly tried to escape state restrictions by leaping into Uncle Sam's arms. The Supreme Court has found it expedient to deny them this sanctuary because society appears to be better served on the whole (or at least the people's political representatives are better satisfied) by state rather than national regulation."[138] The Court, it argued, had not foreseen that its decision would later be used to forestall more effective regulation.[139] Under these conditions, the Justice Department was "justified in adopting a fresh and original approach" and should not "permit itself to be confused in the jurisdictional forest by devoting too much time to the contemplation of single trees."[140] In conclusion, the staff recommended that the Division open a comprehensive investigation of fire insurance industry practices.[141]

Assistant Attorney General Thurman Arnold agreed with his staff's analysis. In his memo to the Attorney General, he wrote: "Fire insurance has become a self-regulated business with price fixing by company maintained bureaus. It is well recognized that state regulation of rates is ineffective."[142] In his view, this was damaging to policyholders. He believed that "[t]he failure of states to enforce their anti-compact laws and their demonstrated inability to deal with nation-wide practices make it imperative that a remedy be obtained through federal action."[143]

On March 20, 1942, the Attorney General authorized a grand jury investigation that culminated in an indictment on November 20, 1942 charging 198 stock fire companies, their trade organization, the South-Eastern Underwriters Association, and 27 individuals with violating the Sherman Act.[144] The government lost at trial based on *Paul's* holding that "insurance was not commerce."[145] The Justice Department expected this

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137. *Id.* at 14-18.

138. *Id.* at 16.

139. *Id.* at 16-17.

140. *Id.* at 17.

141. *Id.* at 21.

142. *See* Arnold Memo, *supra* note 78, at 2.

143. *Id.*

144. *Joint Hearings*, *supra* note 75, at 62. The Justice Department charged the companies with both price-fixing and conspiracy to monopolize the insurance business. *Id.*

145. United States v. South-Eastern Underwriters Ass'n, 51 F. Supp. 712, 713 (D. Ga. 1943).

outcome and appealed the case directly to the U.S. Supreme Court.[146] As soon as the Supreme Court granted *certiorari*, state officials immediately began to mobilize to protect their regulatory prerogatives. Thirty-five states filed briefs *amici curiae* arguing in favor of upholding the decision in *Paul*. Congress simultaneously began Joint Hearings to consider taking action to reverse the Court's decision should the Court determine that insurance was interstate commerce.

In its case before the Supreme Court, the Justice Department argued that the fire insurance business was commerce because it required the movement of money, information, and documents on a large scale basis across state lines.[147] The Justice Department further argued that, in passing the Sherman Act, Congress intended to make full use of its power over commerce to prohibit restraints of trade. The Government conceded that, at the time Congress acted, it was aware of *Paul's* holding that insurance was not commerce. Nevertheless, it asserted that Congress had no intention to freeze the Sherman Act "in the judicial mold of 1890 or to deprive the Court of its prerogative to determine whether to adhere to prior decisions."[148] The Government argued that as a matter of policy, no reasons existed to exempt insurance companies from the Sherman Act.[149]

The defendants had argued that insurance companies were forced to fix rates collectively because only by pooling their respective loss experience could they calculate a statistically reasonable rate. The Government

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146. United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 562-63 (1944).

147. *Id.* at 563. The government's argument was that *Paul's* holding was not inconsistent with cases such as *Gibbons v. Odgen*, 22 U.S. 1 (1824), and more recently with *Champion v. Ames*, 188 U.S. 321 (1903), the lottery ticket case. The holding, however, also conflicted with two cases dealing specifically with insurance. One was a case against the American Medical Association (AMA) holding that an enterprise engaged in providing protection against the risk of undue medical expense is trade under the Sherman Act and the other holding that marine insurance was an integral part of exportation and thus commerce. *See* Am. Med. Ass'n v. United States, 317 U.S. 519 (1943); Thames & Mersey Marine Ins. Co. v. United States, 237 U.S. 19 (1915). The Government also argued that because insurance was an instrumentality so essential to commerce, it could be regulated by Congress even if it was held not to be itself commerce due to "the close economic relation between fire insurance and activities which are unquestionably interstate." Brief for Appellant at 61, United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944) (No. 354).

148. Appellant's Brief at 80-81, United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944) (No. 354). Here the brief analogized the current situation to the antitrust cases involving manufacturing. At one point, the Court had declared that manufacturing was not commerce and therefore not subject to the federal antitrust power. Nevertheless, the Court later held that the Sherman Act applied to combinations of producers, despite its earlier holding. *Id.*

149. *Id.* at 108.

disagreed, arguing that "a cooperative statistical venture truly designed to accomplish only the purpose would not be an unreasonable restraint of trade."[150] If calculating a statistically reasonable rate was all the companies were attempting to accomplish, they need not fear prosecution under the antitrust laws. Here the companies were charging not only similar or identical amounts to cover losses, but also insisted on charging the same total rate, which included components designed to cover both profits and administrative expenses, which did not need to be identical.

Pointing to the Court's decision in *Parker v. Brown*, the Government refuted Defendants' argument that ruling insurance was commerce would render the states unable to tax or regulate it in any way. However, contrary to the Court's holding in *Parker*, here the Government argued that no evidence existed that Congress intended the Sherman Act to be subordinate to state policies. Therefore, certain types of anticompetitive state regulations might violate the Sherman Act. Any rates actually set by the state, however, would be valid.[151] Defendants argued that the only issue was whether fire insurance in and of itself was interstate commerce within the meaning of the Sherman Act.[152]

The Defendant's principal argument relied upon *stare decisis*; the Court should not overturn the precedents set over the past seventy-five years. The apparent acquiescence of Congress in the decision further counseled against overturning *Paul*. Moreover, Defendants argued, "State regulation and the Sherman Act are diametrically opposed to each other and cannot exist side by side."[153]

The arguments of the states as *amici curiae* differed from the arguments made by the defendants. The states argued, first, that regardless of the Court's holding on whether insurance was commerce, Congress had

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150. *Id.* at 101-113. The Court had upheld such an arrangement in *Maple Flooring Assn. v. United States*, 268 U.S. 563 (1925).

151. Appellant's Brief at 123-31, United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944) (No. 354). An example of such an invalid state regulation would be a state statute that authorized a private combination of insurance companies to fix premium rates without approval from the state. The Government stated that it had identified five states where state law expressly or impliedly authorized or required rating bureaus to establish rates that were not subject to the approval or disapproval of any governmental agency. Two of these states were states covered by the indictment.

152. *Id.* at 2. They disagreed with the Government's contention that Congress could regulate insurance in the event it was held not to be commerce if there existed "a close economic relationship between fire insurance and activities, which are unquestionably interstate." *Id.* They based this argument on the contention that the Supreme Court was limited to the District Court's construction of the indictment, which charged only a restraint of commerce in fire insurance itself.

153. *Id.* at 34.

not intended that the Sherman Act apply to insurance. Secondly, they argued that the problems inherent in regulating insurance companies could be more effectively dealt with through cooperative action, rather than by application of the federal antitrust laws.[154]

When it came time for the Court to rule, the disagreements among the Justices sitting in the *South-Eastern Underwriters Association* case were so profound that they found it almost impossible to decide the case. Ultimately, the Court held by a bare 4-3 majority that insurance was commerce and, consequently, that the defendants were subject to prosecution under the Sherman Act.[155] Justice Black, the author of the majority opinion, found that the Sherman Act was intended to prohibit the type of anticompetitive activity alleged in the indictment and that insurance was "commerce."[156]

All three dissenting justices wrote separately, and each cited the adverse practical consequences of the holding on existing state regulation as the rationale for their disagreement with the majority, despite their recognition that analytically, insurance should be considered interstate commerce. For example, Justice Stone wrote, "[t]his Court has never doubted, and I do not doubt, that transactions across state lines which often attend and are incidental to the formation and performance of an insurance contract, such as the use of facilities for interstate communication and transportation, are acts of interstate commerce subject to regulation by the federal government under the commerce clause."[157] Nevertheless, he dissented from the majority based on his view that Congress had not "asserted its power over the business of insurance."[158] In his view the lower court's decision should be affirmed "in view of the permanency which should be given to the construction of the commerce clause and the Sherman Act in this respect, which has until now been consistently adhered to by all branches of the government."[159]

The Justices in the majority held different views from the dissenters on the nature of federalism, and as reflected in their views of preemption and of the proper role of stare decisis in constitutional adjudication. Justice Black, the opinion's author, and the justices joining him in the majority (Justice Douglas, Justice Murphy and Justice Rutledge) believed that state

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154. Brief of Amicus Curiae Commonwealth of Virginia at 2-3, United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944) (No. 354).

155. *South-Eastern Underwriters Ass'n*, 322 U.S. at 533.

156. *Id.*

157. *Id.* at 562-63.

158. *Id.* at 563.

159. *Id.*

and national authority could be exercised concurrently. This view tended to accord with recent Supreme Court jurisprudence regarding the scope of the Commerce Clause. Justice Black characterized the issue before the Court as one of first impression. In his view, earlier insurance cases had involved the permissibility of state regulation, not the permissibility of affirmative exertions of federal power over the industry. He assumed that in earlier cases the theory of dual federalism may have implied that if states possessed the power to regulate insurance, then Congress did not. By 1943, however, the Court had recognized a wider scope for concurrent state and national power, making the question of federal regulation of the industry an open question.

Justice Black found insurance to be commerce by applying a "realistic" test for defining interstate commerce, rather than upholding the legal fiction set forth in *Paul.* According to Justice Black, previous jurisprudential distinctions drawn between "local" and "interstate" activities were but "a type of mechanical criterion which this Court has not deemed controlling in the measurement of federal power."[160] "Only by treating Congressional power over commerce among the states as a 'technical legal conception' rather than as a 'practical one, drawn from the course of business'" could the Court find that insurance did not constitute commerce.[161] Justice Black also noted the dominant position of insurance companies in the U.S. economy and pointed out that the entire United States tended to be served by insurance companies concentrated principally in the northeast.[162] Black rejected the argument that application of federal law would necessarily entail the preemption of state insurance regulation, citing *Parker v. Brown* for the proposition that "the primary test . . . is not the mechanical one of whether the particular activity affected by the state regulation is part of interstate commerce, but rather whether, in each case, the competing demands of the state and national interests involved can be accommodated."[163]

Justice Black then held that Congress had intended that the Sherman Act prohibit the type of anticompetitive conduct at issue in the case. He also held that in any case of an actual conflict between the Sherman Act and a state law, the Sherman Act should govern. But because many states

160. *Id.* at 546.

161. *Id.* at 547.

162. He noted that of the 200 companies indicted in the case for restraining and monopolizing trade in six southeastern states, 127 had headquarters in New York, Pennsylvania, or Connecticut. *Id.* at 542.

163. *Id.*

had their own state antitrust statutes, he did not see a policy conflict between state and federal law.

The dissenting justices shared an unspoken premise based on dual federalism that if Congress had the power to regulate insurance, then the states did not. These Justices thought it imprudent to concede federal power to regulate insurance because the effect of such a holding would be to preempt extensive existing state regulation of insurance. Such a holding, they argued, would create chaos in the industry and would violate notions of *stare decisis*. According to Justice Stone:

> Long continued practical construction of the Constitution or a statute is of persuasive force in determining its meaning and proper application . . . The immediate and only practical effect of the decision now rendered is to withdraw from the states, in large measure, the regulation of insurance and to confer it on the national government, which has adopted no legislative policy and evolved no scheme of regulation . . .[164]

Justice Frankfurter wrote separately, but concurred with Justice Stone. Like Justice Stone, Justice Frankfurter agreed that under the Sherman Act stating, "[t]here is no Congressional warrant therefore for bringing about the far-reaching dislocations which the opinions of the Chief Justice and Mr. Justice Jackson adumbrate."[165]

Justice Jackson also wrote a dissenting opinion. As the author of *Wickard v. Filburn*, he held an expansive view of Congressional power to regulate commerce,[166] but advised against holding insurance to be within the scope of such power because of practical policy considerations.[167] He expressed concern that should insurance be held to be commerce, individual states would lose significant tax revenues.[168] Thus, he advocated that the Court adhere to the legal fiction it had established in *Paul* that insurance is not commerce.[169]

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164. *Id.* at 578, 580-81 (Stone, J., dissenting).
165. *Id.* at 584.
166. *See* MASON, *supra* note 101, at 620 n.1.
167. *Id.* at 584-95 (Jackson, J., dissenting).
168. *Id.* at 587.
169. *Id.* at 588.

III. THE McCARRAN-FERGUSON ACT

Even before the Court decided the case, Representative Francis E. Walter of Pennsylvania introduced a bill "to affirm the intent of Congress that the regulation of the business of insurance remain within the control of the several States and that the [Sherman and Clayton Act], as amended, be not applicable to that business."[170] The premise of the proposed regulation was that application of the Sherman Act to insurance would destroy all state power to regulate the industry. The bill's sponsors steadfastly contended this despite testimony to the contrary by federal officials at the Hearings, including U.S. Attorney General Francis Biddle.[171] During the hearings on the bill, the Committee received letters in support of the bill from the Governors of more than twenty states.[172] Representative Hancock of New York articulated the view of federalism held by the bill's sponsors:

> Our system of government is dual. The Federal Government is one of delegated powers. All other powers are reserved to the States, and in their fields the States are supreme. In any given field either the Federal power or the State power is supreme.[173]

Thus, an older view of dual federalism persisted in Congress, even though it had been overtaken in the Court by New Deal legislation and a series of ground-breaking Supreme Court decisions.

The Supreme Court announced its decision in the *United States v. South-Eastern Underwriters Association* on June 5, 1944.[174] Shortly afterward, the insurance industry and the states, fearing a flood of federal regulation requiring competition within the industry, lobbied Congress to avert such an occurrence. The industry predicted that the natural result of increased competition arising from the decision would render many companies insolvent.[175] Following the decision, some companies refused to abide by state regulatory provisions or to pay state taxes on the theory that such regulation and taxation were unconstitutional restraints on interstate commerce.[176]

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170. 89 CONG. REC. 7686 (1943).
171. *Joint Hearings*, *supra* note 75; *see id.* at 2 (statement of Sen. Bailey, N.C.).
172. *Id.* at 140.
173. *Id.* at 112 (statement of Rep. Hancock, N.Y.).
174. 322 U.S. at 533.
175. H.R. REP. No. 78-873, at 8 (1944).
176. S. REP. No. 79-29, at 2 (1945); H.R. REP. No. 79-143, at 2 (1945); 91 CONG. REC.

Congress responded to the Supreme Court's decision in the *South-Eastern Underwriters Association* case with astounding speed. Less than three weeks after the decision was announced, the House of Representatives had passed a bill granting all sectors of the insurance industry a complete exemption from the antitrust laws and the Senate Judiciary Committee soon after reported favorably on a companion bill. Many legislators opposed the original House bill first proposed after the district court decision in the case but before the Supreme Court ruling, arguing that it appeared to be an explicit attempt to influence the outcome of the Supreme Court's decision.[177]

A. THE BAILEY-VAN NUYS BILL

On September 20, 1943, Representative Walter of Pennsylvania introduced H.R. 3270, a bill referred to as the Bailey-Van Nuys bill "to affirm the intent of Congress that the regulation of the business of insurance remain within the control of the several states and that the [Sherman Act and Clayton Act], as amended, be not applicable to that business."[178] A companion bill was also introduced in the Senate, and Joint Hearings were held before both the House and Senate Subcommittees of the Committee on the Judiciary.[179] These hearings stretched from October 20, 1943 until March 30, 1944.[180] The text of the bill read as follows:

> Be it enacted by the Senate and House of Representatives of the United States in Congress assembled, That nothing contained in the Act of July 2, 1890, as amended, known as the Sherman Act, or the Act of October 15, 1914, as amended, known as the Clayton Act, shall be construed to apply to the business of insurance or to acts in the conduct of that business by . . . the several states.[181]

On its face, the bill purported to "construe" the Sherman Act and Clayton Acts. By doing so, it appeared to accept the premise that Congress's commerce power extended to the insurance industry, but it stated that Congress had not intended to exercise such power when it

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478-79 (1945).

177. 90 CONG. REC. 6565 (1944).

178. 89 CONG. REC. 7686 (1943).

179. *Joint Hearings*, *supra* note 75, at 1.

180. *Id.*

181. *Id.*

enacted the Sherman and Clayton Acts. However, Senator Bailey's remarks concerning the bill were at odds with its language, for they suggested that his primary concern in introducing the bill was not to clarify that federal antitrust laws had not been intended to cover insurance, but rather to forestall general federal regulation of the industry. According to Bailey:

> The thesis upon which the proposed legislation rests is that the business of insurance . . . is not commerce and therefore, cannot be considered as 'commerce among the States,' and, therefore, necessarily is not within the plenary regulatory power of the Congress and under the Federal antitrust laws. . and is and ought to be under the police powers of the several states.[182]

Thus, despite the attempt to classify the legislation as a "construction" of a federal statute, Senator Bailey in fact desired to overturn the Supreme Court's decision regarding the scope of the common clause and federal regulatory jurisdiction in *South-Eastern Underwriters Association.*

Senator Bailey represented North Carolina, a state in which few insurance companies were headquartered and, thus, he would seem to be an unusual sponsor of such legislation. Bailey's interest in the legislation may have had more to do with his interest in federalism generally, than the specific industry involved. An example of his interest is that in 1937 Senator Bailey coauthored a statement of principles in Congress that became known as "The Conservative Manifesto." "The Conservative Manifesto" reaffirmed the commitment of the Conservatives in Congress to a constitution respecting states rights.[183] In the same year, the House voted favorably on an anti-lynching bill, opposed by all but one Southern representative, which provided a federal remedy in the case of non-feasance by state authorities. When the bill was defeated in the Senate, Senator Bailey explained Southern opposition as based on federalism concerns, as he stated:

> The proposed antilynching bill is the forerunner of a policy studiously cultivated by agitators, not for the purpose of preventing lynching, but for the purpose of introducing

182. *Id.* at 2.

183. *See* 82 CONG. REC. 1936 (1937); William E. Forbath, *The New Deal Constitution in Exile*, 51 DUKE L.J. 165, 206 (2001).

> the policy of Federal interference in local affairs. The lynching bill would promptly be followed by a civil rights bill, drawn upon the lines of the bill which Thad Stevens tried to put upon the South . . . .[184]

Senator Bailey combined his opposition to federal control over traditional areas of state power with an animosity toward African Americans. In 1938 he wrote to a friend that:

> The catering by our national party to the Negro vote . . . is not only extremely distasteful to me, but very alarming to me. Southern people know what this means and you would have to be in Washington only about three weeks to realize what it is meaning to our Party in the Northern states. It is bringing it down to the lowest depths of degradation.[185]

Senator Bailey acknowledged that the "immediate inducement" to the legislation was the indictment of fire insurance companies in the *South-Eastern Underwriters Association* case and the possibility that the Supreme Court might hold that fire insurance was commerce and thus subject to the federal antitrust laws.[186] Yet he was concerned with maintaining his conception of dual federalism. He stated that "[m]anifestly more than the application of the antitrust laws" was at stake.[187] In his view, there was "no twilight zone or no man's land here: either the Congress would take over the regulation of fire insurance or it would be left to the States."[188] Thus Bailey rejected Arnold's argument that under "the guise of protecting States' Rights" advocates of federalism were creating "a zone where nobody could effectively act."[189]

Bailey argued that federal regulation of insurance would be disastrous for two reasons. First, he asserted that state regulation of insurance, whether or not it involved policing anticompetitive conduct, was both more appropriate and more effective than federal regulation: "[e]very State in

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184. DAVID M. KENNEDY, FREEDOM FROM FEAR: THE AMERICAN PEOPLE IN DEPRESSION AND WAR, 1929-1945, at 342 (1999).

185. JAMES T. PATTERSON, CONGRESSIONAL CONSERVATISM AND THE NEW DEAL: THE GROWTH OF THE CONSERVATIVE COALITION IN CONGRESS, 1933-1939, at 97 (1967) (quoting a letter from Bailey to R.G. Cherry, March 1, 1938).

186. *Joint Hearings*, *supra* note 75, at 2 (statement of Sen. Bailey, N.C.).

187. *Id.* at 4.

188. *Id.* at 3.

189. LYNCH, *supra* note 69, at 589-90.

this Union has adequate antitrust and antimonopoly laws, or full police powers inherent, and . . . each State is fully competent—more fully competent than the Federal Government—to regulate the insurance business. . . ."[190] Second, he argued that application of the federal antitrust laws was insulting to state pride and would destroy the independence of state governments. It would suggest that a state was "unworthy to be a State and ought to become a territory or a dependency looking to the Federal Government for power and for character in which the State itself is assumed to be wanting."[191] He did not explain how insurance differed from other businesses, which were subject to federal antitrust laws.

U.S. Attorney General Francis Biddle testified against the bill during the Joint Hearings.[192] Biddle did not share Senator Bailey's view that the exercise of federal power necessarily diminished the authority of individual states. In his view, the exercise of federal and state regulatory power could be complementary because federal antitrust laws could eliminate certain types of interstate corporate behavior that prevented states from effectively exercising their existing regulatory authority over the insurance industry.[193] Because at the time of the Hearings, the *South-Eastern Underwriters* case was before the Supreme Court, he considered the bill an attempt to interfere with the pending prosecution of fire insurance companies.[194] He also feared that granting an antitrust exemption to the insurance industry would encourage other businesses to lobby for exemptions from the federal antitrust laws.[195]

In Biddle's view, application of the Sherman Act to insurance would not lead to general federal regulation of the industry, nor would it interfere with the ability of states to regulate insurance. He stated that the preemption argument was a "deliberate creation of the insurance companies to confuse the issues and mask the real effect of the bill, which is to place the private empire of the insurance companies beyond the reach of effective governmental control."[196] He testified that, "[t]here is no question at all that States can provide regulations even if they interfere with interstate commerce. The United States courts have never held that the power of interstate commerce excludes appropriate police powers of the State."[197]

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190. *Joint Hearings*, *supra* note 75, at 4.
191. *Id.*
192. *See Id.* at 23.
193. *See Id.* at 49.
194. *See Id.* at 24.
195. *See Id.* at 25.
196. *Joint Hearings*, *supra* note 75, at 49.
197. *Id.* at 31.

He did concede, however, that a state might not be able to authorize naked price-fixing activities by insurance companies.[198] Representative Sumner of Texas, another representative of a state in which few insurance companies were incorporated, also strongly supported the bill. During the hearings he asked Biddle whether states were presently able to exercise effective control over insurance companies.[199] Biddle answered that the state and the federal government could exercise concurrent jurisdiction over commerce.[200] The Sherman Act should not interfere with state regulation because nineteen states currently had passed antitrust statutes that applied to insurance. He quoted the Attorney General of Georgia as stating that the behavior of the firms in the *South-Eastern Underwriters Association* case had violated Georgia law as well as federal law.[201]

Roy McKittrick, the Missouri Attorney General testified before the Committee in opposition to the bill. His experience as a state official led him to believe that the business of insurance could not be controlled by the states alone, either individually or collectively. State governments lacked fire insurance expertise, he testified, changing administrations led to lack of continuity of regulation and state salaries could not attract skilled experts from the private sector.[202] Representative Sumner took issue with McKittrick's statement that the States could not adequately control insurance companies without assistance from the federal government. McKittrick responded that in his experience, if one state were to set up strict insurance regulation, the insurance companies would collectively withdraw from doing business in the state, leaving the citizens of the state without access to fire insurance, a situation which had occurred in Missouri in 1913.[203]

Despite the Bailey-Van Nuys bill's overwhelming passage in the House and the Senate Judiciary Committee's favorable report, the bill failed to pass in the Senate. An impasse was reached in the Senate between

198. *Id.* at 39.
199. *Id.* at 50-51.
200. *Id.* at 52.
201. *Id.* at 55.
202. *Id.* at 81.
203. In 1899, the Supreme Court of Missouri found that stock fire insurance companies were violating state antitrust law. *See* State *ex rel.* Crow v. Firemen's Fund Ins. Co., 52 S.W. 595 (Mo. 1899). As a result of that decision the companies improved their machinery to evade the law, and in 1913 when the Missouri legislature passed a regulatory law that they did not like, they got together and served notice that they would cancel all policies and withdraw from the state. *Joint Hearings*, *supra* note 75, at 82. At that point the Missouri Attorney General filed suit to prevent the companies from collectively withdrawing from the state.

those who supported the bill and those who opposed any type of antitrust exemption for the insurance industry.[204] A colloquy representative of the difference of opinion took place between Representative Hancock of New York, a supporter of the bill, and Senator O'Mahoney of Wyoming, an opponent. Representative Hancock stated that he believed "that the States have full power to regulate the insurance business within the boundaries of the State and to stop any abuses there may be."[205] Senator O'Mahoney responded that "what we are considering here is not at all the power of the States to regulate insurance, but the power of the regional organizations which have been set up by the insurance companies to regulate the business of insurance within the States."[206] He continued, "they have established a supergovernment in the four regions and this supergovernment is the regional organization of the insurance companies regulates things that are beyond the power of the State to regulate. Only the federal government can meet this regional organization of the insurance companies on an equal footing."[207]

The impasse was resolved when, at the suggestion of the Chairman of the House Judiciary Committee, representatives of the insurance industry and State insurance commissioners met over a three month period to draft the compromise measure which was passed with little debate as the McCarran-Ferguson Act (MFA).[208] Section One of the MFA declares that Congress affirms the power of the states to tax and regulate insurance.[209] It further declared that "silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several states."[210] The second provision, section 1012(a), states that "the business of insurance . . . shall be subject to the laws of the several states which relate to the regulation or taxation of such business." These two provisions were designed specifically to remove the restraints of the dormant commerce clause on state taxation and regulation of insurance. Section 1012(b), sometimes referred to as the reverse preemption provision, defined the limits of the primacy of state insurance regulation vis-à-vis federal law, by stating that Congress reserved the right to preempt state law by stating that legislation was intended to apply to the business of insurance. Thus, Congress did not completely renounce its authority to

204. *Joint Hearings*, *supra* note 75, at 137-38.
205. *Id.* at 137.
206. *Id.* at 137-38.
207. *Id.* at 138.
208. 90 Cong. Rec. P. 1111.
209. 15 U.S.C. §§ 1011-1012 (2000).
210. *Id.*

regulate the insurance industry. The bill exempted the business of insurance from the federal antitrust laws to the extent that the industry was regulated by state law. Under the MFA, Congress could at any time in the future begin to regulate the insurance industry, and federal antitrust authorities continued to have jurisdiction to prosecute anticompetitive conduct that rose to the level of "boycott, coercion or intimidation."[211] The Act also provided for a moratorium period during which the states could make any readjustments in their insurance laws necessary to bring them into conformity with the *South-Eastern Underwriters* decision.[212]

B. POLITICAL SAFEGUARDS OF FEDERALISM?

The Senate passed the legislation by voice vote, so it is not possible to examine the voting patterns in that body.[213] In the House of Representatives, however, a greater proportion of Republicans voted in favor of the Act than did Democrats. Of the 193 Republican members of the 79th Congress, all but three either voted in favor of the act or did not vote.[214] Thus only one percent of Republicans opposed the measure. In contrast, only 62 percent of the 229 Democrats in Congress or 143 members, voted for the measure, while 60 of 229, or 26 percent opposed it.[215] When considered as a block, however, Southern Democrats formed an exception to the generalization that Republican Congressmen were more likely to support the MFA than were Democrats. The states of the deep South were represented exclusively by Democrats and these Congressmen also voted overwhelmingly in favor of the Act.[216]

On March 9, 1945, Roosevelt signed an Act "to express the intent of the Congress with reference to the regulation of the business of insurance," otherwise known as the McCarran-Ferguson Act.[217] Soon after its passage, the need for a mechanism to coordinate state insurance regulation led to the formation of two committees composed of representatives of the National Association of Insurance Commissioners and of nineteen insurance industry organizations representing all segments of the insurance

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211. 15 U.S.C. § 1013 (2000).

212. The three-year moratorium period expired on June 30, 1948. *See* 61 Stat. 448 (1947).

213. The single member of the Labor Party voted in favor of the bill.

214. *See* Vote on S.340, 79th Cong. 1122 (1945).

215. *Id.*

216. *Id.* The states of Alabama, Georgia, Mississippi, South Carolina, North Carolina, Florida, Arkansas, and Mississippi were represented by sixty-three Democratic Congressmen. Only one voted against the bill.

217. 59 Stat. 33 (codified as amended at 15 U.S.C. § 1011 (2000)).

business.[218] The Committees immediately began drafting model rate regulatory and related bills for the insurance industries to be considered by state legislatures.

There were two primary responses to the McCarran-Ferguson Act. First, the States adopted new legislation to comply with the provisions of the new statute, setting the tone for insurance regulation for the next twenty years.[219] The second response was a massive amount of litigation aimed at clarifying the respective roles of the state and federal governments under act.[220]

After the passage of the McCarran-Ferguson Act, many state officials recognized that if the states were to successfully regulate an admittedly interstate, national, even international business like insurance, they would need a mechanism to allow them to coordinate their regulatory schemes.[221] The National Association of Insurance Commissioners ("NAIC") stepped in to fill this need in May of 1945 when it organized a group that included representatives of all segments of the insurance business as well as state regulatory officials.[222] This "All-Industry" Committee drafted model legislation granting significant latitude to rating bureaus, but preserving the right of independent companies to refuse to join them.[223] This model legislation was then presented to state legislatures. Rating bureaus are private entities organized by insurance companies to establish uniform rates for their members. The rationale for such organizations is that it is necessary for individual companies to pool information regarding risks in order to set reasonable rates.[224] The legislation also provided that bureau membership must be open to all companies and that state governments must possess a degree of control over the bureaus' operations.[225]

Less than three weeks after Congress passed the McCarran-Ferguson Act, the Supreme Court explicitly sanctioned Congress's actions. In *Southern Pacific Co. v. Arizona*, Justice Stone stated in dictum that: "Congress has undoubted power to redefine the distribution of power over interstate commerce. It may . . . permit the states to regulate the commerce in a manner which would not otherwise be permissible . . . ."[226] Six months

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218. MEIER, *supra* note 64, at 73.
219. *Id.* at 69.
220. *Id.* at 69-70.
221. *Id.* at 69.
222. CENTER & HEINS, ED., INSURANCE AND GOVERNMENT 24 (McGraw-Hill 1962).
223. *Id.*
224. KIMBALL & HEANEY, *supra* note 74, at 16.
225. CENTER & HEINS, *supra* note 222, at 24.
226. 325 U.S. 761, 769 (1945).

later in *International Shoe Co. v. Washington*, Justice Stone repeated the dictum: "It is no longer debatable that Congress, in the exercise of the commerce power, may authorize the states, in specified ways, to regulate interstate commerce or to impose burdens upon it."[227]

In his dissent in *South-Eastern Underwriters*, Chief Justice Stone predicted that the decision would loosen "a flood of litigation and of legislation, state and national, in order to establish a new boundary between state and national power . . . ."[228] True to his prediction, the flood of litigation began even before the state legislatures had an opportunity to amend their statutes.[229]

Shortly after the McCarran-Ferguson Act went into effect, the insurance industry brought a test case challenging the rights of states to continue to levy discriminatory taxes on out-of-state insurance companies. They took this case, *Prudential Insurance Co. v. Benjamin*, all the way to the Supreme Court, which decided the case in 1946.[230] The Court upheld the tax, stating that the McCarran-Ferguson Act specifically provided for "the continued regulation and taxation by the several states of the business of insurance...."[231] The case also held that the division of power set forth in the McCarran-Ferguson Act was constitutional.[232]

IV. ANALYSIS OF THE ROLE OF POLITICAL SAFEGUARDS

How can we explain why Congress declined to exercise its jurisdiction, affirmed by the Supreme Court, over interstate commerce in the area of insurance? This decision to forego regulatory authority is all the more

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227. 326 U.S. 310, 315 (1945). The following year in *Prudential Insurance Co. v. Benjamin*, the Court refuted the view that federal and state control over commerce are mutually exclusive, upholding both the MFA and a state tax authorized by it. The Court indicated that Congressional power over interstate commerce was a power that "Congress may exercise alone, . . . or in conjunction with coordinated action by the states . . . ." 328 U.S. 408, 434-36 (1946).

228. *South-Eastern Underwriters Ass'n*, 322 U.S. at 583.

229. MEIER, *supra* note 64, at 67.

230. 328 U.S. 408 (1946).

231. *Id.* at 429-30 (citing 15 U.S.C. § 1011 (2000)).

232. *Id.* at 437-40. While the Supreme Court was deciding this case, it had before it a second case brought by the insurance industry challenging state regulation of insurance. In *Robertson v. California*, Mr. Robertson sought to act as an agent in California for a non-admitted Arizona insurer. 328 U.S. 440, 445 (1946). He claimed that California's license requirement and exclusion of the Arizona insurer were both unconstitutional restrictions of interstate commerce on the grounds of inadequate reserves. *Id.* at 455-56. The Court disagreed and held that the state of California had the right to regulate insurance within its borders. *Id.* at 460-62.

surprising because not only did Congress decline to affirmatively regulate the business, it also stated that federal policy as reflected in the form of antitrust laws should yield to contrary state interests expressed in state regulatory policy.

A cynical view would suggest that the course of insurance regulation was largely determined by the exceptional strength of the well-organized and financed insurance lobby. Political observers from the time of John Stuart Mill have held such views of the influence of special interests on representative government. According to Mill:

> The *positive* evils and dangers of the representative, as of every other form of government, may be reduced to two heads: first, general ignorance and incapacity, or, to speak more moderately, insufficient mental qualifications, in the controlling body; secondly, the danger of its being under the influence of interests not identical with the general welfare of the community.[233]

Mill's analysis bears some resemblance to views expressed by modern advocates of public choice theory. "Public choice theory," wrote Jonathan Macey, "posits that legal rules are supplied to those groups that bid the most for them and that compensation is provided in the form of political support ... [L]aws will tend to benefit small, cohesive special-interest groups at the expense of the general public ... due to two reasons: (1) individuals lack sufficient incentives to promote laws that directly benefit the general public because of free-rider problems; and (2) interest groups have strong incentives to press for laws that transfer wealth from the general public to themselves."[234]

The regulatory history of the insurance industry offers numerous instances in which the insurance lobby played a role in determining the nature of insurance regulation. As noted earlier, states first began regulating insurance through restrictions included in state-granted corporate

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233. JOHN STUART MILL, CONSIDERATIONS ON REPRESENTATIVE GOVERNMENT 122 (Henry Holt & Co. 1882).

234. *See* Macey, *supra* note 30, at 269 n. 16 (citing Jonathan R. Macey, *Promoting Public-Regarding Legislation Through Statutory Interpretation: An Interest Group Model*, 86 COLUM. L. REV. 223, 230-32 (1986)). "Public choice can be defined as the economic study of nonmarket decisionmaking, or simply the application of economics to political science....The basic behavioral postulate of public choice, as for economics, is that man is an egoistic, rational, utility maximizer." DENNIS C. MUELLER, PUBLIC CHOICE III 1 (Cambridge: Cambridge Univ. Press 2003).

charters, and then subsequently formed "sunshine commissions" to perform economic regulatory functions.[235] As insurance companies began to form regional and national organizations in the mid-nineteenth century whose purpose was to coordinate rates and to lobby these commissions, they also increasingly came to lobby state legislatures. While the bulk of lobbying efforts were directed toward state officials, they also engaged in lobbying Congress. For example, in 1869, industry representatives attempted to persuade Congress to pass a bill to create a federal commissioner of insurance, and in 1897, after the *Paul* decision, to declare that insurance companies doing business outside their state of incorporation were engaged in interstate commerce.[236]

Every governmental investigating commission, whether state or national, that investigated the insurance industry expressed concern regarding the enormous power of the insurance lobby. For example, New York State's Armstrong Investigating Committee in 1905 remarked upon "the systematic efforts of the large insurance companies to control a large part of the legislation of the state."[237] Later, beginning in 1938, The TNEC Hearings revealed the level of economic power possessed by insurance companies due to the level of industry concentration and its access to huge financial resources. During those hearings, insurance companies deluged Congress with letters and engaged in other lobbying activities.[238] Congress was most likely responding at least in part to insurance industry pressure when it chose to hold Joint Hearings in response to the *South-Eastern Underwriters Association* case.[239]

Insurance industry organizations such as the National Bureau of Fire Underwriters not only engaged in lobbying activities, but also coordinated strategic litigation. In fact, *Paul* itself was undertaken at the behest of insurance companies and financed by the NBFU. A second example of strategic litigation was the 1913 case of *New York Life Insurance Co. v. Deer Lodge County.*[240] Moreover, one reason the dissenters gave in the *South-Eastern Underwriters* case for finding insurance not to be commerce was that such a finding would unleash a sea of litigation by insurance companies contesting state regulation,[241] as indeed it did. But the power of

235. *See* THOMAS P. MCCRAW, PROPHETS OF REGULATION 80 (1984).
236. GRANT, *supra* note 53, at 75; *see also* Merkel, *supra* note 55, at 540.
237. LYNCH, *supra* note 66, at 294.
238. *See id.* at 374.
239. 322 U.S. 533 (1944).
240. 231 U.S. 495 (1913).
241. 322 U.S. at 583.

the insurance lobby alone does not explain the regional pattern of voting for the McCarran-Ferguson Act discussed in more detail below.

As the research of TNEC revealed, States could have very different economic interests with respect to the insurance industry. The TNEC found the insurance industry in the late 1930s to be highly concentrated and clustered primarily in the northeastern states, but to some degree also in the Midwest. There were virtually no insurance companies headquartered in either the western or southern states.[242] The geographic aspects of the business of insurance did not escape Justice Hugo Black. He noted in his majority opinion in *United States v. South-Eastern Underwriters Association* that of the 200 companies indicated in the case for restraining and monopolizing trade in six southeastern states, 127 had headquarters in either New York, Pennsylvania or Connecticut.[243] Clearly the northeastern states had an interest in retaining their ability to tax locally headquartered insurance companies that was not equally shared by the southern and western states. And yet, Senators and Congressmen from the southern states overwhelmingly supported passage of the McCarran-Ferguson Act.

One reason for the success of the insurance lobby's endeavors can be explained by the efforts of the highly organized insurance lobby. Nevertheless, recognizing the influence of the insurance lobby cannot explain why the industry chose to lobby for state rather than national regulation or why states with few insurance companies headquartered within their territory should wish to retain state regulation. Insurance industry officials supported the antitrust exemption contained in the McCarran-Ferguson Act for obvious reasons. While aimed at private rather than governmental conduct, the federal antitrust laws were specifically designed to prevent the transfer of wealth from the general public to private interests. However, scholars have argued that most interest groups prefer national to state regulation because it is easier for them to lobby a single national legislature than it is to lobby fifty individual state governments.[244] That apparently has not been the case with insurance regulation, however, due to the large investment that companies had made over many years in obtaining favorable state legislation.[245]

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242. LYNCH, *supra* note 66, at 119.

243. 322 U.S. at 542.

244. *See generally* Macey, supra note 28. *See* also Calvin Massey, *Federalism and the Rhenquist Court*, 53 HASTINGS L.J. 452 (2000) ("A robust federalism makes lobbying harder, more uncertain, more expensive and less effective.") This was the view of several "new left" historians of the 1960s. *See generally,* GABRIEL KOLKO, THE TRIUMPH OF CONSERVATISM: A REINTERPRETATION OF AMERICAN HISTORY, 1900-1916 (1963).

245. Macey, *supra* note 24.

In addition to the insurance lobby, the intergovernmental lobby also played an important role in obtaining passage of the McCarran-Ferguson Act. The intergovernmental lobby is made up of officials from state and local governments that act as experts, advisors, or pressure groups and play a critical role in coordinating action by officials from different states. In the case of the McCarran-Ferguson Act, the National Association of Insurance Commissioners (ANAIC) not only lobbied for the Act, but also drafted proposed uniform state laws. The existence of an alternative to national regulation in the form of these uniform state laws no doubt helped persuade some legislators to choose state over national regulation of the industry. In addition, the National Association of Attorneys General coordinated the states' arguments in *amicus* briefs before the Supreme Court in the *South-Eastern Underwriters Association* case.[246] A related factor which appears to have played a role in influencing voting patterns was that many Congressmen had served as state legislators earlier in their careers. Kramer argues that this phenomenon is one reason why Congressmen tend to take the interests of state legislatures into account.[247] Analysis of voting patterns for the McCarran-Ferguson Act reveals that Congressmen who had previously served in their state legislatures were significantly more likely to vote in favor of the bill than to vote against it. Of the 423 members of the 79th Congress, 122, or twenty-nine percent, had previously served in state legislatures. Of these members, only twelve, or approximately ten percent, voted against the McCarran-Ferguson Act, while 98 members, or approximately eighty percent, voted in favor of it.[248]

Another critical factor in making sense of Congressional voting behavior is the presence of political parties. Both Kramer and Hamilton believe that national lobbies play a major role in Congressional policymaking. But they differ on the role of political parties and how the

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246. According to Donald H. Haider, "Federalism builds into our political system veto politics: a certain conservative bias which tends to expand geometrically as access points on all government levels increase and new constituencies are created. The government interest groups constitute such a veto instrumentality, but also one which has proved to have a significant capacity for joint action as well." HAIDER, *supra* note 65, at 307.

247. Kramer, *supra* note 4, at 285. Other political scientists have also remarked on this pattern. DAVID R. MAYHEW, AMERICA'S CONGRESS: ACTIONS IN THE PUBLIC SPHERE, JAMES MADISON THROUGH NEWT GINGRICH 129 (2000) ("It is said that American politicians operate within an opportunity structure. This is the familiar hierarchy of public offices wherein, in the most familiar scenario, they started as state or local officials, rise to the U.S. House, aspire to the Senate and possibly climb beyond that to a cabinet post or the vice presidency or presidency.")

248. Thirteen Congressmen who had previously served in their state legislatures did not vote.

parties interact with lobbyists, among others. Kramer argues that "the unique American system of decentralized national political parties . . . linked the fortunes of federal office holders to state politicians and parties and in this way assured respect for state sovereignty."[249] Hamilton, on the other hand, disagrees and argues that Kramer makes the critical mistake in his analysis of conflating the interests of state politicians with the interests of the state.[250]

Both the Republican and Democratic parties officially declared their support for the continued state regulation of insurance; both the Republican and Democratic platforms of 1940 contained planks supporting the continued state regulation of insurance.[251] The Republican plank, however, was more strongly worded. It stated, "We condemn the New Deal attempts to destroy the confidence of our people in private insurance institutions. We favor a continuance of regulation of insurance by the several states."[252] The Democratic party platform, in contrast, merely stated, "We favor strict supervision of all forms of the insurance business by the several states for the protection of policyholders and the public."[253] Given these statements of policy, it is not surprising that Congressional Republicans voted more consistently in favor of the McCarran-Ferguson Act than did Democrats.

While party affiliation does appear to have some explanatory power in understanding voting patterns for the McCarran-Ferguson Act, it becomes more meaningful when considered together with geographic region. Nationally, Republicans generally favored state regulation of insurance, but Southern Democrats were even more consistent advocates of state regulation. This fact took on additional importance due to the disproportionate level of influence exercised by Southern congressmen in the mid-twentieth century. In his book, *America's Congress*, David R.

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249. *See* Kramer, *supra* note 4, at 276. Morton Grodzins agrees with Kramer and sees parties playing an important role in the federal system, promoting the national interest by giving citizens and other interested persons a multiple crack at obtaining desired outcomes. In 1966, Grozdins wrote, "the American political system works the way it does due to the peculiar and unique nature of American political parties. The chaos of party explains the chaos of government." MORTON GRODZINS, THE AMERICAN SYSTEM: A VIEW OF GOVERNMENT IN THE UNITED STATES 3-16 (1966); *see also* HAIDER, *supra* note 65. His work "assumes that the advantages of the American noncentralized, nondisciplined party structure and prolific interest-group activity are the protection of State and local interests which operate upon and are reflected at the federal level." HAIDER, *supra* note 67, at xii.

250. Hamilton, *supra* note 3, at 1078.

251. *Joint Hearings*, *supra* note 75, at 5 (statement of Sen. Bailey, N.C.) ("[t]o this I may add that the platforms of the Democratic and the Republican Parties in 1940 declared for regulation and supervision of the business of insurance by the several states....").

252. *Id.*

253. *Id.*

Mayhew examines the degree to which, in general, Southerners have exercised disproportionate influence in Congress. He found that from the 1930s through the 1960s, Congressmen from the South tended to enjoy a period of special influence, a phenomenon he terms the South's "action bonus."[254] He attributes this special power of Southern congressmen during this period to the fact that seniority rules then were rigid, and the Democratic party generally controlled Congress. Because Southern voters overwhelmingly voted Democratic and tended to re-elect the same politicians for many years, those Congressmen tended to become influential committee chairmen.[255]

Historical evidence suggests that Southern Congressmen used their disproportionate influence in congress to protect states rights, especially state prerogatives to exercise control over issues affecting race relations. During the 1930s and 1940s, the controversy surrounding racial issues and federalism was highly charged. The governmental revolution set in motion by Roosevelt with the New Deal made any discussion of federalism issues controversial and, in the minds of many Southern legislators, issues of federalism were intrinsically tied to issues of race. According to William Forbath, the solid South was ruled by a planter and new industrial oligarchy, which chose the majority of Southern congressmen, who then formed a reactionary core at the heart of Roosevelt's liberal coalition.[256] These Southern conservatives held the balance of power in Congress and thwarted liberal measures. However, after the New Deal was upheld by the Court, "a new political-constitutional configuration emerged. Instead of a Democratic president and Congress confronting a conservative Court, Roosevelt and the New Dealers confronted a conservative, anti-New Deal coalition of Republicans and Southern Democrats in Congress.[257] The old constitution's solicitude for "States' sovereignty and local self-government with plenary authority over all domestic, social, and racial relations, . . . all these doctrines were advanced by the anti-New Deal congressional coalition."[258] Thus, he argues that between 1937 and 1945, "Thanks to their numbers, their seniority and their control over key committees, Southern Democrats had a hammerlock on Congress."[259]

As Forbath recognized, the New Deal and the Second World War increased national strife over racial issues and sparked national debate over

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254. MAYHEW, *supra* note 247, at 168, 181.
255. *See id.* at 181
256. Forbath, *supra* note 183, at 165.
257. *Id.*
258. *Id.* at 170.
259. *Id.* at 203.

racial policy in a way that had not occurred since the Civil War and Reconstruction Eras. Designing and implementing New Deal programs had required national politicians to reorganize patterns of federalism and to confront existing racial arrangements in the states. For example, in designing programs such as public works projects, state and local administrators generally pressed hard for "local control," a phrase that in Southern states almost always meant discriminatory implementation of federal programs. New Dealers wishing to counter racial bias thus tended to push for greater federal control over government programs.[260] When President Roosevelt issued Executive Order 7046 in 1935 requiring that works projects not discriminate on the basis of race, opposition to the Public Works Administration (PWA) projects by Southern contractors, building trades unions and Southern congressmen forced the Administration to compromise its non-discrimination policy in cities such as Atlanta, Memphis and Montgomery.[261]

Roosevelt was seen as a great nationalizer by advocates of states' rights and he did not improve his relations with Southern Congressmen when in a 1938 speech in Georgia he criticized the "feudal society" of the South.[262] The Administration further antagonized Southern politicians when in 1939, the Justice Department created the Civil Liberties section to ensure that individual states were enforcing existing federal civil rights laws and which sued states seen to be failing their duties.

At the time of the passage of the McCarran-Ferguson Act, every state in the deep South was represented almost exclusively by Democrats and these Congressmen voted overwhelmingly in favor of continued state regulation of insurance, suggesting that the concept of protecting states' rights in a federal system had greater salience for Southern legislators than for those from other parts of the country.[263] Not surprisingly, the majority of representatives of states from the northeast, the region that was home to the most insurance companies, also voted overwhelmingly in favor of state regulation. The vote was unanimously in favor by representatives from the states of Delaware, Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut.[264] The vast majority of representatives from New Jersey also voted in favor of the bill. In the Midwestern states of Ohio, Michigan, Iowa, Kansas, Missouri and Indiana, Congressmen were

260. HARVARD SITKOFF, A NEW DEAL FOR BLACKS: THE EMERGENCE OF CIVIL RIGHTS AS A NATIONAL ISSUE, THE DEPRESSION DECADE 47 (Oxford University Press 1978).

261. *See id.*

262. PATTERSON, *supra* note 185, at 278.

263. *See* Vote on S.340, 79th Cong. 1122 (1945).

264. *Id.*

split by party affiliation. Republican congressmen tended to vote in favor of the act while Democratic congressmen tended to vote against it.[265] The heavily Republican states of Nebraska, Kansas, Iowa, Wisconsin, and Minnesota strongly supported the bill, while states such as New Mexico, California, West Virginia, and Illinois were more mixed.[266]

One commentator has noted that with respect to regulation of industry by either the states or the national government, there has been "no consistent uniform or logical pattern to regulation .. . ."[267] "The division of responsibility varies with the business regulated" and seems to be determined by historical accident.[268] In the recent decision of *U.S. v. Morrison,* the Supreme Courted noted that in the American political system, states tend to keep jurisdiction over areas that they have traditionally regulated.[269] Surprisingly, this has proven to be the case even in cases such as the regulation of insurance, when the regulated area clearly falls within one of Congress's enumerated powers, in this case, its authority to regulate interstate commerce.

I argue that certain results that at first blush appear to be historical accidents were in fact influenced by the political safeguards of federalism and later reinforced by legal doctrines such as *stare decisis.* The case of *United States v. South-Eastern Underwriters Association* and the subsequent passage of the McCarran-Ferguson Act illustrates that Congress at times has proven to be an even more zealous guardian of federalism than the Supreme Court.[270]

My research suggests that the "states rights" that are protected by any political safeguards are as likely to involve states' rights to protect their prerogatives to discriminate in areas involving racial policy as they are to protect other interests. But more empirical research needs to be done before important normative questions can be answered.

Some have argued that federalism's past association with racial issues has unfairly tainted our view of it today. I would argue that while the dynamics of federalism operate differently today than they did in earlier

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265. *Id.*

266. *Id.*

267. Milton Handler, *Patterns of Trade Regulation in a Federal System,* in FEDERALISM, MATURE AND EMERGENT 357 (Arthur W. Macmahon ed., 1962).

268. *Id.*

269. United States v. Morrison, 529 U.S. 598, 616 (2000).

270. *See* Paul R. Hays, *Federalism and Labor Relations: A Case Study of Congressional Responsibility, in* FEDERALISM, MATURE AND EMERGENT 235-36 (Arthur W. Macmahon ed., 1962) (noting that "the non-ideological pressures within Congress which favor centralization and uniformity are frequently balanced by others which favor state control and local variation").

times, legal and political arrangements are never forged on a clean slate. Older ideas and precedents regarding the proper role of the national and state governments remain embedded within the minds of public officials and existing structures of government. The current Court's impulse to exercise its power to protect areas "where states have historically been sovereign (*Lopez*)[271] and matters of "traditional state concern (*Morrison*)[272] operates to reinforce this inherent tendency in the law. As the *South-Eastern Underwriters Association* case and the debates surrounding the McCarran-Ferguson Act illustrate, concern with protecting traditional state prerogatives was an important factor influencing Congress, as well as the judiciary. Even specifically legal doctrines such as preemption, stare decisis and dormant commerce clause doctrine tended to guide decision-making of certain Senators and Congressmen to a significant degree. In fact, it could be argued that older legal concepts, such as those that surround the principle of dual federalism, survived in their original form in the minds of certain members of Congress, long past the point at which they were forsaken by the courts. Thus Congressmen cited preemption concerns in the debates surrounding the McCarran-Ferguson Act, despite the fact that by 1945 Congress and the states had been concurrently regulating industries such as telecommunications and securities since the mid-1930s.

These factors, in combination with the economic interests of particular states, such as northeastern states that were home to large insurance companies and Southern states eager to protect states rights for historical reasons tipped the balance of Congressional decision-making toward regulation of insurance at the state level, rather than the more logical alternative of national regulation for a national industry. The large level of tax receipts at stake for state governments in states home to insurance companies also provided a significant incentive for state officials and legislatures to exert their influence in Congress through the NAIC and in the Court by the Joint amicus brief filed by state attorneys general.

James Madison argued that individual states would band together as states to protect their common interests in the face of over-reaching by the national government.[273] Evidence from this case study bears this out. Larry Kramer also theorizes that Congressmen often serve as state legislators earlier in their careers and therefore are likely to take the

271. United States v. Lopez, 514 U.S. 549, 563 (1995).

272. *Morrison*, 529 U.S. at 616.

273. THE FEDERALIST NO. 46, at 294 (James Madison) (C. Rossiter ed., 1996).

interests of state legislatures into account. My study also supports this thesis.

As Kramer and others have argued, political parties have historically played a role in mediating state and federal interests in the federal system. The case of insurance and the McCarran-Ferguson Act, however, suggests that the role of political parties can best be understood when considered in tandem with the influence of geographic region, which appears at least in this case, to be an even more accurate predictor of Congressional voting behavior. On the other hand, the criticism of Calvin Massey and others that political parties and the roles they play have changed significantly over time is also valid. This is illustrated by recent developments such as the rise of the influence of political action committees and changes in campaign finance laws.

Hamilton's objection that Kramer's analysis makes the critical mistake of conflating the interests of state politicians with the interests of the state is more complicated. I would argue that for states in which large insurance companies were incorporated, the interests of the state and the interests of state legislators in collecting tax revenues from profitable insurance companies were essentially the same. I would reach the opposite conclusion, however, for the representatives of Southern states who I argue, voted to protect states' rights in order to protect traditional state prerogatives on issues concerning, *inter alia*, race relations. Here the interests of black citizens of Southern states were not the same as the interests of the predominantly, if not exclusively, all-white state legislators.[274]

274. *See generally*, THE FEDERALIST NO. 10 (James Madison).

THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003: THE WRONG PRESCRIPTION FOR OUR NATION'S SENIOR CITIZENS?

Karen M. Wieghaus[*]

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INTRODUCTION

On December 8, 2003, President Bush approved the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("the Act").[1] Notably, this bill creates a prescription drug benefit for Medicare beneficiaries that is slated to begin in 2006. While the purpose of the Act

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1. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

is to facilitate the provision of costly pharmaceuticals to our nation's senior citizens, the Act has several shortcomings in this regard. Although it seems to be a drastic improvement over the current situation, in which Medicare beneficiaries must pay out-of-pocket for their prescription drugs, the combination of the payment structure and a gap in coverage under the Act means that senior citizens will remain responsible for a sizeable portion of the total cost of their life-saving prescription drugs. This is an especially significant cost to Medicare beneficiaries because many senior citizens subsist on only their Social Security benefits and any savings they have accrued over their lifetimes. Moreover, not all pharmaceuticals will be covered by the Act, and seniors will still need to pay for these non-covered prescriptions themselves.

Furthermore, the Act includes two provisions that will have the effect of increasing the cost of prescription drugs to both senior citizens and taxpayers. First, the Act prohibits the Department of Health and Human Services ("HHS") from using its purchasing power to negotiate with major pharmaceutical companies to obtain lower prices. Additionally, the Act forbids the implementation of a price structure for covered drugs. It is not coincidental that the short term solution and response currently taken by many senior citizens is to acquire costly prescription drugs from Canada and other countries. Many of these countries employ price structures in their prescription drug schemes and can therefore offer the same drugs at lower prices.

The United States should amend the Act to allow for the implementation of a price structure. Specifically, senior citizens and taxpayers would benefit from the inclusion of a reference pricing scheme, which has been largely successful as a cost-containment measure in Germany, Denmark, Australia, and British Columbia.[2] Under such a scheme, senior citizens would pay any excess price over the reference price set for the applicable class of drugs, which introduces a voluntary co-payment and an element of price elasticity into an otherwise oligopolistic market. Medicare would cover the cost of drugs priced at or below the reference price. Introducing price elasticity into the market will help contain the costs of Medicare expenditures because seniors will have an option to obtain lower-cost drugs based on their willingness-to-pay.[3]

This article considers the inclusion of a reference pricing scheme in the new Medicare prescription drug benefit under the Act. Section II provides

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2. *See* Karen Wieghaus, Reference Pricing: Implications for U.S. Medicare Reform 3 (2003) (unpublished A.B. thesis, Princeton University) (on file with author and the Princeton University Library).

3. *See id.* at 24-28.

a general background, including a brief discussion of the relevant portion of the Act, the effect of the Act on the economy, and the general structure of the market for pharmaceuticals. Section III explains the general theory of reference pricing, responds to arguments forwarded by the pharmaceutical industry, and presents evidence of its success internationally. Section IV examines the application of reference pricing to Medicare and the expected effects on the pharmaceutical market and the economy in its current state. Section V presents the conclusion that a reference pricing program would provide a substantial benefit to the United States government, taxpayers, and most importantly, America's Medicare beneficiaries.

I. BACKGROUND

A. THE ACT AND ITS EFFECT ON THE ECONOMY

Prior to the Act, most Medicare beneficiaries paid out-of-pocket for their prescription drugs. Many of our nation's senior citizens, some who subsist on Social Security income alone, were forced to compromise their health and longevity because they could not afford the skyrocketing prices of prescription pharmaceuticals. "Everyday millions of Americans...must choose between buying food or medication, or between taking the fully prescribed dosage of medicine or cutting their pills in half because a refill is too expensive."[4] In fact, "the senior population in America pays more for prescription medications than any other population."[5] The implementation of the Act is notable and a significant improvement over the status quo; however, an amendment adding a reference pricing provision would make the cost of the prescription drug benefit more palatable for Medicare beneficiaries, the federal government, and our nation's taxpayers.

Subpart 2 of the Act, which deals with Prescription Drug Plans, contains two provisions relating to the price of prescription drugs:

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4. *See* Michele L. Creech, Comment, *Make a Run for the Border: Why the United States Government is Looking to the International Market for Affordable Prescription Drugs*, 15 EMORY INT'L L. REV. 593, 593 (2001).

5. *See* Abraham N. Saiger, Note, *In Search of a Government that Will Govern: Senate Bill 812 and "Reimporting" Prescription Medication from Canada,* 12 ELDER L.J. 178 (2004) (discussing the viability of the Greater Access to Affordable Pharmaceuticals Act, which would "[allow] for wholesale commercial reimportation of prescription medication from Canada.").

> In order to promote competition under this part and in carrying out this part, the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and [prescription drug plan] sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered...drugs.[6]

Accordingly, HHS is prohibited from using the purchasing power of the Medicare system to negotiate lower prices with the pharmaceutical companies. This is a considerable setback for those ultimately responsible for paying for the drug benefit, including Medicare beneficiaries and taxpayers. Generally, "insurance companies can extract steep discounts from both pharmacies and drug manufacturers."[7] Because Medicare beneficiaries (and taxpayers) cannot reap the benefits of this type of price discrimination, for senior citizens who require drugs not covered by the program or those senior citizens who experience a lapse in coverage due to the "gap" structured into the program, there is no improvement over their current situation:

> The bill's proposed "noninterference" language makes it evident that Congressional leaders do not wish to act in a serious way to win lower drug prices. Most limits on drug costs in the proposed program appear to come at the expense of Medicare patients—in the form of severe limits on coverage—so most patients must continue paying the great majority of their prescription drug costs, including in the "doughnut hole" where they have no coverage at all.[8]

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6. Medicare Prescription Drug, Improvement, and Modernization Act § 1860D-11(i), 117 Stat. at 2098.

7. *See* Arti K. Rai, *The Information Revolution Reaches Pharmaceuticals: Balancing Innovation Incentives, Cost, and Access in the Post-Genomics Era*, 2001 U. ILL. L. REV. 173, 188 (2001) (describing a report issued by the Department of Health and Human Services which "found that, for the most commonly prescribed drugs, third-party payers – who are primarily pharmaceutical benefits managers for insurance plans – paid significantly less to pharmacies than did cash purchasers").

8. *See* Alan Sager & Deborah Socolar, *61 Percent Of Medicare's New Prescription Drug Subsidy Is Windfall Profit To Drug Makers* 1 (Health Reform Program, Boston University School of Public Health, 2003), *available at* http://www.bu.edu/dbin/sph/departments/health_services/health_reform.php (last visited Apr. 9, 2005).

Moreover, and more central to the topic of this article, the Medicare program is banned from implementing any type of price control in order to stabilize and decrease the price levels of drugs that are charged by pharmaceutical companies. However, recent studies have shown that Medicare already pays escalated prices for drugs as compared to Health Maintenance Organizations ("HMOs") and pharmacies. "An HHS inspector general's report in 2001 said Medicare reimbursements for two dozen drugs 'exceeded actual wholesale prices by $761 million a year.'"[9] Furthermore, the prohibition on price negotiations and price controls in the Act has been touted as a major coup for the pharmaceutical companies, and has even led to investment strategies exploiting the new Medicare "program, which . . . is expected to boost industry sales by some 9%, or $ 13 billion a year . . . ."[10] An estimated 67.7% of the $228 billion increase in Medicare dollars spent under the Act will ultimately be retained by pharmaceutical companies as profits.[11] Due to the inherent characteristics of the pharmaceutical market as a high sunk-cost, low variable-cost industry, the "only added costs for drug makers associated with a new Medicare prescription drug benefit are expected to be in manufacturing and in distribution—and these added costs are remarkably low."[12]

In recent years, Medicare costs have skyrocketed. For instance, "Medicare spending in 1999 was around $213 billion, or about $5,400 per beneficiary, accounting for about 12 percent of the federal budget, 2.3 percent of GDP, and 20 percent of all health care costs."[13] Projections for the year 2030 demonstrate a considerable increase in Medicare spending, "[i]n part as a result of rising life expectancy, but mainly as a result of the aging of the baby boom, the number of Medicare beneficiaries is expected to rise from around 39 million (14 percent of the U.S. population) . . . to

9. Donald L. Bartlett & James B. Steele, *Why We Pay So Much for Drugs: How the clamor for cheap Canadian imports is heating up the 2004 campaign and giving Washington a headache*, TIME, Feb. 2, 2004.

10. John Simons, *Investor's Guide - The Perfect Mix For Your Portfolio: Patent expirations, political pressures, and a Medicare reform bill have changed the landscape for Big Pharma--and created an opportunity for investors. We found five drug stocks that look like winners*, FORTUNE, Dec. 29, 2003 at 134.

11. *See* Sager & Socolar, *supra* note 8, at 6.

12. *See id.*

13. *See* Mark McClellan, *Medicare Reform: Fundamental Problems, Incremental Steps*, 14 J. OF ECON. PERSP. 21, 21 (2000) (citing the Congressional Budget Office, 2000 and the Medicare Payment Advisory Commission, 2000).

around 77 million (22 percent) in 2030."[14] Medicare costs threaten to total five to six percent of GDP and one-third of the national budget by 2030.[15]

With regard to the macroeconomic effects of the Medicare prescription drug benefit, the Organisation for Economic Co-operation and Development (OECD) has stated that "extension[s] of Medicare benefits should be undertaken in the context of a broader strategy restoring the system's longer-term financial viability."[16] However, in light of the exorbitant costs expected to be undertaken over the next decade in connection with the prescription drug benefit under the Act, long-term financial viability seems rather bleak. "Congress' . . . overhaul of Medicare will be a bonanza for health care providers, a modest benefit for most seniors, and...a boondoggle that could cost taxpayers billions more than forecast."[17] Projections forwarded by the Congressional Budget Office ("CBO") state that Medicare spending, currently constituting thirteen percent of the federal budget, will multiply by 6.8% annually between 2004 and 2013.[18] Initial estimates indicate that the prescription drug benefit afforded under the Act will carry a price tag of $400 billion over the next decade,[19] the cost of which will be borne by the federal government and ultimately by America's taxpayers. More recent estimates forwarded by the Office of Management and the Budget ("OMB") state that the price of enacting this benefit may in fact be closer to $500 billion, an increase of $100 billion over the figure considered by Congress while voting on the bill.[20]

The director of fiscal policy at the Cato Institute predicts that the cost of funding a prescription drug benefit for seniors under its current structure may be too high a burden on generations of younger taxpayers, and also may "cripple the economy" if interests rates rise to facilitate government

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14. *See id.* at 21 (citing U.S. Health Care Financing Administration, 2000).

15. *See id.* at 21-22 (citing the Congressional Budget Office, 1998 and the U.S. Health Care Financing Administration, 2000).

16. ORG. FOR ECON. CO-OPERATION AND DEV., 74 ECONOMIC OUTLOOK 1, 35 (Dec. 2003).

17. William M. Welch & Julie Appleby, *Medicare bill may benefit seniors but not taxpayers*, USA TODAY, Nov. 24, 2003, *available at* http://www.usatoday.com/news/Washington/2003-11-24-medicare-cover_x.htm.

18. E. Matthew Quigly, *The Federal Medicare Prescription Drug Bill Plan: Its Implications for the New England States*, NEW ENGLAND FISCAL FACTS, Winter 2003/2004, at 1.

19. Mark Gongloff, *Medicare Time Bomb? Critics say the Medicare prescription drug bill could cause explosive budget deficits*, Nov. 25, 2003, *available at* http://money.cnn.com/2003/11/25/news/economy/budget/index.htm.

20. Bob Shepler, *Bush's Budget Woes*, FINANCIAL EXECUTIVE, Mar. 1, 2004, at 78.

borrowing.[21] The effects will intensify as drug prices rise and the "baby boomer" generation begins to subscribe to Medicare: some forecasts predict that the cost of the Medicare prescription drug benefit could reach $2.4 trillion over the next twenty years.[22] In addition to these long-term strains on the economy, the effects of the Act could be stifling on a short-term level because of the nation's current budget deficit:

> Deficits relative to [Gross Domestic Product] are still not as high as they were in the 1980s. But Goldman [Sachs] says the situation is alarming because there is no way the U.S. can grow its way out of the budget deficit and there has been no movement in Washington to address the situation. The Medicare bill is a case in point. Goldman [Sachs] calls any hope for relief "a pipe dream until political priorities adjust."[23]

Notwithstanding the high expected costs to be borne by the government and taxpayers, the Act will in effect provide only modest protection for seniors. "Unfortunately, the 2003 Act . . . has serious flaws that needlessly increase its cost . . . ."[24] The plan under the Act carries a monthly premium estimated to be $35,[25] a $250 annual deductible,[26] and a 25% co-insurance rate.[27] Furthermore, the program will then only cover 75% of drug cost up to a maximum of $2,250.[28] A gap in coverage then occurs, requiring seniors to pay out-of-pocket for the next $2,850 of prescription drugs.[29] Coverage then resumes, and Medicare will cover 95% of costs that exceed the $3,600 threshold.[30] Although the Act attempts to protect against high

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21. *See* Gongloff, *supra* note 19.

22. *See* Welch & Appleby, *supra* note 17.

23. Dan Ackman, *Top of the News – Medicare Budget Buster on Track*, FORBES, Nov. 25, 2003.

24. Gary Becker, *Comments on Medicare Reform*, BECKER-POSNER BLOG, Feb. 13, 2005, *at* http://www.becker-posner-blog.com (suggesting that total costs under the Act be reduced by increasing the annual deductible to as high as $1,000 and eliminating the gap in coverage) (last visited Apr. 9, 2005).

25. Douglas Waller, *Six Questions About the New Medicare Bill: Parts of the legislation could generate contention when the plan takes effect*, TIME, Dec. 8, 2003.

26. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L. No. 108-173 § 1860D-2(b)(1), 117 Stat. 2066, 2077 (2003).

27. *Id.* § 1860D-2(b)(2)(A), 117 Stat. at 2077.

28. *See id.* § 1860D-2(b)(3)(A), 117 Stat. at 2077; Waller, *supra* note 25.

29. *See* Waller, *supra* note 25.

30. *See* Medicare Prescription Drug, Improvement, and Modernization Act §1860D-2(b)(4)(B), 117 Stat. at 2078; Waller, *supra* note 25.

out-of-pocket expenditures, the gap in coverage (or "donut hole") will leave many seniors with moderate expenses without protection: "Economists are puzzled by the very low deductibles in Medicare (including the prescription-drug benefit – the annual deductible is only $250). Almost everyone can pay the first few hundred dollars of a medical bill; it is the huge bills that people need insurance against in order to preserve their standard of living . . . ."[31]

B. THE PHARMACEUTICAL MARKET

The United States pharmaceutical companies have clinched the position as the worldwide leader in pharmaceutical innovation and production.[32] Pharmaceutical companies are regularly listed at the top of each annual *Fortune* 500 list,[33] and the "pharmaceutical industry in general is reported to enjoy profit margins nearly four times that of the average *Fortune* 500 company."[34] In 2002, *Fortune* reported that the profits of the top ten pharmaceutical companies totaled almost $36 billion.[35] American pharmaceutical companies produced almost half of the world's new "breakthrough" drugs during the period between 1970 and 1992.[36] In the years 1998-2003, "shareholders of pharmaceutical stocks have enjoyed an annual rate of return of 18.4 percent – twice the 9.2 percent average return to stockholders of the Fortune 500 companies."[37]

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31. Richard Posner, *Prescription Drugs and Medicare Reform*, BECKER-POSNER BLOG, Feb. 13, 2005, *at* http://www.becker-posner-blog.com (suggesting the extreme tactic of abolishing Medicare, although he supports the inclusion of a prescription drug benefit in the current version of Medicare).

32. *See* Andrew Harris, *Recent Congressional Responses to Demands for Affordable Pharmaceuticals*, 16 LOY. CONSUMER L. REV. 219, 221-22 (2004).

33. *See Hearing on Generic Pharmaceuticals: Hearing on S. 812 Before the S. Comm. on Commerce, Science., & Transportation,* 107th Cong. (2002) (Statement of Sen. Charles Schumer); *But cf.* Jerry Stanton, Comment, *Lesson for the United States from Foreign Price Controls on Pharmaceuticals*, 16 CONN. J. INT'L L. 149, 155-57 (2000) ("Economics of the pharmaceutical industry cannot be compared to that of most other Fortune 500 industries due to the high sunk costs involved in developing a new drug...pharmaceuticals are more akin to utilities rather than the majority of other Fortune 500 industries." Stanton suggests using internal rates of return as "[t]he common denominator by which to compare profit levels among disparate industries....").

34. *See* Stanton, *supra* note 33, at 154.

35. *See* Sager & Socolar, *supra* note 8, at 12.

36. *See* Harris, *supra* note 32, at 221.

37. *See* Farin Khosravi, Comment, *Price Discrimination in the United States: Why are Pharmaceuticals Cheaper in Canada and Are Americans Seizing Opportunities Across the Border?*, 9 NAFTA L & BUS. REV. AM. 427, 430 (2003).

The American pharmaceutical market is unique, "marked with inherent characteristics that create market conditions conducive to high profits" [38] for pharmaceutical firms. These inherent characteristics allow drug companies to charge retail prices in great excess of the cost of manufacturing the pills, to the disadvantage of consumers whose lives depend on access to these drugs.[39] Because of the limited number of suppliers in the market and existence of differentiated products, the market can be classified as oligopolistic.[40] Therefore, the market is not perfectly competitive which often leads to a loss in social welfare.

> In short, pharmaceutical market imperfections create: (i) a reduced price sensitivity on the demand side; (ii) a certain degree of market power on the supply side; and, (iii) demand curves that do not reflect true social benefits. Pharmaceutical demand is stronger and less price-elastic than it might otherwise be. The reasons are the *price insensitivity of consumers*, especially when their drug expenditures are reimbursed by public or private insurers. Insurance tends to encourage over-use, higher prices and therefore welfare losses.[41]

Therefore, the market is characterized by a price-insensitive demand curve, which is due to asymmetry of information in the market and the agency relationship between the physician and the patient. "[T]he relationship between patients and their physicians involves agency, information, trust, and professionalism . . . patients rely on providers to help them articulate their own demand for care . . . patients may go beyond this and cede partial or complete authority to providers to make treatment

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38. *See* Wieghaus, *supra* note 2, at 2.

39. *See* Stanton, *supra* note 33, at 154-55 ("The drug Levamisole was sold by Johnson & Johnson for six cents a tablet when it was used as a medication for sheep, but the company raised its price to six dollars a tablet when new research found it efficacious in treating colon cancer in humans. Wide disparities between retail pricing and manufacturing costs similarly exist for AZT (for treating AIDS), Foscavir (for treating a viral disease that causes blindness), and others.")

40. GUILLEM LÓPEZ-CASASNOVAS & JAUME PUIG-JUNOY, REVIEW OF THE LITERATURE ON REFERENCE PRICING 7 (Dep't of Econ. and Bus. Research, Ctr. for Health and Econ. (CRES), Universitat Pompeu Fabra, Working Paper, 2000), *available at* http://www.uv.es/bibsoc/GM/data/Papers/upfupfses362.html (last visited Apr. 9, 2005).

41. *Id.*

decisions."[42] The insurance aspect of the market may also cause this price-insensitive demand curve to be shifted outward, causing an increase in demand, as compared to other markets where consumers are direct purchasers of goods.[43] Altogether, these market characteristics create an inflated demand and an even greater loss of social welfare.

Another aspect of the pharmaceutical market which affords a mechanism for market power for pharmaceutical firms is patent protection, which is generally regarded as a socially efficient way to protect profits, some of which are used for research and development ventures. Patents have an unmistakable value in society and "can be thought of as a type of insurance policy for inventors, including research-based pharmaceutical companies."[44] However, in the pharmaceutical industry, firms are often able to extend patent protection, as well as preserve their high profit level, by changing an *ineffective* ingredient. Even though there is no marked benefit to society from such a change, under the extension of patent protection, the pharmaceutical firms retain the ability to charge a price above the socially efficient, market-clearing level. For instance, one type of questionable practice is called evergreening:

> [W]hereby a company, as its product is about to go 'off-patent' will begin to patent additional features of the product or introduce a slightly modified version of the existing drug form. Companies may, for example, introduce a new dosage formulation or an over-the-counter version of the product. Sometimes these changes provide superior therapeutic advances. But exclusivity has been granted to brand companies for minor product and labeling changes that many have argued present little or no therapeutic benefit.[45]

Drug companies also attempt to patent imitator or "me-too" drugs to extend the life of their patents and increase their profit margins. "The cost effectiveness of me-too drugs...is questionable. Although the me-too drug may prove more effective than the innovator drug for a certain population

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42. Randall P. Ellis & Thomas G. McGuire, *Supply-Side and Demand-Side Cost Sharing in Health Care*, 7 J. OF ECON. PERSP. 135, 137 (1993).

43. *See* Wieghaus, *supra* note 2, at 2.

44. ROBIN J. STRONGIN, HATCH-WAXMAN, GENERICS AND PATENTS: BALANCING PRESCRIPTION DRUG INNOVATION, COMPETITION AND AFFORDABILITY 3 (Nat'l Health Policy Forum, Background Paper, 2002) (analyzing the "complex connections among intellectual property protection, competition, and access to affordable prescription drugs.").

45. *Id.* at 13-14.

of patients, the marginal benefit is likely to be small."[46] Despite the negligible therapeutic effects of "me-too" drugs, the effect on the pharmaceutical market is staggering: "Between 1993 and 1998, the introduction of imitator, or 'me-too' drugs in four relatively well-established categories – oral antihistamines, antidepressants, cholesterol-lowering drugs, and anti-ulcerants – accounted for almost one-third of pharmaceutical cost increases."[47] Similarly, drug companies have sought to patent polymorphs, which are identical in chemical composition but differ in structure, as another strategic move to extend patent life and protect profits.[48] Therefore, in addition to the inherent characteristics of the oligopolistic pharmaceutical market, opportunities to extend patent lives of pharmaceuticals without corresponding increases in effectiveness or therapeutic benefit signal a need for the federal government to implement a pricing scheme to lower Medicare costs.

Ambiguities and "loopholes" in the Hatch-Waxman Act are also often blamed for frivolous patent extensions.[49] The Act's "three year-exclusivity for new uses" clause is often specifically singled-out as a cause for concern.[50] Drug companies have also been exploiting the Hatch-Waxman Act by filing patent infringement suits just prior to patent expiration in order to invoke a "stay imposed by the law [that] continues even after the patent-in-suit expires, granting the patent holder a maximum thirty month reprieve from generic competition."[51] Many other opportunities exist that allow drug companies to extend the life of their patents, including extensions under the Drug Price Competition and Patent Term Restoration Act and extensions due to regulatory delay under the North American Free Trade Agreement ("NAFTA").[52]

The pharmaceutical companies are not regulated by government agencies, and because of the market structure whereby the drug companies

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46. *See* Rai, *supra* note 7, at 205.

47. *See id.*

48. CARLOS CORREA, INTEGRATING PUBLIC HEALTH CONCERNS INTO PATENT LEGISLATION IN DEVELOPING COUNTRIES 53 (2000), *available at* http://www.southcentre.org/publications/publichealth/publichealth.pdf (last visited Apr. 9, 2005). This article was published by the South Centre, an intergovernmental organization of developing countries, in an effort to aid developing nations in their integration of The Agreement on Trade-Related Aspects of Intellectual Property (TRIPs) into their laws with regard to pharmaceutical production and development.

49. *See* Saiger, *supra* note 5, at 194 ("Patents have limits for a reason – there is a bargain according to which the inventor shares his or her ideas with the public in exchange for the initial opportunity to take advantage of the idea.").

50. *See id.*

51. *See* Stanton, *supra* note 33, at 159.

52. *See id.* at 159-60.

are involved with every aspect of providing a new drug on the market, these companies have complete discretion in setting the price of their drugs.[53] Drug prices in America are the highest in the world because drug companies in the United States have every incentive to charge the highest price the market will bear for their products.

> Experts in the health care industry speculate that drugs may be priced according to one of the following methods: first, pricing the drug by taking into account other expenditures such as packaging, marketing research, distribution and retail markups in addition to the cost of the actual price of manufacturing the product; second, determining the price by volume of the drug being purchased; third, setting the price by the employment of a marketing-research driven scale, in which the price is set solely on the basis of the maximum profit that can be derived; fourth; pricing based on a monopolistic scheme where prices will be set higher because only one drug manufacturer currently manufactures it, or; fifth, pricing the drug high to reap benefits before lower priced copycat drugs and generics enter the market.[54]

Because of the international demand for brand name prescription drugs, pharmaceutical companies also profit from a price discrimination technique known as Ramsey Optimal Pricing.[55] Due to patent protection and the lack of government controls, pharmaceutical companies can charge the highest price that the American pharmaceutical market will bear.[56] American drugs sold in foreign countries are often subject to price caps and other forms of price controlling mechanisms; however, because of the high level of profits accrued from the American market, drug companies can afford to sell their drugs abroad at a deeply discounted rate.[57] As long as the foreign prices exceed marginal cost, which is extremely low in the high sunk-cost, low-variable cost pharmaceutical market, "the seller generating large profits in one market can afford to barely break even in other markets because the firm's overall losses will not exceed gains."[58] This price discrimination scheme gives pharmaceutical giants even more incentive to

53. *See* Creech, *supra* note 4, at 598.
54. *See id.* at 599.
55. *See* Saiger, *supra* note 5, at 185.
56. *See id.*
57. *See id.* at 185-86.
58. *See id.* at 185.

maintain high prices for their products in America, in an attempt to counteract the lower prices set in foreign countries.

II. REFERENCE PRICING

A. PRICE-SENSITIVITY

Reference pricing is generally defined as a pricing scheme in which "the price paid by [a] third-party is established by reference to interchangeable drugs, with any excess cost being borne by the consumer as an out-of-pocket payment."[59] In this particular application to Medicare, the third-party would be the federal government. In a therapeutic reference pricing system, drugs are grouped into classes based on therapeutic result, and a reference price is assigned at a level between the highest- and lowest-priced drugs in the class. In all reference pricing schemes, the reference price is the maximum amount of reimbursement and the patient pays any differential between the price of the chosen drug and the reference price.[60] What is notable about this type of pricing structure is that pharmaceutical companies retain complete discretion in pricing their products because there are no direct government price controls.[61]

The implementation of a reference pricing scheme has direct economic benefits. Most significantly, it introduces price sensitivity to the pharmaceutical market.[62]

> [Reference pricing] is sometimes rationalized as a strategy to promote competition and hence base reimbursement on a "competitive" price level. The argument is that competition between drugs is weak because patients and physicians are uninformed and/or insensitive to

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59. ANNA MERINO CASTELLO, THE IMPACT OF THE REFERENCE PRICE SYSTEM ON THE SPANISH PHARMACEUTICAL MARKET: A THEORETICAL APPROACH 6 (Nat'l Econ. Research Assocs. Inc. (NERA), Universitat Pompeu Fabra, UPF Economics and Business, Working Paper No. 524, 2000) (analyzing the impact of the reference price system on the price-setting strategies of the pharmaceutical firms and on the level of generic usage, while explicitly taking into account the impact of the reference price mechanism on the level of competition between brand-name and generic drugs).

60. *See* Wieghaus, *supra* note 2, at 8-9.

61. PATRICIA M. DANZON, REFERENCE PRICING: THEORY AND EVIDENCE 1 (The Wharton School, Univ. of Pennsylvania, Working Paper, 2001), *available at* http://hc.wharton.upenn.edu/danzon/PDF%20Files/barcelonaEditfinal%20.pdf (last visited Apr. 9, 2005).

62. *See id.* at 2-3.

> prices, due to insurance. By paying a common reimbursement price for products that are "close substitutes," with the patient liable for any excess, [reference pricing] creates incentives for prescribers and patients to be price sensitive.[63]

Because more information will be made available to Medicare patients under a reference pricing policy, an increase in price sensitivity can be effected. This information flow will be a welcome addition to a market where advertisements make more of an impression on patients than does a medication's therapeutic value.[64] Under a reference pricing program, doctors and patients would weigh the expected therapeutic effects of each drug in the class as compared with the cost of each drug. A patient with high cholesterol who places a high-value on well-known brand name drugs might be willing to pay the differential over the reference pricing subsidy to obtain the highest-priced, most effective drug; whereas, a gastrointestinal patient with a mild stomach condition may choose a moderately-priced drug that is closer to the reference price. Therefore,

> [t]he use of reference pricing successfully introduces price information and, therefore, price sensitivity, into the market because a company marketing a drug with additional benefits or increased efficacy over the other drugs in each therapeutic class could lucratively charge a higher price for

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63. *Id.* *See* PATRICIA M. DANZON & JONATHAN D. KETCHAM, REFERENCE PRICING OF PHARMACEUTICALS FOR MEDICARE: EVIDENCE FROM GERMANY, THE NETHERLANDS AND NEW ZEALAND 2 (Nat'l Bureau of Econ. Research, Working Paper No. 10007, 2003). The Dutch reference pricing system was implemented to effect this goal:

> [C]onsiderable effort was expended by the Dutch government to stimulate price competition in the pharmaceutical market...Only when the necessary information about a specific medicine in relation to its substitutes is readily available can the demand side of the market, i.e. consumers, doctors, patients and insurance companies, make decisions on the fairness of prices. In the Netherlands, this objective was achieved by categorizing medicines into groups of interchangeable drugs and making doctors and patients aware of the interchangeability of medicines within such groups.

Id.

64. *See* Rai, *supra* note 7, at 206 ("It should come as no surprise that insured consumers demand advertised medication, even when the medication has low benefit. What is more surprising is that many of these demands (about 50%, according to the FDA survey) are met. As the 18% annual growth in pharmaceutical costs suggests, the managed care takeover has failed to spur significant cost-benefit tradeoffs, particularly (although not exclusively) in the area of pharmaceuticals.").

> its drug as long as patients were inclined to pay a higher price for its superiority.[65]

Consequently, under a reference pricing scheme, "doctors would be able to treat senior citizens effectively while optimizing a two-fold set of constraints involving price minimization and efficacy maximization."[66]

If adopted under the Act, the reference pricing reimbursement would be a direct subsidy to be paid to all Medicare subscribers, and significantly, "*the consumer will receive [a] subsidy whether he or she chooses a drug that is higher or lower than the reference price.*"[67] Because most Medicare beneficiaries currently do not receive financial assistance when purchasing prescription drugs, these senior citizens will generally regard the subsidy under the reference pricing scheme as a discount to be used to offset their personal expenditures, rather than view the dollar amount of the reference pricing subsidy as the total cost they should incur.[68] This subsidy effect will be important during the discussion of the arguments forwarded by the pharmaceutical industry.[69] The increased price sensitivity will thereby cause a shift in the economic model of the market for Medicare drugs to a shape that is more akin to a competitive x-shaped supply and demand curve, where demand slopes downward with price.[70]

B. THE INSURANCE MARKET

The inherent characteristics of reference pricing programs make this type of program appropriate for social insurance schemes like Medicare. Reference pricing is generally regarded as a superior cost controlling mechanism than some forms of managed care.

> A managed pharmaceutical care strategy is an efficient response of competitive markets to the fundamental problem of health insurance...[b]ut by insulating patients from costs, traditional insurance has the unfortunate effect of making consumers and providers insensitive to costs. Unrestricted

65. Wieghaus, *supra* note 2, at 25. *See also* DANZON, *supra* note 61, at 3.
66. Wieghaus, *supra* note 2, at 26.
67. *Id.* at 23.
68. *See id.* at 24.
69. *See infra* pp. 420-24.
70. *See* Wieghaus, *supra* note 2, at 26.

> insurance thus tends to encourage the overuse of medical services, driving up health spending.[71]

Furthermore, most insurance programs encounter the problem of adverse selection, a self-selection issue whereby those who desire insurance benefits are the same people who generally incur the greatest costs for the insurer.[72] This phenomenon, which results from asymmetric information between the insured and the insurer, causes significant resource allocation problems in various insurance industries, including the health, life, and health insurance sectors.[73] Adverse selection in the health insurance industry can be described as the scenario whereby:

> Younger, healthier individuals often decline to purchase insurance until they or a family member anticipate significant expenses...Those who purchase insurance individually, therefore, tend to be at a significantly greater risk for health care costs than those insured through employer groups. This raises the price to a level that many individuals cannot afford or are not willing to pay unless they know they are likely to use the benefits.[74]

However, because the Medicare prescription benefits program with reference pricing provision would be offered to all Medicare beneficiaries, the problem of adverse selection will be minimized because with automatic enrollment, high-risk patients cannot purchase packages with higher coverage.[75] In a related vein, reference pricing programs focus on therapeutic value and therefore do not "sacrifice equity...for cost savings,"

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71. PATRICIA M. DANZON, PRICE COMPARISONS FOR PHARMACEUTICALS: A REVIEW OF U.S. AND CROSS-NATIONAL STUDIES 35 (1999).

72. *See* Wieghaus, *supra* note 2, at 30-31; *See also* Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1511 (1994) ("Adverse selection occurs when policyholders are able to anticipate health care needs more accurately than insurers and then act on that knowledge by adjusting their insurance purposes.").

73. *See generally* Georges Dionne et al., *Adverse Selection in the Insurance Market, in* HANDBOOK OF INSURANCE 185-88 (Georges Dionne ed., 2000).

74. *See* Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685, 687 (1999).

75. *See* MICHAEL L. KATZ & HARVEY S. ROSEN, MICROECONOMICS 572 (3d ed. 1998) ("Since everyone has to receive insurance coverage, the [insurer] faces the average risk of having to pay benefits on a policy.").

a typical scenario under many insurance programs.[76] This premium placed on therapeutic value effectively precludes the prevalence of issues otherwise common in the insurance industry including "pric[ing] insurance out of the reach of older or chronically ill people . . . [or] declin[ing] to cover high-risk individuals or groups" altogether.[77]

Moral hazard is another issue often encountered in the insurance industry. In general, this issue results from the reduced incentive for the insured to take precautions to minimize risk under an insurance contract.[78] This issue arises in the health insurance sector specifically as the over-consumption of insurance for risks known by the insured.[79] "It is well known and intuitive that the contractual response to moral hazard is to leave some of the risk uninsured, i.e., borne by the risk adverse insured individual rather than transferred entirely to the insurer."[80] This is accomplished by structuring co-payments and deductibles into the

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76. *See* ALAN CASSELS, PAYING FOR WHAT WORKS: BC'S EXPERIENCE WITH THE REFERENCE DRUG PROGRAM AS A MODEL FOR RATIONAL POLICY MAKING 8 (2002) (report published by the Canadian Centre for Policy Alternatives), *available at* http://www.policyalternatives.ca/documents/BC_Office_Pubs/rdp_report.pdf (last visited Apr. 9, 2005).

77. *See* Hall, *supra* note 74, at 687-88.

78. *See* Ralph A. Winter, *Optimal Insurance under Moral Hazard*, *in* HANDBOOK OF INSURANCE 155 (Georges Dionne ed., 2000); M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 260 (2003) ("Medical insurance...creates 'moral hazard' by enabling patients to purchase case for a fraction of its actual price and its true cost to society. This fraction, in the form of deductible and co-payment requirements, sets the threshold above which the perceived value of a medical service must rise to prompt a decision to purchase it. Patients experience only this fractional cost because they...have already incurred insurance premiums, which collectively cover most medical costs."). *See also* Greaney, *supra* note 72, at 1511 ("[I]nsured individuals will be more likely to seek care and demand more expensive services than they would if they had to bear the full costs of these services. Moral hazard distorts markets...[and] causes an inefficient allocation of resources....").

79. *See* Raisa B. Deber, *Canadian Medicare: Can it Work in the United States? Will it survive in Canada?*, 19 AM. J.L. & MED. 75, 87 (1993) ("Those individuals who know that they are more likely to need services are more likely to purchase insurance against those risks...[t]he moral hazard argument would predict that someone with a family history of heart disease would be more likely to seek health insurance than his lower-risk neighbor."). *See also* Bloche, *supra* note 78, at 261-62 for a discussion of the moral hazard problem with specific application to health insurance. "'Moral hazard' is used differently in discussion of medical insurance...health care economists invoke the notion of moral hazard to characterize the influence of insurance on consumers' medical-purchasing decisions, not their risk-taking behavior...medical insurance lifts consumers' medical demand curves from a starting point of zero when people confront illnesses treatable only at costs exceeding their incomes and life savings. Such costs make purchase of treatment impossible without insurance." *Id.* at 261.

80. *See* Winter, *supra* note 78, at 157.

insurance contract.[81] However, these tactics do not fully eradicate the problem of moral hazard.[82] The Act as written already includes provisions for co-payments and annual deductibles,[83] which will minimize the moral hazard problem to some extent, although legislators and program administrators will still need to be aware of potential moral hazard issues.

C. PRICE CONTROLS

Reference pricing is not a means of formal price controls, such as price caps or ceilings, which inevitably lead to market inefficiencies. Reference pricing schemes already in place in other countries are described as "loose regulation of drug prices . . . in contrast to tight regulatory systems."[84] Although "the history of Medicare . . . demonstrates that reimbursement mechanisms and price controls tend to develop together,"[85] the most significant aspect of a reference pricing program is that the pharmaceutical companies will retain their discretion to set prices, and will not be limited by any price caps set by the federal government.[86] In fact, reference pricing plans are most often analogized to a specific type of insurance plan rather than a means of price control: "Because reference pricing controls the reimbursement but not the manufacturer's price, this approach is potentially less restrictive than price controls"[87] and is in some ways similar to a defined contribution approach to insurance subsidization.

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81. *See* KATZ & ROSEN, *supra* note 75, at 581-82.

82. *Id.* at 582 ("[S]ome moral hazard remains so long as the co-insurance rate is not 100 percent or the deductible is not infinite (i.e., as long as the person buys some insurance).").

83. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L. No. 108-173, 117 Stat. 2066, 2077, §§ 1860D-2(b)(1)-(b)(2)(A) (2003).

84. *See* Creech, *supra* note 4, at 618-19.

85. JOHN E. CALFEE, PRICES, MARKETS, AND THE PHARMACEUTICAL REVOLUTION 54 (2000).

86. *See* Wieghaus, *supra* note 2, at 32.

87. DANZON & KETCHAM, *supra* note 63, at 2. For a general description of a defined contribution health insurance plan, *see* GREG SCANDLEN, NAT'L CENTER FOR POL'Y ANALYSIS, DEFINED CONTRIBUTION HEALTH INSURANCE (2000); *see also* AM. MED. ASS'N, COUNCIL ON MEDICAL SERVICE, ADVERSE SELECTION AGAINST GENEROUS HEALTH INSURANCE UNDER DEFINED CONTRIBUTION SYSTEMS (1998), *available at* http://www.ama-assn.org/ama/upload/mm/372/a98cms11.doc (last visited Mar. 22, 2005) ("Under a 'defined contribution' system, the employer contributes a fixed-dollar amount towards the employee's health insurance, and the employee is responsible for paying any difference between the employer contribution and the premium of the chosen plan. The defined contribution could be equal to the premium of the lowest-cost option or capped at a higher amount, in which case, the employee typically does not pocket the savings from choosing an option costing less than the cap. Defined contributions are variously called 'capped

By means of analogy, there is relevant case law concerning the applicability of price regulation to state Medicaid programs. Although the dynamics of Medicaid and Medicare are somewhat different,[88] the goals and procedures for both programs are quite similar. "The [Medicaid] program authorizes federal financial assistance to States that reimburse certain costs of medical treatment for needy persons."[89] In *Pharmaceutical Research and Manufacturers of America v. Walsh*, the drug industry trade group PhRMA sued the Commissioner of the Maine Department of Human Services to stop Maine from requiring drug manufacturers to participate in the state's new rebate program. The rebate program was being implemented in an attempt to reduce the price levels of prescription drugs for all Maine residents.[90] The Supreme Court upheld the decision of the First Circuit Court of Appeals, which found that "the Maine program actually furthered the purpose of Medicaid by allowing access to prescription medications to those residents who were in need of assistance . . . ."[91] This decision illustrates the Supreme Court's recognition of the need to facilitate the provision of drugs to the elderly and needy at affordable prices. In line with this notion, the Court of Appeals for the Eleventh Circuit held in a similar suit: "[b]y stretching its Medicaid dollars . . . [a similar] Florida law has the potential for providing more and better medical services to the target population."[92] The inclusion of a reference pricing provision as a means of Medicare cost containment under the Act would be consistent with this sentiment as enunciated by the Supreme Court in *Walsh* and by those Courts of Appeals that have confronted similar issues.

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benefits,' 'uniform contributions,' 'standard contributions,' 'fixed-dollar contributions' or 'equal-dollar contributions.'").

88. "Medicaid is a program that pays for medical assistance for certain individuals and families with low incomes and resources. This program became law in 1965 and is jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in providing medical long-term care assistance to people who meet certain eligibility criteria. Medicaid is the largest source of funding for medical and health-related services for people with limited income." *See Welcome to Medicaid*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, *at* http://www.cms.hhs.gov/medicaid/ (last visited Apr. 9, 2005).

89. *See* Pharm. Research & Mfrs. of Am. v. Walsh, 538 U.S. 644, 650 (2003).

90. *See id.*

91. *See* Jason Levine, *Supreme Court Decides Fate of Maine Rx Drug Rebate Program*, HEALTH L. UPDATE (Univ. of Conn. Student Health Law Org., Hartford, Conn.), Fall 2002, at 1-3.

92. *See* Pharm. Research & Mfrs. of Am. v. Meadows, 304 F.3d 1197, 1209 (2002) (PhRMA claimed that a preferred drug provision under the Florida law was a "formulary" within the meaning of 42 U.S.C. § 1396r-8(d)(4)).

D. RESPONSE TO RESISTANCE BY THE PHARMACEUTICAL INDUSTRY

The companies comprising the pharmaceutical industry generally oppose the implementation of any reference pricing program. This is because these firms enjoy the high level of profits they earn due to the fact that the markets for their brand-name drugs are essentially monopolies and oligopolies. It is argued that pharmaceutical companies maintain these monopolies through "secrecy and not allowing generic brands to develop equivalent drugs."[93] In the pharmaceutical market, "patent-generated monopolies, mergers and oligopolies, administered pricing, substantial information inadequacies and distortions, supplier-induced demand, insurance coverage, and other forces all tend to inflate prices . . . above the levels that would be found in the free market."[94] Furthermore, because of their ability to product-differentiate based on brand name, pharmaceutical companies can enjoy "supranormal" profits even in the wake of competition.[95] Naturally, the companies in this industry oppose any type of pricing schemes that have the potential impact of altering the enviable position that the pharmaceutical companies hold.

The most common argument by the pharmaceutical companies is that, with the implementation of a reference pricing program, these firms will no longer be able to invest in research & development ("R&D"). This is theorized by some to be correlated with the existence of a monopoly: "if one wants to induce firms to undertake R&D one must accept the creation of monopolies as a necessary evil."[96] Although many complain that the pharmaceutical industry inflates prices "beyond what is reasonable," the pharmaceutical companies respond by arguing that this is the only way to provide for R&D in order to improve existing drugs and produce new drugs in the future.[97] Furthermore, investment in R&D is risky and expensive for pharmaceutical companies because of the time and expenses necessary to develop a drug, complete clinical trials, and apply for approval by the

93. *See* Rhonda Kay McPherson, *Pharmaceuticals: Politics, Policy, and Availability: Policy Considerations: Medicare and Prescription Drug Coverage*, 8 GEO. PUBLIC POL'Y REV. 25, 31 (2003).

94. Alan Sager, Winning Durably Affordable Innovative Drugs: A Few Lessons from the Arguments over Importing Drugs from Canada, Remarks at the Connecticut Journal of International Law Symposium (Oct. 29, 2004).

95. JEAN TIROLE, THE THEORY OF INDUSTRIAL ORGANIZATION, 305-06 (1988).

96. *See id.* at 390.

97. *See* McPherson, *supra* note 93, at 31-32.

FDA.[98] Recent statements estimate that it costs approximately $800 million to successfully bring a new drug into the pharmaceutical market.[99] "Extensive research is required before the development costs of a new drug or its benefits are known; most new drug development projects fail, sometimes after substantial financial and time costs."[100]

However, the price of drugs should not be dependent on these high R&D costs. "[D]rug manufacturers don't charge prices to pay for R&D; they perform R&D in the hopes of creating products for which they can charge high prices."[101] This idea has been accepted and even embraced by the pharmaceutical companies themselves. For instance Raymond V. Gilmartin, the Chairman and Chief Executive Officer of Merck & Co., has publicly stated:

> The price of medicines isn't determined by their research costs. Instead, it is determined by their value in preventing and treating disease. Whether Merck spends $500 million or $1 billion developing a medicine, it is the doctor, the patient and those paying for our medicines who will determine its true value. Those medicines that deliver the best value - in terms of true medical advances - will command prices commensurate with that value. Those medicines that represent marginal or no improvement over existing therapies will gain little respect in an increasingly demanding marketplace.[102]

Therefore, the price of a drug should be set after consideration of patients' willingness-to-pay as "determined by . . . the health benefits of the product . . . [and] the availability of competing products."[103] Because drug

98. *See generally* Wieghaus, *supra* note 2, at 33-34 (commenting on the time, effort, expense, and risk involved in R&D). "[A]ny industry that relies on innovation to promote further productivity, such as the pharmaceutical sector, must reward firms for their research and development expenditures." *Id.*

99. *See* Saiger, *supra* note 5, at 188.

100. John E. Calfee, *Pharmaceutical Price Controls and Patient Welfare*, 134 ANNALS INTERNAL MED. 1060, 1060 (2001).

101. John E. Calfee, Can Administrative Pricing Improve Pharmaceutical Markets?, Remarks at the Connecticut Journal of International Law Symposium (Oct. 29, 2004) (transcript on file with author).

102. Raymond V. Gilmartin, Meeting the Challenge of Pharmaceutical Innovation in an Environment of Rising R&D Costs, Remarks at the Tufts Center for the Study of Drug Development (Nov. 30, 2001), *available at* http://www.merck.com/newsroom/executive_speeches/113001.html.

103. *See* Calfee, *supra* note 101.

prices should be set in terms of consumer willingness-to-pay and not in reference to sunk costs like R&D, the imposition of a reference pricing program under the Act becomes even more appropriate because it embodies this very idea. Although pharmaceutical revenues may decrease, this will be done in a socially optimal manner based on consumer willingness-to-pay and increased price sensitivity.

R&D ventures are certainly important to the future health of all Americans, not only Medicare beneficiaries. Any program that has the potential effect of decreasing expenditures made for this type of research should of course be considered at great length, and the benefits and detriments should be weighed, especially when there is a chance that the detrimental effects of such a plan are great.[104] The mere existence of this possibility should not automatically preclude the implementation of such a program under the Act; however, it presents a trade-off that must be thoroughly considered prior to the implementation of such a plan. Where there are significant costs and benefits to evaluate, such as with the implementation of a reference pricing program under the Act, the crucial decision is where to strike a balance between the two.[105]

It is important to note that a reference pricing program under the Act would only affect Medicare beneficiaries, and not the total market for pharmaceuticals. Therefore, the effect on R&D would not be as profound, and the magnitude of revenues lost would not be as great, as currently feared by the pharmaceutical companies. Furthermore, if drug prices for pharmaceuticals were lowered for Medicare beneficiaries under a reference pricing program, basic laws of supply and demand dictate that with a downward-sloping demand curve (that will be effected by an increase in

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104. *See generally* John A. Vernon, *New Evidence on Drug Price Controls*, 27 REGULATION 13 (2004). This article utilizes a short-run elasticity of R&D investment (as compared with pharmaceutical drug prices in the United States) of 0.583 and concludes that "the long-run economic costs of imposing price controls on pharmaceuticals in the United States could be quite high. Thus, any benefits associated with improved access to today's medicines through price controls must be weighed carefully against the potential long-run costs." *Id.*

105. John A. Vernon, Examining the Links Between Price Regulation, Importation and Firm Investment in Pharmaceutical R&D, Remarks at the Connecticut Journal of International Law Symposium (Oct. 29, 2004) (transcript on file with author). *See also* William S. Comanor, *The Political Economy of the Pharmaceutical Industry*, 24 J. ECON. LITERATURE 1178, 1180 (1986) ("The essential trade-off pertinent to this industry is the choice between competitive prices and quantities for existing drugs and extensive information. Consumers surely benefit from prices that reflect costs. And some consumers are deterred from purchasing prescribed drugs by their high prices. On the other hand, consumers have benefited enormously from the array of new drugs that have become available during the past 35 years.").

price sensitivity) these lower prices will cause an increase in demand.[106] As noted by commentator Abraham N. Saiger:

> Innovation is not at risk. Abnormally high profit margins are not a prerequisite to innovation in the pharmaceutical industry. There is a tremendous market for the product and someone will perform the necessary tests and manufacturing to satisfy that market . . . . [I]nnovation is spurred not only by money, but also by the pursuit of science – which is funded in large part by the U.S. government directly through research and indirectly through grants and education to scientists. To suggest that the pharmaceutical industry is at risk of running out of money and incentives to continue to manufacture its product is naive.[107]

RAND researchers analyzed data from the 1970's to estimate that price-elasticity of demand in this scenario is approximately 0.3.[108] However, it is theorized that the currently applicable value of price-elasticity of demand would be significantly higher than the value calculated in the RAND study for two reasons: (1) over the past thirty years, the trend has changed toward "higher-cost chronic-use drugs;" and (2) Medicare beneficiaries were not included in this study.[109] The inclusion of Medicare beneficiaries in the estimation of cross-price elasticity is important because they are "typically among the highest users of high-cost drugs . . . [and are] those most sensitive to price . . . because of the influence on demand of drug maker's marketing and advertising."[110] This cross-price estimation argument also supports the fact that drug companies will experience a colossal loss in revenue and will therefore still be able to undergo R&D ventures.

Furthermore, the pharmaceutical industry receives large capital contributions from the National Institutes of Health that subsidize research in the early phases of drug development.[111] In 2002 alone, approximately $19 billion was granted to pharmaceutical companies and universities for

106. *See* Sager, *supra* note 94.
107. *See* Saiger, *supra* note 5, at 191.
108. *See* Sager, *supra* note 94, at 9.
109. *See id.*
110. *See id.*
111. *See* Saiger, *supra* note 5, at 191-92.

research grants, training, and R&D contracts.[112] Moreover, some argue that if the pharmaceutical industry cut back on spending for advertising and promotions, these companies would have much more capital to invest in their research phases. Critics of the pharmaceutical industry also argue that promotional expenditures made by drug companies can total up to two-thirds of the amount that these companies spend on R&D.[113] One study demonstrated that nine major American pharmaceutical companies spent $26.4 billion more on marketing, advertising, and administration than they did on R&D ventures.[114] Another study demonstrated that "pharmaceutical companies devote the largest portion of their income (22.5%) to marketing and promotional activities, and a lesser amount (16%) to R&D."[115] Although a certain level of marketing is desirable to boost profits, excessive spending itself can be a greater threat to R&D than a reference pricing provision for Medicare beneficiaries under the Act.

Some authorities hypothesize that R&D may actually be positively affected by the transformation of the pharmaceutical market under the new Medicare prescription drug benefit.[116] In fact, these studies are hopeful that the race to maintain profit levels will cause an increased efficiency in pharmaceutical innovation and production:

> Even though major pharmaceutical companies are spending billions of dollars on research and development, innovation is eluding many. The process of bringing new medicine to market has increased in time, cost, risk and complexity . . . . Although the rate of new drug approvals in the United States doubled in the past three decades, annual R&D spending has increased more than 12 times in inflation-adjusted dollars . . . . The result is a new R&D paradigm that stresses better, faster, and cheaper.[117]

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112. *See id.*

113. *See* Harris, *supra* note 32, at 225.

114. *See id.*

115. *See* Stanton, *supra* note 33, at 155.

116. *See* Charles Boersig, *Challenges & Changes: For the First Time, the Difficulties are Crystallized; All Pharmaceutical Companies Need to do is Revise their Standard Operating Procedures*, EUROMONEY INSTITUTIONAL INVESTOR, Dec. 1, 2003, at 1.

117. *See id.*

E. INTERNATIONAL SUCCESS WITH REFERENCE PRICING

There have been many recent studies examining the effects of reference pricing programs implemented in foreign countries and provinces. Canada, Australia, Denmark, Sweden, and British Columbia have all established a type of reference pricing program.[118] A regression analysis of data compiled in 2002 by the OECD showed positive economic effects of reference pricing programs on foreign pharmaceutical markets.[119] Analysis of an aggregate international data set inclusive of all five reference-pricing jurisdictions demonstrated that the implementation of a reference pricing program caused a slight decline in the demand for drugs, which is not necessarily socially detrimental.[120] The primary goal of a reference pricing program is to increase market efficiency, decrease frivolous prescriptions, and reduce expenditures; therefore, a slight decrease in demand for drugs is well within these objectives.[121] Furthermore, this scenario can create a social benefit whereby incentives are created for pharmaceutical companies to innovate in classes of drugs that are currently less saturated.[122]

> This situation will provide the greatest increase in consumer surplus because the subclasses that experience a decrease in demand with the implementation of reference pricing are already saturated with competitors. With a decreasing marginal consumer welfare attributed to the entrance of more producers into a subclass...the greatest consumer welfare increase will occur as more producers enter the competition in those areas that are not yet well-represented by pharmaceutical companies.[123]

Germany, which was the first country to implement a reference pricing program, experienced success with the program. Studies have shown that since the reference pricing program was implemented in 1989, the price index for drugs included in the program decreased by approximately 30%

118. *See* Wieghaus, *supra* note 2, at 48-56.
119. *See generally* Wieghaus, *supra* note 2.
120. *See id.* at 81.
121. *See id.*
122. *See id.* at 82.
123. *Id.*

between the years of 1989 and 2001.[124] Furthermore, the price index for prescription drugs has remained relatively stable in Germany since the implementation of a reference pricing program,[125] unlike recent data collected for prescription drugs in the United States. Similarly, New Zealand claims that their reference pricing program has saved NZ$473 million in 2002 alone.[126]

There is a plethora of literature specifically examining the effects of British Columbia's Reference Drug Pricing Program ("RDP"), which was implemented with the goal of lowering the costs of prescriptions under the province's Pharmacare program.[127] British Columbia's RDP program was implemented in 1995, and the program encompasses five classes of drugs, most of which are used to treat medical issues traditionally suffered by the elderly: non-steroidal anti-inflammatory drugs ("NSAIDs") (osteoarthritis and rheumatism); histamine-2 receptor antagonists (dyspepsia); oral nitrates (angina); angiotensin-converting enzyme (ACE) inhibitors (hypertension); and dihydropyridine calcium-channel blockers (hypertension).[128] A study done by the Canadian Centre for Policy Alternatives concluded that seven years of experience and several solid evaluations have definitively shown that BC's Reference Drug Program has resulted in significant cost savings to Pharmacare with no evidence of negative impact on patient health.[129] The study estimates that between the implementation of the RDP program in 1995 and the publication of the study in 2002, RDP produced a savings of $161 million without causing Pharmacare beneficiaries to cease treatment and without affecting the withdrawal of R&D funding in the province, as previously threatened by the pharmaceutical industry.[130] A similar study demonstrated positive results under RDP, including moderate to large savings in expenditures and no detrimental health effects.[131]

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124. Panos Kanavos & Uwe Reinhardt, *Reference Pricing for Drugs: Is it Compatible with U.S. Health Care?*, 22 HEALTH AFF. 16, 26 (2003) (describing a German study published by the Wissenschaftliches Institut der AOK).

125. *See id.* at 26.

126. *See id.* at 27; *see also* PHARMAC, *Annual Review 2002* (2003), *at* http://www.pharmac.govt.nz/pdf/AR02.pdf (last visited Apr. 9, 2005).

127. *See generally* Cassels, *supra* note 76, at 4.

128. *See id.* at 5, 9.

129. *See id.* at 4.

130. *See id.* at 11-13.

131. *See* Sebastian Schneeweiss et al., *Pharmaceutical Cost Containment with Reference-Based Pricing: Time for Refinements*, 167 CMAJ 1250, 1250-51 (2002); *see also* Joel Lexchin, Controlling Drug Costs: Learning from Canada, Remarks at the Connecticut Journal of International Law Symposium (Oct. 29, 2004) (transcript on file with author)

An econometric study "found little evidence that when reference pricing for ACE inhibitors was introduced in British Columbia, patients stopped treatment for hypertension or that health care utilization and costs increased."[132] This study included every resident of British Columbia over the age of sixty-five that was enrolled in the RDP program and was prescribed an ACE inhibitor with a price in excess of the reference price assigned to that category.[133] An econometric regression yielded positive results including no effect on patient mortality, hospitalization rate, or physician visits.[134] Furthermore, the study showed that the probability of a patient ceasing therapy actually decreased under the RDP.[135] Only 18% of patients who were prescribed a drug with a price set in excess of the reference price for that therapeutic class switched to a lower-priced drug.[136]

III. REFERENCE PRICING AND MEDICARE

A. APPLICATION TO MEDICARE

"The work of . . . researchers has demonstrated that reference pricing in British Columbia is a model of rational drug policy, well worthy of replication in other jurisdictions."[137] The Medicare program in the United States is an example of a jurisdiction that would benefit from this type of program. The Medicare market is very similar to the Pharmacare market in British Columbia, which has experienced great success with its reference pricing program.[138] Pharmacare was enacted by the British Columbian government to "improve the health status of British Columbians by providing reimbursement to ensure reasonable access to and appropriate use of prescription drugs and related benefit services for eligible residents of the province."[139] Similarly, the United States government is

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(supporting and recommending the implementation of a reference pricing program for Medicare beneficiaries in the United States).

132. Sebastian Schneeweiss et al., *Outcomes of Reference Pricing for Angiotensin-Converting--Enzyme Inhibitors*, 346 NEW ENG. J. MED. 822, 822 (2002).

133. *See id.*

134. *See id.*

135. *See id.*

136. *See id.*

137. Cassels, *supra* note 76, at 16.

138. *See generally id.*; Schneeweiss, *supra* note 131; Schneeweiss, *supra* note 132.

139. BC MINISTRY OF HEALTH SERVICES, Pharmacare Trends 2002 Update 1, June 2004, *at* http://www.hlth.gov.bc.ca/cpa/publications/pharmacare_trends_2002.pdf. In addition to providing a prescription drug benefit to enrolled citizens, British Columbia's Patented Medicines Prices Review Board ("PMPRB") also regulates the prices of new

implementing the Act to facilitate access by our nation's senior citizens to lifesaving medications. Like Medicare, residents eligible for prescription benefits coverage under Pharmacare are primarily elderly residents over age sixty-five (although Pharmacare is also inclusive of British Columbian citizens who reside in long-term care facilities, suffer from cystic fibrosis, or require financial assistance).[140] Just as Pharmacare enacted its reference pricing program to control the escalating Pharmacare outlays,[141] the United States could implement a similar program to control the staggering costs that the Act's Medicare prescription drug benefit is expected to generate. Rising numbers of prescriptions and the skyrocketing prices of drugs are increasing the burden on American citizens each year.[142] Most importantly, a reference pricing program could reduce the cost of prescription drugs to our nation's senior citizens, many of whom will remain laden with high expenditures for non-covered prescriptions and who will be exposed financially by the gap in coverage under the Act.[143]

A positive externality that may result from the implementation of a reference pricing program for Medicare is increased innovation because "[g]iven the dominant US share of the global market, it seems likely that manufacturers would rationally choose to launch new drugs, since the foregone sales from non-launch would be far higher than in a small[er national] market."[144] "Although a few top pharma companies may be able

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drugs. *See also* Cassels, *supra* note 76, at 7; Lexchin, *supra* note 131 (describing the process by which PMPRB regulates price increases in British Columbia).

140. *Compare* Cassels, *supra* note 76, at 8-9, *with* U.S. DEP'T OF HEALTH AND HUMAN SERV., MEDICARE ELIGIBILITY TOOL, *at* http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment#TabTop, (last visited Apr. 9, 2005) (eligible residents include citizens and permanent residents over the age of sixty-five, citizens with disabilities, and permanent kidney failure requiring dialysis or transplant).

141. Cassels, *supra* note 76, at 4.

142. *See* Saiger, *supra* note 5, at 180 ("Pharmaceutical spending in the United States increased dramatically over the last ten years. As a percentage of health care spending, prescription drug spending increased from 5.6% in 1993 to 7.9% in 1998. The cost of drugs rose 19.1% in 1999, and continued to rise in 2001 – increasing nearly 19% to more than $132 million. Additionally, the number of prescriptions written every year is expected to double in the next ten years, possibly exceeding 4.5 billion prescriptions per year as early as 2004.").

143. *See* McClellan, *supra* note 13, at 39. "In thinking about the reform of Medicare financing, the financial status of Medicare beneficiaries is increasingly important, because the contribution of Medicare to their overall financial well-being is growing with the intensity of the medical treatments they receive...[M]ost beneficiaries have relatively low incomes, and they are already spending a significant portion of their disposable income on out-of-pocket expenditures." *Id.*

144. *See* DANZON & KETCHAM, *supra* note 63, at 36.

to maintain momentum for some time, the majority will need to change their strategies to meet the realities of the market . . . drug developers will need to reduce their dependence on wildly successful drugs and implement strategies to fill weak pipelines."[145]

B. AN ALTERNATIVE TO DRUG IMPORTATION

A recent phenomenon encountered in the wake of overpriced prescription drugs combined with the lack of prescription drug coverage (prior to the commencement of the Act's prescription drug benefit) is the importation of prescription drugs from Canada. It is estimated that Americans would have saved approximately $60 billion in 2004 if they were paying Canadian prices for their brand name drugs.[146] This discrepancy is only growing larger with time: "The U.S. average price excess, over prices of drugs in Canada and six European nations rose from 60 percent higher in 2000 to 81 percent higher in 2003 – a rise of one-third in three years."[147] Considering that our Canadian neighbors pay an average price for brand name drugs that is 38% lower than in the United States,[148] it is no wonder that so many of America's senior citizens have turned to importation as a way to obtain costly medications at more reasonable prices, even though cross border importation is currently banned and will continue to be banned under the Act.[149]

> Although purchasing prescription drugs from Canada and Mexico has been on the rise, under the Federal Food and Drug Cosmetic Act (FDCA), interstate shipment of any prescription drug that lacks required FDA approval is illegal. Accordingly, importing drugs manufactured in a foreign country into the United States is against the law. The FDCA, however, permits re-importation of prescription

145. Boersig, *supra* note 116 ("Medicare controls on the prescription drug benefit" is listed as one driving force that is "transforming the drug industry."); *see also* Wieghaus, *supra* note 2, at 82.

146. *See* Sager, *supra* note 94, at 2.

147. *Id.* at 3.

148. *See* Saiger, *supra* note 5, at 179 (describing a study done by Senator Byron L. Dorgan of North Dakota). *See also, e.g.*, Khosravi, *supra* note 37, at 428. "[A] three month supply (180 pills) of Tamoxifen, a cancer-fighting drug, costs $298 in the United States, but only $26 in Canada; forty-five capsules of Prozac retails for $115 in the United States but only $35 in Canada." *Id.*

149. *See* Joyce Frieden, *Some in Congress Seek to Amend New Medicare Reform Law: Significant Holes?*, FAM. PRAC. NEWS, Mar. 1, 2004, at 7.

> drugs made in the United States and exported through a foreign country only if the drugs original manufacturer imports the drug back into the United States. Although the FDA warns Americans about the dangers of purchasing medications from foreign countries and consistently advises against the illegal practice, the FDA has issued an informal policy recognizing circumstances when FDA field agents can choose to take no action against the importation.[150]

Notwithstanding this policy, senior citizens have been taking advantage of the lower prices in Canada by filling their prescriptions at Internet pharmacies[151] and joining their fellow elderly constituents on bus trips organized by their senators to transport them to Canada to fill their prescriptions.[152] This "pharmaceutical arbitrage" is increasing in intensity and has been aptly labeled the "Boston Tea Party of the 21st century."[153]

The implementation of a reference pricing program for Medicare beneficiaries under the Act can be effective as an alternative to the current importation issue. Because a reference pricing program introduces price sensitivity to the market, this pricing scheme would benefit exactly the same group of people that currently benefit from cross border importation: "price-sensitive American citizens living at the border."[154] However, a reference pricing program under the Act would also benefit those Medicare beneficiaries who cannot afford to travel to Canada to purchase their drugs, and who do not reside near the Canadian-American border. Furthermore, with a reference pricing program, Medicare beneficiaries will be able to

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150. *See* Khosravi, *supra* note 37, at 436.

151. *See id.* at 435 ("Internet pharmacies offer many conveniences. The consumer can access drug prices, comparison shop, and purchase from the cheaper provider. Online pharmacies eliminate the need to travel to a traditional pharmacy so the disabled and those living far away from the pharmacy have better access to prescriptions. In addition, purchasing prescriptions online offers some anonymity; customers may talk with a pharmacist over the phone or via e-mail and not be concerned about bystanders hearing.").

152. *See id.* at 427-28, 434-37. Bus trips to Canada have been organized by Vermont Senator Bernard Sanders, Michigan Senator Debbie Stabenow, and South Dakota Senator Tim Johnson. *Id.* at 427.

153. *See* Kevin Outterson, *Pharmaceutical Arbitrage: Balancing Access and Innovation in International Prescription Drug Markets*, 5 YALE J. HEALTH POL'Y L. & ETHICS 193 (2005). Outterson believes this "pharmaceutical arbitrage" has become more popular and easier to accomplish due to the use of the Internet's downward effect on transaction costs, differences between the regulatory regimes in Canada and the lack thereof in the United States, and the use of "virtual arbitrage" whereby "lower observed prices are [used] as an external reference price." *Id.* at 275-82.

154. *See* Khosravi, *supra* note 37, at 436.

obtain the drugs that they need at lower costs, but without any drug-safety fears that currently pervade the importation issue.[155] Opponents of importation, as well as the Bush Administration and HHS, argue that imported drugs are unsafe because "[o]nce an FDA-approved prescription drug is exported for sale in another country, it is no longer subject to U.S. requirements and can no longer be monitored by U.S. regulators."[156] Moreover, a functional alternative to drug importation will become increasingly necessary as the Health Minister of Canada considers halting over-the-border importation by stopping the unethical practice whereby Canadian doctors co-sign American prescriptions without examining the American patient.[157] "Canadian law requires that prescriptions bear the signatures of Canadian doctors, so such a move could cut off many of the estimated 2 million Americans who buy drugs from Canada . . . ."[158]

The major American drug companies would be in a better position under a reference pricing scheme than they would be if cross-border importation – or in the extreme, globalization of the pharmaceutical industry – was allowed to continue or was legalized. Already, "the major world markets for pharmaceutical markets are moving closer together through the establishment and work of the [European Medicines Agency ("EMEA")] and domestic pressures on both the EMEA and the FDA."[159] Without nationally segregated pharmaceutical markets, drug companies would no longer effectively profit under the Ramsey Optimal Pricing theory. More importantly, these companies would no longer be isolated from foreign regulations, which would have a more profound effect on the profits of the American pharmaceutical industry than would the inclusion of a reference pricing scheme under the Act.

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155. The Bush Administration opposes prescription drug importation from Canada because United States regulators cannot guarantee their safety as they can with drugs sold in the United States. *See* Collin McClelland, *Canada Considers Proposal Aimed at Shutting Down Prescription Drug Trade*, Jan. 6, 2005, *available at* http://technologyreview.com/articles/05/01/ap/ap_2010605.asp?trk=nl.

156. *See* Saiger, *supra* note 5, at 209 (quoting a letter from Tommy Thompson, Director of HHS, to Sen. James Jeffords of Vermont (July 10, 2001)).

157. *See* Julie Appleby, *Canada May Stop Over-the-Border Drug Sales*, USA TODAY, Dec. 29, 2004, at A1.

158. *Id.*

159. *See* Michael J. Malinowski, *Legal Development: Globalization of Biotechnology and the Public Health Challenges Accompanying It*, 60 ALB. L. REV. 119, 169 (1996) (examining "the status of the U.S. and U.K. biotechnology industries and . . . major regulatory challenges").

CONCLUSION

"[Reference pricing] for prescription drugs in the United States would be ethically and logically consistent with current efforts to change . . . Medicare from their traditional defined-benefit approach to one based on defined contributions, because the reference prices are nothing other than defined contributions toward the purchase of prescription drugs."[160] With a reference pricing provision included in the Act, the United States government can better ensure access to costly but life-saving medications that will help prolong the lives and ease the pain suffered by our nation's senior citizens. Cost containment measures are imperative, so that America can support the prescription drug benefit under the Act and provide this important form of insurance well into the future.

160. Kanavos & Reinhardt, *supra* note 124, at 28.

KEEPING THE PROMISE: WILL THE BUSH ADMINISTRATION'S PLAN TO PRIVATIZE THE SOCIAL SECURITY SYSTEM ACTUALLY WORK?

James E. Hennessey[*]

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INTRODUCTION

Our current Social Security system was built on one simple assumption: several workers pay into the system for every retiree that cashes out. However, because of demographic changes, this simple

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assumption no longer applies.[1] As the Baby Boomer generation begins to retire in ever increasing numbers over the next twenty years, the public Social Security system developed by the government in the 1930's will be unable to serve all of the individuals eligible to collect benefits.

A shrinking workforce exacerbates the problem as fewer working age people exist to pay into the Social Security system. In 1950, there were 16.5 covered workers per beneficiary, meaning that each beneficiary's payments were covered by payroll taxes paid by 16 workers. By 2004, that ratio was down to 3.3 covered workers per beneficiary. And, according to various government estimates, that ratio will be between 1.8 and 2.3 covered workers per beneficiary by 2040.[2] Such a high number of beneficiaries compared to a diminishing number of workers will eventually overburden the Social Security system. Currently, the system still runs a surplus every year, but within twelve years the United States Government estimates that payments will far exceed receipts.[3] Because of this reality, public officials have begun to grapple with the options for preserving the system as long as possible. These alternatives include significantly raising the retirement age, reducing or eliminating payments for those above a certain income or asset scale, privatizing the system, or eliminating the system as a whole.

Social Security reform hit the spotlight during the 2000 Presidential Election as the candidates focused on the impending problems with the system during the presidential debates.[4] At that time the major party nominees, George W. Bush and Al Gore, each favored different proposals for fixing the Social Security system.[5] Gore supported a plan that

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1. Edward M. Gramlich, *The Goals of Social Security Reform*, 58 WASH. & LEE L. REV. 1229, 1230 (2001); SYLVESTER J. SCHIEBER & JOHN B. SHOVEN, THE REAL DEAL: THE HISTORY AND FUTURE OF SOCIAL SECURITY 230-32 (1999).

2. *See* BD. OF TRUSTEES OF THE FED. OLD-AGE & SURVIVORS INS. & DISABILITY INS. TRUST FUNDS, THE 2005 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF FEDERAL OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS 47-48 (2005), *available at* http://www.ssa.gov/OACT/TR/TR05/index.html [hereinafter "BD. OF TRUSTEES"] (last visited Apr. 9, 2005) (based on the actuarial data contained in Table IV.B2 and giving low, intermediate, and high-cost alternatives for the system based on different demographic models).

3. *See id.* at 3 (stating that the Board of Trustees expects, starting in 2017, that the level of revenue coming into the program will be less than the costs, and that payments to beneficiaries will exhaust the present build-up in the Social Security trust fund in 2041).

4. *See, e.g.*, Scott Shephard, *Gore Warns Voters on Social Security*, ATLANTA J. CONST., Oct. 19, 2000, at 16A.

5. Although this may have been the first instance where major party presidential candidates were willing to touch the "third rail" of American politics, calls for reforming the Social Security system began more than thirty-five years ago. *E.g.*, JOSEPH PECHMAN ET.

eliminated the use of Social Security surpluses as interest free loans to the rest of the government, which the government used to meet their yearly budgetary needs. Bush, on the other hand, called for partial privatization.[6] Broadly speaking, privatization refers to a shift toward a defined contribution system in which each worker sets aside funds in a personal retirement account over the course of his or her working life and controls the investment of funds in the account.[7] With Bush's election in 2000, privatization appeared to be the plan of choice. However, in the next ten months Bush focused his legislative efforts on passing tax cuts and education reform, and took few actions to fix the looming Social Security problems.[8]

Moreover, with the September 11, 2001 terrorist attacks in New York City and Washington, D.C., the Bush Administration and Congress directed their attention to the global war on terror. It was not until the Presidential election campaign in 2004 that Bush once again reiterated that the Social Security system should be privatized, at least partially, to preserve it for future generations. After Bush's re-election in the fall of 2004, the Administration made reforming the Social Security program through personal accounts a central goal of his second term.[9] President Bush, however, has been very short on specifics. As of the date of this publication, the Bush Administration has given only five broad tenets for an acceptable reform proposal: personal accounts, permanent sustainability, no increase in payroll taxes, no changes for those now retired

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AL., SOCIAL SECURITY: PERSPECTIVES FOR REFORM 214-26 (1968); MICHAEL J. BOSKIN, *Social Security: The Alternatives Before Us*, *in* THE CRISIS IN SOCIAL SECURITY: PROBLEMS AND PERSPECTIVES 173, 177-80 (Michael J. Boskin, ed., 1977).

6. Raja Mishra, *Two Views on Pension: It's Status Quo Versus Private Role, But Toughest Choices are Put Off*, BOSTON GLOBE, Oct. 30, 2000, at A13; Richard W. Stevenson, *Gore and Bush Clashing Over Retirement Proposals*, N.Y. TIMES, Nov. 2, 2000, at A27.

7. *See* MARTIN FELDSTEIN, *Introduction*, *in* PRIVATIZING SOCIAL SECURITY 1, 2 (Martin Feldstein ed., 1998) (defining the "essence" of privatization as giving individuals "control over their own investments").

8. *See, e.g.*, David Jackson, *Tax Cuts Herald the Bush Economy*, DALLAS MORNING NEWS, Jun. 8, 2001, at 1A; Ronald Brownstein, *Bush: The First 100 Days*, L.A. TIMES, Apr. 29, 2001, at A26.

9. *See* Robin Toner & Richard W. Stevenson, *Bush Pledges a Broad Push Toward Market-Based Policies*, N.Y. TIMES, Nov. 4, 2004, at P1 (indicating that in Bush's re-election address that he was committed to overhauling Social Security and rethinking the tax system).

or nearing the retirement decision,[10] and a "system where benefits for low-income workers will grow faster than benefits for people who are better off."[11] This general conception has been very controversial with many stakeholders and analysts questioning the viability of a plan that would remove some governmental control over the public retirement system.[12]

In order to understand why President Bush chose partial privatization as the theoretical framework for saving the Social Security system, it is important to analyze the goals of reform.[13] One of the major goals in reforming Social Security's structure is to preserve the many social protections that it has provided over the past six decades.[14] Social Security provides a large share of the income of the aged and has been responsible

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10. This requirement is generally understood as not changing the benefit structures for Americans age 55 years or older. Janet Hook & Mary Curtius, *Republicans Say the Sales Pitch Is in the Details*, L.A. TIMES, Feb. 3, 2005, at A20.

11. President George W. Bush, Press Conference of the President (Apr. 28, 2005), *at* http://www.whitehouse.gov/news/releases/2005/04/20050428-9.html (last visited May 2, 2005). *See also* President George W. Bush, State of the Union Address (Feb. 2, 2005), *at* http://www.whitehouse.gov/news/releases/2005/02/20050202-11.html (last visited Apr. 9, 2005).

12. *See* Robert Pear, *AARP Opposes Bush Plan to Replace Social Security With Private Accounts*, N.Y. TIMES, Nov. 12, 2004, at A19 (acknowledging that the AARP might accept incentives for private retirement savings plans, but that they opposed any plan that would re-direct payroll taxes into private savings accounts). Additionally, the largest lobbying groups for those over 55 years of age announced that they were committed to openly fighting any legislative proposal that would allow diversion of Social security payments into private accounts. *Id.* While the group acknowledged that many younger individuals favored a plan that would allow them to invest their own money in private accounts, seniors with only a few years left before retirement would be harmed by a system that reduced the amount of payments being received by the federal government. *Id. See also* Jonathan Weisman, *Analysts Call Outlook for Bush Plan Bleak*, WASH. POST, Nov. 5, 2004, at A8 (citing a number of economists and business experts that question the viability of the Bush plan to reform Social Security). Based on the problems with the federal government's deficit, these experts cited the fact that an ongoing war in Iraq coupled with the effect of any reduction in the federal income tax rates would make it less economically feasible for any President to decrease the amount of funds taken into the Social Security system with a plan that would allow private retirement accounts funded with payroll tax dollars. *Id.*; Sheryl Gay Stolberg & Robin Toner, *Republicans are Chastened about Social Security Plan*, N.Y. TIMES, Feb. 27, 2005, at 22 (reporting the negative responses many Republican members of Congress received regarding Bush's Social Security reform plan in town hall meetings with constituents).

13. *See* ROBERT M. BALL & THOMAS N. BETHELL, STRAIGHT TALK ABOUT SOCIAL SECURITY: AN ANALYSIS OF THE ISSUES IN THE CURRENT DEBATE 59-64 (1998) (discussing "the nine guiding principles of Social Security": 1) universal, 2) earned right, 3) wage-related, 4) contributory and self-financed, 5) redistributive, 6) not means-tested, 7) wage-indexed, 8) inflation-protected, and 9) compulsory).

14. Gramlich, *supra* note 1, at 1229.

for a significant reduction in old-age poverty.[15] Not only is Social Security a protection for the elderly, but the system also provides payments for work disability, protection for when the breadwinner in the family dies early and leaves children without support, and full protection against inflation.[16]

The other central goal of Social Security reform is to raise national savings.[17] The government acknowledges that as soon the Baby Boomer generation retires, there are going to be vastly fewer workers to pay for the retired population in the future than in the past.[18] The only way to pay for this massive retiree population is to generate more capital. And that new capital comes only if the country saves enough to create it.[19] Another way to analyze the issue is to look at the rate of return that the system gets, based on its investments versus its outlays. The rate of return on the taxes set aside for the Social Security system has been about one percent, because it has been almost exclusively a pay-as-you-go system.[20] Payments made by current workers are deposited in the United States Treasury and invested in Treasury bonds, and then used to pay for the benefits of current retirees. If it was possible to create additional national savings and invest that for future generations, then the system might be able to survive for a longer period of time.[21]

President Bush's reform theory is based on this second goal. If younger workers can invest their Social Security taxes into vehicles that will return more money to them then at the current low rate of return, the President believes then the system will be able to last longer than its current

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15. Craig Copeland, *Social Security Reform Issues*, 58 WASH. & LEE L. REV. 1203, 1203 (2001). *See also* HENRY J. AARON & ROBERT D. REISCHAUER, COUNTDOWN TO REFORM: THE GREAT SOCIAL SECURITY DEBATE 8-10 (1998) (discussing the necessity of Social Security benefits to cure the problems of poor voluntary national savings for the possibilities of retirement and disability). The authors contend that "most people would save too little voluntarily to finance retirement or to sustain family income if they become disabled or die prematurely . . . [W]ithout mandatory savings through Social Security, retirement at customary living standards would be impossible for most of today's older workers." *Id.*

16 . Gramlich, *supra* note 1, at 1229-30.

17. *Id.* at 1230.

18. BD. OF TRUSTEES, *supra* note 2, at 47-48; *see also* Gramlich, *supra* note 1, at 1230.

19. Gramlich, *supra* note 1, at 1230.

20. *Id.*

21. *Id.*; *but see* John Geanakoplos et al., *Would a Privatized Social Security System Really Pay a Higher Rate of Return? in* FRAMING THE SOCIAL SECURITY DEBATE: VALUES, POLITICS AND ECONOMICS 137 (R. Douglas Arnold et al. eds., 1998) (arguing that a privatized social security system would not actually improve the rate of return and would therefore fail to extend the life of the system through increased capital resources).

projected insolvency date.[22] By extending the life of the system, the President believes he will have overcome one of the major policy challenges of the twenty-first century. His notion for fixing the system, however, is not without its vocal critics.[23] The Bush Administration's proposal, although presented only in broad outlines, has also been met with skepticism by the American public.[24]

As the nation's politicians consider Social Security reform, many concerns arise about the soundness and probability of success of a partially privatized system. Namely, five major areas of concern exist: sustainability, equity return rate, "guaranteed" benefits, transition and administration issues, and redistribution and fairness.[25] Additionally, the experiences of other countries moving from a fully public pension system to a partially privatized system are relevant to the debate in America, and should be considered. While neither the Bush Administration nor any member of Congress has formally introduced specific legislation at this time, these concerns will be central to the ensuing discourse to restructure the Social Security system. These several areas will be discussed in greater depth later, but the major issues within each topic are discussed below.

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22. Julie Hirschfeld Davis, *Battle Joined Over Social Security; Bush, Critics Open Debate Over Need for Change Now*, BALT. SUN, Jan. 12, 2005, at 1A.

23. Pear, *supra* note 12, at A3.

24. Public opinion polls indicate that the majority of respondents think "permitting individuals to invest part of their Social Security taxes in private accounts, the centerpiece of Mr. Bush's plan, was a bad idea . . . The number who thought private accounts were a bad idea jumped to 69 percent if respondents were told that the private accounts would result in a reduction in guaranteed benefits." Adam Nagourney & Janet Elder, *Bush Doesn't Share Public's Priorities, New Poll Indicates*, N.Y. TIMES, Mar. 3, 2005, at A1; *see also* Jonathan Weisman, *Skepticism of Bush's Social Security Plan Is Growing; Polling and Interviews Find Concerns Across Age Groups*, WASH. POST, Mar. 15, 2005, at A01. Weisman cites poll data showing that:

> 58 percent of those polled this time said the more they hear about Bush's plan, the less they like it . . . A majority of elderly voters have turned against the plan for private accounts, even though the White House has assured them it would have no impact on their Social Security benefits. Younger workers, who have the most to gain, also tend to be the most difficult to mobilize, according to interviews. And many middle-aged workers are faced with the reality that there would not be enough time before their retirement to gain much financial benefit from the new approach.

Id.; *But see* Steven Thomma, *Poll: Young Adults Back Bush's Plan for Social Security*, SEATTLE TIMES, Mar. 3, 2005, at A10 (discussing the results of a poll conducted by the Pew Research Center showing that "66 percent of those aged 18-29 [years] support private accounts, up from 64 percent in December [2004]").

25. Copeland, *supra* note 15, at 1211-20.

The first issue is sustainability. The current program, based on estimates by the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds (Board of Trustees), is not sustainable.[26] However, will a partially privatized system last any longer than the current one? Supporters of privatization argue that "individual account proposals will achieve sustainability by decreasing future liabilities, whereas the present system is unsustainable without continuous tax increases or benefit cuts."[27] The way individual accounts could help to achieve sustainability is by pre-funding some of the future benefits with money put into the system now, which would reduce money that would have to be paid in by future workers.[28]

The second issue is equity return rate. The historical equity premium, or the rate of return on stocks above the return on United States Treasury bills, has been 4.0 percent.[29] Yet, many analysts have predicted that the stock market will likely not continue to have such a high equity premium over the next seventy-five years.[30] Additionally, the stock market's rate of return will be different every year.[31] A problem therefore arises when one set rate of return is used in order to calculate future earnings in the system. Finally, "the additional uncertainty of [equity investments] makes predicting the soundness of the program seventy-five years in advance even more difficult."[32] Therefore, it is important when analyzing all reform plans, including those currently under consideration by the government, to acknowledge the way that each proposal predicts the future of the equity market, and to ensure that it does so in an accurate and realistic fashion.

The guaranteed benefits problem is the third vital issue. Under current law, a complex formula determines the amount of benefits an individual receives based on the individual's work record.[33] A particular work record

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26. BD. OF TRUSTEES, *supra* note 2, at 3. Annual cost will begin to exceed tax income in 2017 for the combined OASDI Trust Funds, which are projected to become insolvent (i.e., unable to pay scheduled benefits in full on a timely basis) when assets are exhausted in 2042 under the long-range intermediate assumptions. *Id.* at 2.

27. Copeland, *supra* note 15, at 1219.

28. *Id.*

29. Peter A. Diamond et al., *What Stock Market Returns to Expect for the Future?*, *in* ESTIMATING THE REAL RATE OF RETURN ON STOCKS OVER THE LONG TERM 19-20, Table 2 (2001), *at* http://www.ssab.gov/NEW/Publications/Financing/estimated%20rate%20of%20return.pdf (last visited Apr. 9, 2005) (discussing the future potential for growth in the stock market).

30. *Id.* at 20.

31. Copeland, *supra* note 15, at 1212.

32. *Id.*

33. *See* BD. OF TRUSTEES, *supra* note 2, at 98-102.

means a worker will receive a concrete benefit when they retire.[34] However, under a privatized system with money being invested outside of the Social Security Administration (SSA), these guaranteed benefits would likely no longer exist.[35] Two workers with the same work record could, when they retire, have two completely different retirement benefits based on their investments during their lifetime.[36] An important question is whether such a system should still have a minimum benefit for all workers, regardless of their investment strategy.

Fourth, there are also numerous administrative issues in managing personal retirement accounts that will create many new tasks for an already burdened SSA. The following are a sample: enrolling new beneficiaries, sending contributions to accounts, providing investment education, managing funds, and documenting compliance with laws and regulations.[37] Such a number of new administrative duties would radically change the mission of the thousands of SSA employees almost overnight from a tax receipt and payment administrator to a much more complex financial services management institution. Changing the current public system to a partially privatized one would also result in substantial transition costs.[38]

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34. *See id.* (explaining how the benefit formula operates to determine an eligible retiree's primary insurance amount (PIA), or monthly benefit payment from the Social Security Administration). In short, the formula uses two "bend points," correlated with cost-of-living adjustments, to determine the amount of the individual retiree's benefit based on their past earnings. *Id.* For those persons eligible to begin collecting in the year 2004, the formula gave them a benefit of 90 percent of their average indexed monthly earnings (AIME) up to $612, plus 32 percent of the AIME between $613 and $3,689, plus 15 percent of AIME above $3,690. *Id.* For example, a person retiring in 2004 with an AIME of $4,350 would have a monthly PIA of $1,640.88. *Id.*

35. *See* Patricia E. Dilley, *Taking Public Rights Private: The Rhetoric and Reality of Social Security Privatization*, 41 B.C. L. REV. 975, 979 (2000). Ms. Dilley asserts that Social Security provides:

> the guarantee of lifetime benefits that substantially reflect economic growth both before and after retirement, that enables workers at lower and middle income levels to take the risk of stopping work in early old age. The push to privatize Social Security represents an attempt to take this public claim private--fundamentally changing not the overall size of the problem of support for the elderly generally, but rather, the size and income distribution of individual claims on future productivity.

Id.

36. *See generally* Kent Smetters, *The Effect of Pay-When-Needed Benefit Guarantees on the Impact of Social Security Privatization*, *in* JOHN Y. CAMPBELL & MARTIN FELDSTEIN, RISK ASPECTS OF INVESTMENT-BASED SOCIAL SECURITY REFORM 91, 91-92 (2001) (discussing guaranteed benefit issues).

37. CONGRESSIONAL BUDGET OFFICE, ADMINISTRATIVE COSTS OF PRIVATE ACCOUNTS IN SOCIAL SECURITY 3-5 (2004) [hereinafter "CBO"].

38. *See* SCHIEBER & SHOVEN, *supra* note 1, at 365-66 (1999).

Based on the original legislation to partially privatize Social Security, the transitions costs were estimated at $2.7 trillion.[39] It is necessary to know if the current legislators' estimates for transition costs are realistic. Whether the reform plan determines that reducing benefits or increasing taxes is necessary in order to meet this cost is a political question. Nevertheless, whether the Bush Administration presents reasonable estimates of the real future financial burden in switching to personal accounts is an important measure of the long term viability of the Social Security System.

The fifth issue is the amount of redistribution and fairness that would take place under a partial privatization plan. Under the current benefit structure, lower income workers' income is replaced at a higher ratio than the higher income worker, while at the same time higher income workers have higher overall benefits than lower income earners.[40] What happens with a reformed Social Security system is an important issue. Would a defined contribution plan be viewed as treating those in higher and lower incomes as fairly as the current guaranteed benefits plan? This fairness question could ultimately determine whether the current cohort of congressional leaders has the political will to undertake President Bush's privatization plan.

I. CHALLENGES TO PRIVATIZING SOCIAL SECURITY

A. DOES PRIVATIZING THE SOCIAL SECURITY SYSTEM MAKE IT SUSTAINABLE?

The Bush Administration's assertion that the system will go bankrupt if things are not changed leads to the question of whether a change to privatization will actually create a system that can endure far longer than the current one. The Board of Trustees concluded that either future revenue must be increased or future benefits reduced in order for the system to remain solvent.[41] If nothing is altered, the effect of demographic

39. *See id.* (estimating costs of transition for various reform proposals).

40. *See supra* note 34.

41. *See* BD. OF TRUSTEES, *supra* note 2, at 3. The Board of Trustees concluded that:
[f]or the trust funds to remain solvent throughout the 75-year projection period, the combined payroll tax rate could be increased during the period in a manner equivalent to an immediate and permanent increase of 1.89 percentage points, benefits could be reduced during the period in a manner equivalent to an immediate and permanent reduction of 12.6 percent, general revenue transfers equivalent to $3.7 trillion (in present value) could be made during the period, or some combination of approaches

changes will slowly drain the Social Security Trust Fund.[42]

Individual accounts might achieve sustainability by pre-funding at least some of the future benefits through reducing the claims for benefits from future worker cohorts.[43] The problem with this approach, however, is that the Bush plan includes estimates that allow workers to invest only four out of six percent of their Social Security tax payments. The Bush plan, therefore, still contains a future guaranteed benefit component. Thus, at some point in the future, the Trust Fund will need to have some money in its coffers to pay this future benefit.[44] If even the reduced amount of money needed to pay a lower guaranteed benefit is not there, the system would clearly not be sustainable. The likelihood that the personal option system might lessen the problems caused by the Trust Fund deficit is relatively good; the chances that it will altogether eliminate the problem are much less likely.

B. THE EQUITY RETURN RATE: WILL THE EQUITIES MARKET FIX THE PROBLEM?

President Bush has told anyone who will listen that partially privatizing the Social Security system will benefit younger workers who can invest a portion of their payroll taxes in the United States securities markets. President Bush argues that failing to do so will lead to a bankrupt public retirement system.[45] Instead, by supporting the Bush Administration's goal of expanding America's "ownership society," the system can only remain solvent if individual taxpayers are given the opportunity to invest a portion

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could be adopted. Significantly larger changes would be required to maintain solvency beyond 75 years.

Id.

42. *See id.* (the Board of Trustees concluded that "[t]he combined OASDI Trust Funds are projected to become insolvent (i.e., unable to pay scheduled benefits in full on a timely basis) when assets are exhausted in 2042 under the long-range intermediate assumptions.").

43. SCHIEBER & SHOVEN, *supra* note 1, at 391-92.

44. *See* BD. OF TRUSTEES, *supra* note 2, at 7 (The board made short-term projections of the Social Security system's financial resources. Based on estimated revenues and expenses between the period of 2004 and 2013, the Board determined "[b]oth the OASI and the DI trust fund ratios under the intermediate assumptions exceed 100 percent throughout the short-range period and therefore satisfy the Trustees' short-term test for financial adequacy").

45. *See* Davis, *supra* note 22, at 1A. (President Bush stated: ""[i]f you're 20 years old, in your mid-20s, and you're beginning to work, I want you to think about a Social Security system that will be flat bust, bankrupt, unless the United States Congress has got the willingness to act now . . . [t]hat's what we're here to talk about, a system that will be bankrupt.")

of their income in a better economic opportunity.[46] In effect, Bush argues that the rate of return on the stocks, bonds and other investments that individuals will personally choose will offset the diminishing amount of money coming into the system.

Recent scholarship, however, calls into question the basic economic assumption made by the proponents of partial privatization: that individual investment will be sufficient to save the public retirement system. Analyzing economic data over the past 200 years, these economists' stance differs with the Bush Administration's view that private investment will generate enough additional capital to offset the declining working population.

The Social Security Administration's Office of the Chief Actuary (OCACT) has generally used the figure of a 4.0 percent annual equity premium for stocks to predict future rates of return in the market.[47] This equity premium is calculated based on the difference between the estimated real return of 7.0 percent for stock investments and the estimated real return of 3.0 percent for Treasury bonds.[48] Based on a very long-term analysis

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46. *See* David E. Rosenbaum, *Bush to Return to 'Ownership Society' Theme in Push for Social Security Changes*, WASH. POST, Jan. 16, 2005, at 1/20. Vice President Dick Cheney argued that:

> [o]ne of the great goals of our administration is to help more Americans find the opportunity to own a home, a small business, a health care plan or a retirement plan. In all of these areas, ownership is a path to greater opportunity, more freedom and more control over your own life, and this is a goal worthy of a great nation. Everyone deserves a chance to live the American dream, to build up savings and wealth and to have a nest egg for retirement that no one can ever take away.

Id. See also President George W. Bush, Address at the Presidential Inauguration Ceremony (Jan. 20, 2005), *at* http://www.whitehouse.gov/news/releases/2005/01/20050120-1.html (last visited Apr. 9, 2005). When President Bush laid out the administration's goals for transforming American society, he stated:

> [t]o give every American a stake in the promise and future of our country, we will bring the highest standards to our schools and build an ownership society. We will widen the ownership of homes and businesses, retirement savings and health insurance preparing our people for the challenges of life in a free society. By making every citizen an agent of his or her own destiny, we will give our fellow Americans greater freedom from want and fear, and make our society more prosperous and just and equal.

Id.

47. Diamond, *supra* note 29, at 18; *but see* MARTIN FELDSTEIN & ANDREW SAMWICK, *The Transition Path in Privatizing Social Security*, *in* PRIVATIZING SOCIAL SECURITY 215, 248 (Martin Feldstein ed., 1998) (emphasizing that the real rate of return on stocks over the past several decades is 9.0 percent, and arguing that economic models for analyzing Social Security reform plans should utilize this higher figure).

48. Diamond, *supra* note 29, at 18.

undertaken to encompass data over the past 200 years, such a figure is a relatively accurate reflection of the stock market's premium rate of return over bonds.[49] However, the recent downturn in the stock market and other changing economic factors suggest that in the future the 4.0 percent figure is likely inflated and gives a more positive outlook for the next seventy-five years than may actually occur.

These historically positive trends may not be of much use in projecting future economic models. There are two major factors that scholars have focused on when discussing future rates of returns for stocks. First, recent patterns in the capital markets might actually be signaling a decline in the equity premium that has fueled the high rate of return for stocks because of the stock market's current historically high prices.[50] The basic thesis is that investors have flocked to stocks because of two related reasons: one, the decrease in the price of the acquiring stocks has caused more people to purchase these equities and two, the increasing availability of mutual funds coupled with the lower costs of administering these funds has made more and more people view the stock market as a good place to put their investment portfolios.[51]

In short, mutual funds have given people with little or no experience in choosing stocks a less risky way to invest their money, allowing them to exercise control over their investments while lessening the burden of researching individual corporations and stocks on the investors themselves. This diminished burden has made stock purchasing easier for those with no

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49. *See id.* at 19, table 1 (discussing alternative investment vehicles' rate of return versus Treasury bonds). Based on that analysis, stocks are clearly the best investment over the long term. *Id.* The compound annual real return on stocks in the period from 1802-1998 was 7.0 percent. *Id.* Other common investments were much lower in returning the investment. *Id.* Bonds annual return was only 3.5 percent, Treasury bills were only 2.9 percent, and gold was actually a loser, with a compound annual return of -0.1 percent. *Id.* Thus, while stocks return may not be as good as advertised in the future, it has proven to be the best creator of wealth when compared to other common personal investment vehicles that might be available under the Bush Administration's partial privatization plan. *Id. See also* John H. Cochrane, *Where is the Market Going? Uncertain Facts and Novel Theories*, 21 ECON. PERSP. 1, 3 (1997) (discussing the historical equity premium puzzle that many economists have struggled to explain). While stocks should have a better rate of return than bonds, the fact that the compound annual return of stocks has been twice that of bonds has baffled many economists. *Id.* The risk-reward differences between stocks, a more risky investment, and bonds, less risky because of heightened insolvency protections given to bondholders, does not explain the wide gap that has manifested itself in the past two centuries. *Id.*

50. Diamond, *supra* note 29, at 21-22.

51. *See id.* at 21-24 (explaining the economic underpinnings of these two trends in the equities market).

financial background who might typically view the stock market as too risky for their money. Similarly, because more investors have found mutual funds to be an attractive investment vehicle, the cost of administering these funds has lessened. The lower cost of the administration is thus passed onto the investor and increases his rate of return on the investment.[52] With an increased rate of return, the investment in the equity is even more attractive to the individual who has yet to put money into stocks, and compels those actors to invest money in the stock market as well.[53]

However, this increased attractiveness of stocks tends to put upward pressure on stock prices in the long term.[54] Thus, many individuals realizing gains from the stock market on their purchases that were made in the 1950's, 1960's, and 1970's are deriving a return, not only from an actual rate of return based on the economic soundness of their investment, but also on a increased realization of the price pressures that occurred after they purchased their stock.[55] One could view this as inflation limited only to the stock market.

This inflation creates a problem because those who would be investing in the equities market now with the proceeds from their Social Security payroll taxes would be receiving no such realization on the historical price increases that are a function of a one-time change in the economic model that is unlikely to be repeated again.[56] Therefore, while the Baby Boomer generation may benefit from the explosion in popularity of the stock market as an investment price pusher, which increased the rate of return over what it would have been otherwise, newcomers to the stock market would enjoy no such benefit.[57] To base future long run rate of return models on a one time historical anomaly would distort those findings.[58] Such a distortion, if adopted by the proponents of the plan to privatize the Social Security system, could damage the system if the real-world conditions that workers

52. *See* John D. Rea & Brian K. Reid, *Trends in the Ownership Cost of Equity Mutual Funds*, 4 PERSP. 5, 9-10 (1998) (illustrating that the investment cost for equities' investors has decreased over the past two decades, from 2.25 percent of the initial investment in 1980 to 1.49 percent in 1997).

53. *See id.* at 14 (concluding that in the past twenty years individuals focused their money in equities funds with lower costs in order to receive higher rates of return on their investments).

54. Diamond, *supra* note 29, at 22.

55. *Id.*

56. *Id.* at 22-25.

57. *Id.* at 22-23.

58. *Id.* at 22-25.

and investors face in the coming decades vary greatly from the models used to predict the needs of future retirees.[59]

Stock prices are also considered to be over-priced based on several common indicators. When compared to earnings, dividends, book values, and gross domestic product (GDP), the market value at this time is relatively higher when compared to other time periods for the stock market.[60] This higher market value, combined with projected slower economic growth, makes the 7.0 percent rate of return on which the Bush Administration bases its privatization plans a dubious figure. To counter this over-valuation problem, economists have suggested lowering the expected rate of return for the stock market to a more realistic 4.0 to 4.5 percent over the long run.[61] Such a rate of return would diminish the equity premium from 4.0 percent to between 1.0 and 1.5 percent. Thus, the financial outlook for the privatized portion of the Social Security system could be between 62.5 percent to 70 percent lower than the Bush Administration's calculations. The proposal for a substantially improved public retirement system based solely on privatizing the funds into the equities market is not as clear a solution as some proponents claim.[62]

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59. The price pressure problem, while the most significant, might not be the only issue that investors could face in a partially privatized system. Another potential problem could be the fact that the influx of trillions of dollars of new capital might fundamentally affect the behavior of the stock market. *But see* ROBERT M. BALL, *A Public-Private Investment Strategy*, *in* INSURING THE ESSENTIALS: BOB BALL ON SOCIAL SECURITY 233, 234-36 (Thomas N. Bethell ed., 2000).

60. Diamond, *supra* note 29, at 24.

61. *Id.* at 26.

62. *See* Colleen E. Medill, *Challenging the Four "Truths" of Personal Social Security Accounts: Evidence from the World of 401(k) Plans*, 81 N.C. L. REV. 901, 930-31 (2003) (discussing the assumptions made by the President's Commission to Strengthen Social Security). *Id.* In short, the Commission makes several questionable assumptions when arguing that the equities market will help individuals be significantly better off through personal investment than if the payments were made to the Treasury. *Id.* In particular,

> [f]irst, the Commission assumes that the worker will invest in a portfolio that consists of 50 percent equity mutual funds, 30 percent corporate bond mutual funds, and 20 percent government bond mutual funds. This prescribed investment allocation is central to the Commission's projections, all of which are based on a 4.6 percent average annual real rate of investment return. The Commission justifies using a 4.6 percent annual average rate of investment return by assuming that the equity mutual fund portion of the worker's account will earn an average annual real rate of return of 6.5 percent. The corporate bond mutual fund and government mutual fund portions of the account are assumed to earn average annual real rates of return of 3.5 percent and 3.0 percent respectively. Second, the Commission assumes that the worker will rebalance her account portfolio annually to maintain the perceived 50/50

Data also suggests slower economic growth over the next seventy-five years. The basic principle is that over the next several decades, based on a slowdown in labor force growth and a continued slowdown in productivity growth, the growth rate of the United States' economy will be significantly slower than at any other time in the country's recent history.[63] One of the possible effects of this economic slowdown is a gradual decrease in the rate of return for stocks and bonds. Investors base the attractiveness of a stock on its ability to increase earnings, a factor that would be limited in an economy that was not growing as fast as it had previously.[64] Economic models suggest, therefore, that the prices of stocks would either become depressed or would slow to meet these more realistic expectations for the future growth in earnings.[65] In either case, the limitations created by the slowing economic growth would likely decrease the equity premium from the 4.0 percent used by the Bush Administration in formulating its Social Security privatization plan.[66]

In total, the economic data indicates that the Bush Administration's plan to save the Social Security system by allowing taxpayers to privately invest money, and therefore take advantage of the higher rates of return in the equities market, is seriously flawed and based upon faulty assumptions. That it is not to say that investing a portion of payroll taxes would not be beneficial to both the government and young workers saving for retirement. However, it is clearly not the panacea its proponents claim it to be.[67] Simply investing funds in the equities market, without any other structural changes to the program, will not save the Social Security system from the likelihood of future insolvency. Fortunately, President Bush conceded this

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> ratio of equity and bond funds. Third, in its primary results the Commission assumes that at retirement the worker will use the entire balance of her account to purchase a variable annuity that will continue to earn a 4.6 percent annual rate of real return during the worker's retirement years until death.

Id.

63. Diamond, *supra* note 29, at 30.

64. *Id.*

65. *Id.* at 31-33.

66. *Id.*

67. Consistent with this analysis, congressional leaders had a difficult time building early support for the Bush Administration's proposal. *E.g.*, Mike Allen & Charles Babington, *Social Security Vote May Be Delayed; Critics Could Force Proposal to Change*, WASH. POST, Mar. 2, 2005, at A1 (reporting that Senate Majority Leader Bill Frist showed a hesitancy to bring President Bush's reform proposal to the Senate Floor: "'In terms of whether it will be a week, a month, six months or a year, as to when we bring something to the floor, it's just too early,' Frist said." Frist also "acknowledged to reporters that the [personal accounts] plan is in trouble").

point when he said that investing money in the stock market alone will not fix the problem, and that a viable solution requires a combination of system alterations.[68]

C. ARE "GUARANTEED" BENEFITS STILL GUARANTEED?

The Bush Administration's reform concept is based on the assumption that private investment vehicles will provide a higher rate of return than a payment to the Treasury alone would. As discussed *supra* Section B, there are numerous reasons to question that underlying rate of return assumption. However, that is not the only difficulty with relying on the private markets to solve the Social Security Trust Fund's insolvency problems. Another important issue is the fact that the partial privatization notion fundamentally alters the Social Security system from a defined-benefit plan to a defined-contribution plan. This is a significant shift in policy and a major step away from the guiding principle behind Social Security: to reduce elderly poverty by providing beneficiaries with a minimum monthly income for their necessary living expenses.[69]

What the partial privatization plan does, to the contrary of the above-mentioned goal, is remove the guarantee of a certain level of benefits for a retiree at the time they begin to collect social security. A simplified example is illustrative of this point. Worker A is a factory worker in Lansing, Michigan. He assembles cars at an American automobile company. From age twenty until age sixty-five, he works full-time at the factory. When he retires, under the current system, the Social Security Administration takes his highest thirty-five years of income and averages them, puts it in a Primary Insurance Amount formula,[70] and determines his benefit amount based solely on his income and the cost-of-living adjustments over the years. Worker B, with the identical work record and salary, retires at the same age. Both workers will receive the same benefit from the Social Security Administration.

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68. *See* Jim VandeHei, *Bush Defends Iraq Coalition, Prods Hill on Social Security*, WASH. POST, Mar. 17, 2005, at A6 (President Bush told reporters: "Personal accounts do not solve the issue . . . [b]ut personal accounts will make sure that individual workers get a better deal with whatever emerges as a Social Security solution.").

69. ROBERT J. MYERS, SOCIAL SECURITY 26 (4th ed. 1993) (the author explains that one of the basic principles of the Social Security system is "that the benefits under a social insurance system should, along with other income and assets, be sufficient to yield a reasonably satisfactory minimum standard of living for the great majority of individuals.").

70. *See* BD. OF TRUSTEES *supra* note 33 and accompanying text.

Now Worker A and B are living in a partially privatized world. Worker A invests four percent of his Social Security payments in a plan administered by his employer. Worker B invests in a plan administered by an outside financial services company. Worker A's investment turns out to be much more profitable than B's. The automobile company decides to invest the money in its own stock, which, due to the downturn in foreign automobile sales in the Unites States, does extremely well over the long run.

Worker B's financial services portfolio is invested in paper products and metal goods. Because of increasing environmental problems, paper companies become less profitable as new areas for logging become more expensive, reducing corporate profits. Due to the downturn in the need for metals due to the continued development of alternative plastics that work just as well, the metals markets collapse and that investment becomes nearly worthless.

Most would say that both investments were typically conservative choices. However, based on the inherent risks in the market, which are now borne by the individual investor, Worker A has substantially more equity built up in his individual account than does Worker B. In fact, Worker B's investments have done so poorly he cannot even meet his daily expenses from the retirement payment he receives from the government, which has been reduced due to the expected increase in value of his equities portfolio.[71]

The market risk is now entirely on the employee, and there is no longer a guaranteed benefit that will necessarily prevent the incidents of elderly poverty that was the impetus for the Social Security program at the outset. Opponents of plans to privatize the Social Security system argue that

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71. *See* Daniel Halperin, *Assuring the Future of Social Security: Privatization and Other Reforms: The Case Against Privatization*, 65 OH. ST. L.J. 75 (2004), for a discussion of the inadequacies of a system where individuals choose to invest some of their Social Security payments. Halperin asserts:

> the idea that individuals can choose their own level of market risk is a weak argument for voluntary individual accounts. Wealthier investors can diversify their private portfolios. It is true that some hold their entire wealth in Social Security, but these individuals are less likely to choose individual accounts (which is sensible given their lower tolerance for risk in these circumstances), and less likely to invest wisely if they do . . . In any event, even if the supporters of privatization are correct that, politically, we are much less likely to achieve significant increases in advanced funding or to permit investment in equities without individual accounts, I still believe that the potential gains from these moves are not worth the increased risk that individual accounts entail.

Id. at 78.

beneficiaries should not be exposed to the risk of fluctuations in the stock market.[72] They additionally argue the fact that many employees are already involved in private contribution plans through their employers, and that their current risk exposure to the stock market should not be exacerbated by even more exposure to risk through a privatized public system.[73]

The real crux of the problem is that lawmakers cannot guarantee that the Social Security benefits will remain at their current level forever. This political risk is the reason that Social Security, until recently, has been ignored by politicians. In order to reduce the political risk of having to reduce benefits in absolute terms, one solution is putting the risk on the individual employees.[74] A plan that partially privatizes the system would diminish the political risk on lawmakers who might be vulnerable in the voting booth if they were to vote to reduce or eliminate benefits in fixed terms. Instead, lawmakers could offer that benefits will not be reduced, and that through the wonders of the stock market, the system could be saved without any sacrifice. The tactic of transferring the risk to individual employees means that there is no longer a guarantee that retirees will have sufficient benefits to meet their living expenses. This undermines the basic purpose of the Social Security system: to protect retired senior citizens from the pernicious threats of poverty.[75]

D. ADMINISTRATION OF PARTIALLY PRIVATIZED INDIVIDUAL ACCOUNTS

One of the major challenges facing plans to privatize the Social Security system is the two-fold problems of administering this new benefit system: (1) changing over from purely public plan to a partial public, partial private plan; and (2) the continued administration of the two-part system thereafter. Issues as to who will carry the burden of administering the plans have not been decided. But problems will occur regardless of whether the employers or the Social Security Administration administers the system. The tasks associated with the administration of any retirement plan include collection and processing of contributions, benefit payments,

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72. Copeland, *supra* note 15, at 1216.

73. *Id.*

74. *See* John McHale, *The Risk of Social Security Benefit Rule Changes: Some International Evidence*, *in* RISK ASPECTS OF INVESTMENT-BASED SOCIAL SECURITY REFORM 247, 247 (John Y. Campbell & Martin Feldstein eds., 2001) (defining political risk alternatively as "the risk that benefit rules will be changed through the political process before or during one's retirement, thereby changing the value of retirement benefits").

75. MYERS, *supra* note 69, at 26.

enforcement and oversight, asset management, and marketing and sales.[76] The costs for these services must be paid by someone in order for a privatization plan to exist.

Administering a partially privatized Social Security system would be the largest undertaking in the history of the United States financial services industry.[77] Currently, the Social Security system is the largest single entitlement program in the country. Nearly 96 percent of employees and their employers participate in the program, with a total of 153 million individuals participating in the system.[78] Experts who have studied the system's administration requirements have determined that at this time and for the foreseeable future, without any major structural changes in the financial services market, no unified system currently has the capacity to administer 153 million individual accounts.[79]

In fact, when compared to the private benefits system that is currently being administered, the sheer number of new participants versus benefits providers is staggering. The number of workers covered by Social Security is nearly four times more than the total number of workers participating in all defined contribution plans in this country.[80] These plans are then administered by hundreds of different financial services entities. If all eligible workers participated in the plan to partially privatize their Social Security funds, the program would cover almost fifteen times the number of accounts than the single largest defined contribution plan administrator currently manages.[81]

If one assumed *arguendo* that the Federal Thrift Savings Plan (TSP), which covers approximately 3 million federal government employees, provided an adequate model of the administrative costs that would be faced by the Social Security system, it is possible to estimate the potential administrative costs of the Bush Administration's plan.[82] Under the TSP,

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76. CBO, *supra* note 37, at 3-5.

77. Kelly A. Olsen & Dallas S. Salisbury, *Individual Social Security Accounts: Issues in Assessing Administrative Feasibility and Costs*, 34 EMPLOYEE BENEFIT RES. INST. SPECIAL REP. 1, 4 (1998).

78. CBO, *supra* note 37, at 7.

79. Olsen & Salisbury, *supra* note 77, at 4.

80. *Id.*

81. *Id.*

82. The Bush Administration has argued that the TSP should be a model for revamping Social Security. *See* President George W. Bush, State of the Union Address (Feb. 2, 2005), *available at* http://www.whitehouse.gov/news/releases/2005/02/20050202-11.html (President Bush stated: "[p]ersonal retirement accounts should be familiar to federal employees, because you already have something similar, called the Thrift Savings Plan, which lets workers deposit a portion of their paychecks into any of five different broadly-

the reported administrative and investment costs totaled about $75 million in 2002, translating to about $25 per employee.[83] If that figure was applied to the Social Security system, the administrative and investment costs would total about $3.825 billion per year.[84] That cumulative figure would, of course, rise as the number of people participating in the system increased. It is obvious that privatizing the Social Security system, simply in terms of administering the plan, would be an undertaking whose magnitude has never been attempted in this country's history.

The next issue is the initial start-up and transition costs required in privatizing the system. Since nothing like this has ever been attempted before, the costs are uncertain. However, based on other, much smaller and somewhat similar plans, some estimates can be attempted. The TSP was created by Congress in the 1980's and is the largest public defined contribution plan in existence today.[85] The start-up costs for the TSP were relatively low with each new account having a start-up cost around five dollars.[86] If the Social Security system was to assume the same start-up costs in privatizing itself into individual accounts, the total would be approximately $1.333 billion.[87]

However, such a modest figure is unlikely because of several major differences between the Social Security and TSP system.[88] First, the Social Security system covers a substantially different type of workforce and employee base than does the TSP system. Another difference would be that the Social Security systems start-up costs would not likely be provided for in a congressional appropriation like the TSP plan.[89] Instead, scholars have estimated the true transition costs of a Social Security privatization

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based investment funds. It's time to extend the same security, and choice, and ownership to young Americans").

83. CBO, *supra* note 37, at 12.

84. *See id.* (concluding that an "annual cost of $25 would reduce the assets in an account receiving 2 percent of earnings by about 5 percent at retirement").

85. *See* Olson & Salisbury, *supra* note 77, at 4-6. Despite being the largest public defined contribution plan in existence today, a privatized Social Security system would cover nearly 83 times the number of people that the TSP currently covers. Such an enormous jump in scale calls into question the validity of comparing the two plans, but the lack of any other comparable data compels the author to at least analyze the possibility of expanding the administrative experience of the TSP to a larger scale project. *Id.* at 6.

86. *Id.*

87. *See id.* at 6 (this figure is based on the current number of participants in the system, 153 million individuals, multiplied by the initial start-up costs of the TSP plan, five dollars per participant, factoring in an assumed constant inflation rate of 3 percent per year, and expressed in 2004 dollar values).

88. CBO, *supra* note 37, at 12.

89. Olson & Salisbury, *supra* note 77, at 4-6.

plan at $2.7 trillion.[90] These substantial costs would be passed onto the participants in the individual Social Security accounts, and would likely unfairly burden those with administrative costs who have the shortest amount of time, because of their older age, to accumulate wealth through these private investments.[91]

It is, however, likely that the ongoing administrative costs of the plan would dwarf the start-up and transition costs. These costs differ based on how the Social Security system would be administered. There are four different ways the plan could be administered: through the government, employers, individuals, or in a system similar to the current payroll tax combining efforts of both the government and employers. Each of these four options has different costs associated with them.

First, upon considering a joint employer-government plan similar to the payroll tax system, many issues are raised as to whether such a system would be efficient. While a government run system would likely have advantages in being able to centralize the administration process in one particular agency and would provide economies of scale, those benefits could be offset by the likely inability of the agency to keep up with more efficient technological advances as well as the costs that go with increased bureaucratic red-tape.[92]

An employer-based system might be more efficient because of competition between private administrators to keep management costs down. But such efficiency might be offset by one important problem. In the current employer-based payroll tax system, the employer is only required to report the payroll taxes once per year.[93] These relatively infrequent report requirements have two cost implications: 1) less reporting means less work for the plan administrators, which translates into costs savings; 2) payroll taxes are "floated" over that period without the employee receiving the benefit of his earlier contribution in the form of payment for the present value of the contribution.[94]

In the current Social Security system, such a float is not a concern because the system is credit-based. The total number of credits is calculated over the person's lifetime, and any floats do not diminish the value of the credits the individual has earned over their working life.[95]

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90. SCHIEBER & SHOVEN, *supra* note 1, at 366.

91. Olson & Salisbury, *supra* note 77, at 4-6.

92. *Id.*

93. Francis X. Cavanaugh, Statement before the U.S. Senate Budget Committee (July 21, 1998), *available at* http://www.ourfuture.org/docUploads/20010920105821.pdf.

94. Olson & Salisbury, *supra* note 77, at 11-19.

95. *Id.* at 14.

However, in a defined contribution plan where an employee puts the money into the system, a "float" of anywhere from twelve to twenty-two months, creates a large burden because those funds will not be put into their investment portfolio for such a long period.[96] Instead of being able to earn interest or investment returns on that money, it disappears into the ether of government bureaucracy, not to return and work for the employee until much later.[97] Such a cost must be figured into any plan if it is to be based on the current employer-based, annual reporting model.

Solutions to solve the problem of a payroll tax "float" do not diminish the costs of administration. A more efficient proposal might require quarterly reporting by employers to the government of employee contributions. However, with this increased reporting comes the increased costs of compiling the information accurately.[98] Instead of one report being generated and audited, now the process is repeated over a shorter period of time. In reviewing the effect of such a plan on small business, it was estimated that a quarterly reporting system would be an additional cost to small employers of at least $1.074 billion each year.[99] Realistically, these costs would be passed onto employees participating in the plan. Additionally, even though float times would be reduced, those costs would not be entirely eliminated because the float would still exist for three months until the reports were filed. A system modeled after the current payroll tax system does not efficiently meet many of the administrative problems that a privatized Social Security system would create.

Another approach is through an employer-based plan similar to the current 401(k) system. Under this administrative method, the employer is responsible for depositing contributions soon after they are made by the employee. This would likely eliminate the "float" problem that is a major

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96. *Id.* at 11-19. The lag time for employees that are part of a small or large employer is generally about one to 12 months. *Id.* A payment in December will be reported in January, whereas a payment in January will sit for a year. *Id.* A self-employed individual will have their payments credited even farther in the future. *Id.* Based on estimates by the Department of Commerce, the lag-time for the self-employed is usually anywhere between sixteen to twenty-two months before the government is able to differentiate in the tax reporting between federal income tax and payroll tax. *Id.* During this lag, the money contributed is not working for the individual participant, and therefore such lag must be considered as a cost of the plan in terms of foregone possible investment return. *Id.*

97. *See* CBO, *supra* note 37, at 17.

98. *See id.* (explaining that more frequent reporting requirements would drive "the costs . . . higher because faster processing would require some combination of more employees, improved hardware, and more sophisticated software").

99. *See* Olson & Salisbury, *supra* note 77, at 15 (the report concluded that additional small employer's expenses could run as high as $900 million. This figure was adjusted for inflation using a constant 3 percent rate and is expressed in 2004 dollars).

drawback of the payroll tax model. However, many employers do not currently have 401(k) plans offered to their employees, and requiring them to do so would greatly increase their administrative costs.[100]

Finally, Social Security could be administered through an individual-based system modeled after the current Individual Retirement Account (IRA). Under this plan, there would be no "float" because the individual would control the deposit of their own money and it would be immediately credited to the individual's account. The administrative problems with this approach, however, are likely to offset the "float" costs and make the IRA-based system unfeasible. For example, individuals would not be able to bargain as well as larger entities in securing lower administrative fees from financial services providers.[101] Additionally, economies of scale in efficiently grouping together millions of individual accounts in a central process like that done in the government or employer based system would also be lost in an individual based system.[102]

The administrative costs of any privatized Social Security system are of paramount concern. Each system has different problems associated with it, and with each, there is likely to be a substantial cost that will have to be passed onto employees. The benefits of privatizing the system must therefore take into account the significant additional administrative costs that will erode some of the advantages of investing Social Security payments in other investment vehicles.

E. FAIRNESS AND REDISTRIBUTION

1. What is the Effect of Privatization of Low-Income and Minority Workers?

The Bush Administration asserts that the traditional Social Security system is unfair to low-income or minority workers who die prior to ever receiving benefits, or who have a shorter life expectancy as a group and therefore do not receive their money's worth in traditional benefit

100. *See* Paul Yakoboski, *Employment-Based Retirement Income Benefits: Analysis of the April 1993 Current Population Survey*, 25 EMPLOYEE BENEFIT RESEARCH INST. SPECIAL REPORT 48 (Sept. 1994). There is no concrete data on the proportion of employers who offer 401(k) plans. Based on employment data, however, which show that only slightly more than a third of employees participate in 401(k) plans, and that those employees are likely employed by the minority share of large employers, it is likely that most employers do not offer 401(k)-type plans to their employees. *See id.* Thus, such a plan would likely be a highly costly administrative burden to this proportion of the employers in the country. *Id.*

101. CBO, *supra* note 37, at 18.

102. Cavanaugh, *supra* note 93.

payments.[103] In order to solve this unfairness, reform proponents argue that low-income workers should be able to invest some of their Social Security taxes in a vehicle that will allow them to build wealth in a personal account that they will own even if they do not survive to collect traditional Social Security benefits. Proponents claim that allowing this investment outside of the traditional Social Security system would be a way for these groups to transfer wealth intergenerationally. Under the old Social Security system, the Bush Administration argues that these workers would be forced to make payments they would not receive the benefit of when, or if, they survive to retirement. The personal accounts would let these workers or their heirs actually have ownership over an account that could not be taken from them because of their shorter life expectancy.[104]

One of the problems with this argument is the fact that the requirements set out by the Bush Administration for the privatization plan would likely strip away any advantages reaped by low-income and minority workers. Based on the President's Commission to Strengthen Social Security (PCSS) requirements for minimum amounts of funds for retirees, it is likely that low-income worker and minorities would not be able to meet the requirements and still be able to take advantage of the wealth created in their accounts.[105]

The PCSS's recommendations include a requirement that all retirees have a minimum amount of funds so that they will have sufficient annual income to keep them above the poverty line at retirement age.[106] In order to meet this poverty line requirement, retirees have two options: self-annuitize, which would build up enough wealth in the account to be able to access payments each year above the poverty line, or to purchase an annuity at retirement, which would guarantee the minimum amount of payments during the retirement years.[107]

Low-income workers are much less likely to have accumulated a significant amount of other personal and retirement savings during their

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103. Medill, *supra* note 62, at 953; *but see* SCHIEBER & SHOVEN, *supra* note 1, at 224-25 (contending that the notion that minority workers, in particular African-American males, are disadvantaged by the current Social Security system is perhaps an overly simplistic analysis of the available demographic data).

104. Suffice it to say that many critics of the Bush Administration plan counter that this admission is compelling evidence that the government has not done enough to improve the health and welfare of lower income and minority workers. Instead of advocating private accounts to make up for the shorter life expectancy, these commentators suggest that the root cause of this problem should be addressed instead of just treating a symptom.

105. Medill, *supra* note 62, at 953-55.

106. *Id.* at 955-56.

107. *Id.*

lifetimes to draw upon during their retirement years.[108] Thus, low-income workers are poorly positioned to assume the risks of longevity themselves and self-annuitize their personal accounts to satisfy the Commission's minimum income retirement standard. Controlling for health status factors, this means that low-income workers will be more likely to select the traditional annuity option than higher income workers.[109] The adverse selection problem created by giving workers the option of satisfying the Board's minimum retirement income requirement by choosing between a traditional annuity and a self-annuity will raise the cost of an annuity for everyone who selects the traditional annuity.[110] But unfortunately, the group of workers upon whom the costs of adverse selection is likely to fall most heavily will be low-income workers. These, however, are the very workers who are supposed to be building wealth through personal Social Security accounts.[111] The privatization plan appears to fail low-income and minority workers chiefly because of its own internal financial requirements.

Other critics of the privatization plan argue that the plan will not increase fairness for low-income and minority workers due to the investments that these groups will choose. The cornerstone of the Bush Administration's privatization theory is ownership and coupled with that impetus is the responsibility of choosing the appropriate investment vehicle. However, data suggests that low-income and minority workers might not benefit to the same degree as other groups under a privatization plan because of the types of investments this group would likely choose.

Proponents of privatization appear remarkably confident that a system of private accounts would spur workers to become successful investors.[112] The experience with defined-contribution arrangements such as 401(k) plans and IRAs, however, suggests that this confidence may be misplaced. Individuals with relatively low family incomes and little education tend to choose investments with lower levels of risk and correspondingly lower returns than those with higher incomes and more education.[113] Thus, it seems quite likely that groups with relatively low levels of income and

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108. *Id.* at 908-09.

109. *Id.*

110. *Id.* at 908.

111. *Id.*

112. *See supra* note 46 and accompanying text.

113. Cynthia M. Fagnoni, *Social Security and Minorities: Current Benefits and Implications of Reform, Testimony before Subcomm. on Soc. Sec. of the House Comm. on Ways and Means*, 106th Cong. 1 (1999), *available at* http://waysandmeans.house.gov/legacy.asp?file=legacy/socsec/106cong/2-10-99/2-10fagn.htm (last visited Apr. 9, 2005).

education, including many black workers, would receive disproportionately low returns under a system of private accounts.[114] Unless all workers are properly equipped to take advantage of new investment opportunities, those opportunities may perpetuate existing racial inequalities.[115]

2. What is the Effect of Privatization on Spousal Benefits?

Social Security reform also presents redistribution and fairness issues with respect to spousal benefits. Presently, spousal benefits redistribute income from two-earner couples to one-earner couples.[116] The nonworking spouse in a one-worker couple receives fifty percent of the spouse's benefit at the normal retirement age and receives the spouse's full benefit if the working spouse passes away.[117] Despite qualifying for this benefit, both earners in a two-earner couple also still pay payroll taxes and, depending upon the couple's earning levels, may receive nothing additional from their contributions beyond what a nonworking spouse would receive.[118] A two-earner couple is also disadvantaged in that, upon death, one of the spouses is likely to receive smaller benefits than a nonworking spouse would.[119]

Even without the addition of individual accounts, these benefit rules may no longer match the present demographics of the country, given the higher female labor force participation and divorce rates. In light of those demographic changes, the current benefit rules may actually lead to less effective poverty prevention.[120] If individual accounts are added, spousal benefits would involve additional complexities, such as allocating individual account proceeds to the spouse after divorce.[121]

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114. *Id.*

115. Andrew F. Brimmer, *Income, Wealth, and Investment Behavior in the Black Community*, 78 AM. ECON. REV. 151, 154-55 (1988).

116. *See* Medill, *supra* note 62, at 953-55.

117. *See id.*

118. *See* W. ANDREW ACHENBAUM, SOCIAL SECURITY: VISIONS AND REVISIONS 127-28 (1986).

119. *Id.* at 129-30.

120. *See* URBAN INST., *Social Security: Out of Step with the Modern Family* 6-13 (2000).

121. *See* AARON & REISCHAUER, *supra* note 15, at 96-100, for a possible solution to the problems associated with formulation of spousal benefits after divorce.

II. LESSONS FROM OTHER COUNTRIES

A. THE CHILEAN APPROACH TO SOCIAL SECURITY REFORM

Chile was the first Western nation to adopt an individually capitalized public retirement system. Therefore, a comparative analysis between the Chilean and the US social security experiences can help advance the understanding of whether the individual capitalization system would be an option for US social security reform.[122] Now that the United States is considering a move from the traditional pay-as-you-go system, lessons that can be derived from the experiences of other countries could be useful in determining whether the current privatization plan has an opportunity to work well in the United States.

The origin of the American Social Security system was, as discussed *supra*, a desire by politicians to eliminate elderly poverty in the country through a system that would provide a safety net for those older retirees on a fixed income. The evolution of the Chilean Social Security system followed a different pattern. It was the consequence of an extended social movement that intensely pushed the political system to improve the social condition of workers. This process was strongly influenced by two sources: the laical social thought, and the Catholic social thought.[123]

Bowing to the pressures from the church and the powerful social movements, a semiautonomous agency was created in 1924 to administer the pension system of blue-collar workers, the Mandatory Security Fund (Caja del Seguro Obligatorio)—popularly known as the Worker Security Fund (Caja del Seguro Obrero).[124] Membership in the fund was mandatory and the benefits included health and dental care (even after retirement), subsidies for illness, indemnification for death, and disability and retirement pensions.[125] The following year, a similar agency was created to deal with social security for white-collar workers, the Private Employees Security Fund (Caja de Previsio de Empleados Particulares-EMPART).[126]

While the origins differed, the systems, and their problems, are similar. The crisis in Chile manifested itself much earlier than the problems in the American system. By 1980, the system was in chaos with projections for

122. Muricio Olavarria-Gambi, *Social Security in Perspective: A Parallel Between Chile and the United States*, 5 GEO. PUBLIC POL'Y REV. 165, 165-66 (2000).

123. *Id.* at 168.

124. *Id.*

125. *Id.* at 168-69.

126. *Id.*

insolvency within the next two decades.[127] The major problem was the sheer number of retirement regimes and the old Chilean system's lack of uniformity.[128] Some workers could retire with a very high pension at forty-two years of age, while others had to wait until age fifty-five or sixty-five.[129] Additionally, not all of the pensions were subject to an automatic cost of living adjustment.[130] Contrary to the architects' intent, the system had become increasingly unfair after fifty years of operation.[131] As a result, several politicians undertook a broad-brush analysis of the system, similar to the President's Commission to Strengthen Social Security, to determine the inadequacies and to formulate plans to fix those problems.

The commission studying the Chilean system advocated an overhaul that was very similar to the proposals being considered by the Bush Administration and Congress. To that end, the new Chilean social security system has been built on different bases than the original. First, the system is managed by private companies but supervised by the government.[132] Second, workers contribute to a personal account rather than a general fund.[133] All workers contribute ten percent of their earnings, subject to a ceiling, and an additional three percent for disability and survivor's insurance.[134] Third, pension fund companies, called Administradoras de Fondos de Pensiones (AFPs), invest workers' contributions in government issued bonds and profitable and secure private corporations.[135] Fourth, pensions are a direct consequence of both workers' contributions and the profitability of those pension funds.[136] However, the AFP system must guarantee a minimum profitability, defined as "the lesser of the average performance of all AFPs minus 2 percent of 50 percent of the average real return of all AFPs."[137] Fifth, workers are free to choose the company that

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127. *Id.* at 169.

128. Sebastian Edwards, *The Chilean Pension Reform: A Pioneering Program*, *in* PRIVATIZING SOCIAL SECURITY 33, 37 (Martin Feldstein ed., 1998).

129. *Id.*

130. *Id.*

131. *Id.*

132. Olavarria-Gambi, *supra* note 122, at 171.

133. *Id.*

134. MONIKA QUEISSER, THE SECOND-GENERATION PENSION REFORMS IN LATIN AMERICA 24 (1998).

135. Olavarria-Gambi, *supra* note 122, at 171; *see also* Edwards, *supra* note 128, at 39 (explaining the fundamental reforms of the pension fund companies included limiting each AFP to managing only one retirement fund, and rigorously enforcing a strict separation between the retirement fund and the management firm's assets).

136. Olavarria-Gambi, *supra* note 122, at 171.

137. Queisser, *supra* note 134, at 25.

will manage their personal accounts, [138] but participation is mandatory for all private and public sector employees entering the workforce and optional for the self-employed.[139]

These AFPs represent a substantial shift from the previously government managed system. The main role of these companies is to make the pension fund they manage, and consequently the workers' personal accounts, profitable and secure.[140] This is also their principal basis of competition: to enroll more workers in accounts managed by their company.[141] Chilean workers have the freedom to choose the AFP with which they want to be affiliated; they also can transfer their funds freely among AFPs.[142] The competition between the AFPs to increase their own number of enrollees has steadily driven down administrative costs across the board, in turn raising the rate of return for those who contribute to the retirement accounts.[143]

The results for the reformed pension system in Chile are somewhat encouraging. The most positive result of the privatization model has been its great profitability. In the period of 1981-1999, the annual average rate of return was 11.3 percent, much higher than the projected four percent.[144] Another publicized result of Chile's private pension system has been the level of assets that it has accumulated. As of September 1999, Chilean pension funds had accumulated approximately $33.12 billion in a country with a labor force of about five million workers. The funds are invested in a diversified portfolio: government bonds represent 36.2 percent, financial shares and bonds 32.58 percent, company shares and bonds 17.71 percent, debt bonds 6.25 percent, and foreign mutual funds, shares and other investments 7.26 percent.[145]

This result has to be taken with a caveat, however, that might apply to any reform attempted in the United States. As discussed *supra*, the United

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138. Olavarria-Gambi, *supra* note 122, at 171.

139. *See* Queisser, *supra* note 134, at 23 (discussing the fact that at the time of reformed system's inception, the members of the old pension system were given the choice of remaining in the public scheme or moving to a private AFP).

140. *Id.*

141. *See id.*

142. Edwards, *supra* note 128, at 40.

143. *See id.* at 45 (Initial "administrative costs were extremely high. In 1984 for example, they amounted to 9 percent of wages, or 90 percent of the contributions to the retirement system! By 1994, however, costs had declined significantly, amounting to 1 percent of wagers or 10 percent of contributions. In spite of these high costs, the new capitalization system is significantly more efficient than the old pay-as-you-go regime").

144. Olavarria-Gambi, *supra* note 122, at 171-72.

145. *Id.*

States' stock market's historical equity rate of return was much lower than the figures that the Chilean system was able to achieve in the seventeen year period of that country's reformed system.[146] Additionally, the period in which the Chilean system saw the most growth was in the early 1990's, where much of the world's stock markets had an extremely high rate of return when compared to their historical averages.[147] Thus, it is unlikely that the high profitability that the Chilean system was able to harness in the two decades of its initial formation could be replicated in the United States.

The Chilean system has not, however, been without its faults. According to some scholars, Chile's new pension system is unfair since it only requires worker contributions, while the United States Social Security system requires employer contributions as well.[148] In the Chilean reformed pension system, total wages have been equated to total labor cost without either increasing costs or reducing workers' wages.[149] Also, in the Chilean case, although the employer contribution was eliminated, worker contributions to social security were reduced and take-home wages were increased.[150]

A final problem the Chilean system confronts is the continued need for governmental financial assistance in order to provide the minimum amount of benefits required by the privatization law. According to one estimate, "Chile has spent more than $66 billion on benefits since privatization was introduced. Despite initial projections that the system would be self-sustaining by now, spending on pensions makes up more than a quarter of the national budget, nearly as much as the spending on education and health combined."[151] Such results serve as a prescient warning to proponents of a privatized pension system who have created a plan based on the assumption that it will be self-sufficient in the future.

B. THE AUSTRALIAN PRIVATIZED RETIREMENT SYSTEM

Australia is implementing a privatized retirement system that might provide a model for reform in the United States. The key to the Australian

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146. *See supra* section II-A for a discussion of the expected rate of return in the stock market over the next several decades.

147. *See* Olavarria-Gambi, *supra* note 122, at 172-74 (detailed discussion of the equity returns for the Chilean system in the period from 1981-1998).

148. *Id.* at 174.

149. *Id.*

150. *Id.*

151. Larry Rohter, *Chile's Retirees Find Shortfall in Private Plan*, N.Y. TIMES, Jan. 27, 2005, at A1.

system is something called "superannuation."[152] Superannuation "is a system of private, tax-advantaged retirement accounts that have mandatory contribution requirements."[153] When fully implemented, employers will be required to contribute nine percent of each employee's earnings up to a specified maximum earnings level (of about 26,000 Australian dollars per quarter) into a private retirement account.[154] If this contribution is not made, the employer will be taxed for the required amount, and the government will make the contribution. This tax "is known as the superannuation guarantee charge (SGC)."[155] "Employees must also contribute 3% of their salary up to a specified level."[156] The contributions are taxed at levels much lower than ordinary income up to some maximum limits. Restrictions are placed on withdrawals, but emergency access is permitted before retirement age. "Some funds provide disability and life insurance, as well as retirement benefits."[157]

Contributions are invested in regulated superannuation funds. These are trust funds that are managed by private trustees. These trust funds may be employer-specific, industry-specific, or available to any member of the public. "Three regulatory bodies are given jurisdiction to assure that these trust funds are invested and managed properly."[158] "Local trust law also applies to provide protection, and auditors and actuaries must report to regulators violations of legislation that provides for the protection of superannuation funds."[159] Investors are often given a choice of investment strategies that range from "guaranteed" minimum returns to funds with significant investment risk.[160] Investors may be able to spread or switch their investments among funds with varying strategies. "Defined benefit

152. Australian Taxation Office, *Superannuation Guarantee: The Facts for Employees* (2002), *at* http://www.ato.gov.au/content/downloads/nat1991.pdf (providing an overview of "Superannuation") (last visited Mar. 15, 2005); *see also generally* TERRY CARNEY & PETER HANKS, SOCIAL SECURITY IN AUSTRALIA 23-49 (1994) (offering an historical perspective on the challenges facing the Australian pension program prior to the development of the superannuation system).

153. Jerry W. Markham, *Privatizing Social Security*, 38 SAN DIEGO L. REV. 747, 813 (2001); *see* Malcolm Edey & John Simon, *Australia's Retirement Income System*, *in* PRIVATIZING SOCIAL SECURITY 63, 69-70 (Martin Feldstein, ed. 1998) (discussing the complex tax treatment rules for superannuation contributions from both employees and employers).

154. Markham, *supra* note 153, at 813.

155. Edey & Simon, *supra* note 153, at 66-67.

156. Markham, *supra* note 153, at 813.

157. *Id.*

158. *Id.*

159. *Id.*

160. *See id.* at 814.

plans are also allowed."[161]

Backstopping the superannuation funds is a social security network. "The Australian government thus provides an Age Pension for the elderly, at an age that is moving toward sixty-five."[162] It is the equivalent of our Social Security pension, except that it is needs based and funded from general revenues. Unlike Social Security, the Australian Age Pension is viewed as a safety net for those unable to provide for themselves in retirement. "Income to the recipient of an Age Pension or assets . . . in excess of specified levels will, consistent with that concept, result in the reduction or elimination of benefits."[163]

Initial data on the reformed Australian system is not encouraging. "On the basis of currently available data, aggregate net contributions to superannuation funds do not yet show the upward trend expected to result from the compulsory plan."[164] This could be an outlier result based on the timing of the data recordation that coincided with an economic recession in Australia. Coupled with the fact that the Australian plan allows for emergency hardship withdrawals, the lack of increased contributions could be due to a one-time depletion of resources not likely to be repeated.[165] Economists still project improvements in the amounts invested via the superannuation program as the economic fortunes of individuals ameliorates over the next several years.[166]

The Australian system is thus a possible model for the United States to follow. Again, however, there are important distinctions between the two systems that could determine if such a plan would be appropriate. First, and most importantly, is the difference in how income or assets disqualifies some of the Australian elderly from receiving any Age Pension benefits from the government. It is a significant issue as to whether the elected representatives of this country have the political will to eliminate this benefit even for the wealthiest Americans who might feel that they have paid into the system and should therefore receive some benefit regardless of actual need.[167]

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161. *Id.* at 813 (citing Nat'l Info. Ctr. on Ret. Ins., *A Super Guide* (July 24, 2000)).

162. Markham, *supra* note 153, at 813-14 (citing Centrelink, Age Pensions: All You Need to Know 4 (May 2000)).

163. *Id.* at 814.

164. Edey & Simon, *supra* note 153, at 72.

165. *Id.* at 72-73.

166. *Id.* at 81-82.

167. The Bush Administration's priorities in eliminating tax liabilities for high-income individuals through both federal income tax rate reductions and federal estate tax reductions make it unlikely that one avenue chosen by the Bush Administration to fix the Social Security system would be to reduce or eliminate benefits to these same individuals.

Second, the superannuation model used in Australia, while ensuring that a certain level of benefits are available to retirees, faces the same problem that the American system of minimum retirement resources also has faced. As discussed *supra*, many low-income and minority worker would not be able to accumulate enough wealth over the course of their lives to have sufficient resources to draw from at retirement to meet the requirements of having income above the poverty line during their retirement years.[168] Instead of then being able to draw from the wealth accumulated in their privatized portion of the Social Security payments, these individuals would be required to purchase an annuity that would guarantee them an annual income over the poverty line. The Australian superannuation model does nothing to address this disparity between low-income workers and those who are able to self-annuitize and then take advantage of that accumulated wealth in their privatized accounts.

A third key difference is that the Australian system is compulsory, while all of the outlines presented by American politicians would make personal accounts a voluntary choice.[169] This could minimize the effectiveness of any reform program if a majority of the population does not participate. Failing to have near full participation could mean that the risks inherent in privatization are shouldered by a relatively small proportion of the working population.

III. A MODEST PROPOSAL

After an analysis of the predicament facing those entrusted with keeping the promise to our nation's elderly retirees, a proposal to solve the problem is appropriate. In both acknowledging that demographics and structural forces are at play, this modest proposal encompasses immediate, intermediate, and long-term changes in the system. Both political and market risk are involved in any decision to privatize the social security system, and this proposal is meant to be an alternative and realistic choice for those in the seats of power.

However, there are indications that such plans could be on the negotiating table. *See* VandeHei, *supra* note 68, at A06 (reporting "Bush highlighted one possible proposal for cutting benefits that is popular inside the White House: 'progressive indexing.' ... [The] proposal would reduce benefits the most for those making more than $113,000 . . .").

168. *See generally* discussion *supra* Part I.D.1, of the requirements of the President's Commission to Strengthen Social Security that each individual retiree have enough resources for the annual income in their retirement years to be sufficiently above the poverty line.

169. VandeHei, *supra* note 68, at A06.

First, it is of paramount importance to understand the crucial factor that demographics play in creating the Social Security crisis. More people are having fewer children, and retirees are now living longer. Any reasonable proposal to fix the system must acknowledge, as discussed *supra*, that there will be less workers to support more retirees, and that these retirees, under the current benefit structure, will receive payments from the government for a much longer time than originally anticipated.[170]

Therefore, the eligibility age for collecting benefits should be raised from its current level of sixty-five to a more realistic age of seventy.[171] This eligibility age increase should not, however, be done immediately. At the core of our public Social Security program is the promise from one generation to the next that each will take care of their predecessors. It would be patently unfair to change the rules for those contemplating retirement within the next ten years by raising the retirement age and giving those individuals no opportunity to realign their financial choices.

Thus, beginning in 2016, the benefit eligibility age should gradually be raised from sixty-five years of age to seventy years of age. In 2016, the eligibility age should be raised to sixty-eight years of age. In 2020, the eligibility age should be raised to seventy-years of age. This more realistic age of eligibility would have a two-fold result: reduction in the number of eligible beneficiaries, thereby reducing the Social Security Trust Fund's liabilities, and increase the amount of revenues into the Trust Fund by increasing the number of individuals who continue to work and pay into the system. While estimates are unclear as to how much money could be saved through raising the eligibility age, what is clear is that the process would be much more realistic and in line with current actuarial estimates.

Second, the United States Social Security system should reduce and eliminate benefits for those individuals whose age makes them eligible, but whose income or assets makes the Social Security payments unnecessary. This means-testing approach would ensure that Social Security funds continue to be paid to almost all American workers, while at the same time improving the financial condition of the Social Security Trust Fund by eliminating the most generous benefits for those with ample retirement

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170. *See generally supra* Part I, for a discussion of the demographic changes that are combining to create many of the problems with the Social Security system.

171. *See* Jake Thompson, *Hagel Details Own Plan for Retirees*, OMAHA WORLD-HERALD, Mar. 6, 2005, at 1A (detailing Senator Chuck Hagel's plan to save the Social Security system). Hagel's proposal includes phasing in a higher retirement age to 68, using personal investment accounts for those under the age of 44, and basing Social Security payments on life expectancy estimates. *Id.*

resources.[172] Starting with those individuals with more than $500,000 in assets at the age of retirement, a "benefit index" formula would be applied to determine the reduced benefit. The value of a primary residence and certain other investments would not be included in the applicable assets.[173] The value of assets owned by married couples jointly would be divided equally between the two spouses for the purpose of this "benefit index" formula. Social Security benefits would be reduced by 0.025 percent for each $1,000 in assets over the cap, with benefits eliminated for those individuals with assets of $4.5 million or more.[174]

This would not alter the condition of the vast majority of beneficiaries. Instead, it would ensure that those who needed the payment directly from the government received them in order to stay out of poverty, but those who accumulated sufficient wealth to pay for their retirement would not needlessly drain funds from the Treasury. Much like the Australian system, those with sufficient assets would have reduced or eliminated benefits, with a backstop for those who did not meet minimum annual requirements to live above the poverty line. Thus, the goal of the system remains intact, because elderly poverty is still being effectively combated, but the system is more realistic in being able to pay out benefits only to those who truly need financial assistance to protect them from the threats of elderly poverty.

Third, regarding the structure of the Social Security system, the best option is to retain the employer-reporting mechanism to the government,

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172. Although the amount of money saved by the Treasury would be diminished by the increased administrative costs of a means-testing program, reducing benefits for the extremely well off would still significantly diminish the dollar value of benefits the Trust Fund is required to pay. *See* MERTON C. BERNSTEIN & JOAN BRODSHAUG BERNSTEIN, SOCIAL SECURITY: THE SYSTEM THAT WORKS 13 (1988) (citing data illustrating "need-test procedures increase[ ] program costs prodigiously. While the Social Security cash programs (for retirees, survivors, the disabled and their families) incur slightly more than 1 percent of payments for administrative expenses, Supplemental Security Income (SSI), which pays benefits to a comparable population but on a needs-tested basis, costs 7.05 percent to operate").

173. Contingent term life insurance policies are also not included as assets for the purposes of the benefit phase out formula. However, stocks, bonds, commodities futures, certificates of deposits, savings and checking accounts, money market accounts, annuities and all other investment vehicles are included.

174. Two examples are useful in explaining the proposed "benefit index" formula. One, if a married couple jointly owned assets valued at $1.5 million, each individual's benefits would be reduced by 6.25 percent. Second, if an individual owned assets valued at $4.26 million, her benefits would be reduced by 94 percent. The benefit phase out formula is represented by the following equation: % of benefit reduced = [(value of assets in $ - $500,000) /1000] x (.025).

with the government administering the public retirement program. The efficiencies generated from the economies of scale, as well as the institutional knowledge of having administered such a large benefits program will be invaluable in the future. The one slight change would be to eliminate a portion of the rate of return costs of the program by requiring employers to report contributions to private accounts on a quarterly basis instead of a yearly basis. While there will still be some lag in the system, quarterly reporting will be much more fair and will allow the money invested to begin working harder even earlier.

Fourth, system privatization should be minimal. Thus, workers would be eligible to invest only one percent of their taxable income into a private account that can be invested in stocks, bonds and other equities. This proportion is significantly lower than the four percent offered by the Bush Administration.[175] The stock market alone, however, cannot save the Social Security system. While the returns from investments in equities will likely be better than the return from the money sitting in the Treasury, any large amount of risk should not be placed on the shoulders of the individual worker. Thus, the proposal to limit the private account to one percent of taxable income will have a two-fold effect: wealth can be accumulated outside of the Social Security system to be used for retirement, and the lost funds to the Treasury will be limited to only one percent of receipts, at most, to ensure that there are still sufficient resources to pay for future obligations of the system.

These four changes, enacted in concert, create the opportunity for a Social Security system that can function for generations to come. By acknowledging realistic demographic shifts, embracing the value of protecting the most vulnerable of the elderly from the threats of poverty, using the efficiencies of scale that the large government agency can utilize, and allowing individuals to take advantage of the equities market to create some private wealth outside of the system without eliminating the vast proportion of payments, the system will keep its promise of one generation protecting its predecessor.

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175. *See* VandeHei, *supra* note 68, at A6 (reporting that "[i]n keeping with the second-term focus of the White House, Bush spent most of the time [at a March 16, 2005 press conference] promoting his plan to restructure the 70-year-old Social Security program and to allow workers younger than 55 to voluntarily divert 4 percent of their taxable income into private investment accounts").

CONCLUSION

The Bush Administration's notion of saving Social Security hinges on partially privatizing the system. Such a solution, enacted without any other structural changes, is inadequate. While the concept of building individual wealth outside of the public retirement system is a valid one, the failure to acknowledge many of the short-falls that such a plan creates is irresponsible.

Investing funds in the equities market will create a better rate of return than simply handing the money over to the Treasury. However, those increased funds alone will not be enough to create a system that can be sustainable for future generations. Much deeper changes are needed in order to ensure that generations from now people will still have the guarantee from the government that it will not turn its back on them when they are at their most vulnerable in their elderly years.

Thus, proposals such as raising the eligibility age and reducing or eliminating benefits for the most wealthy in society must be on the table. Such plans would allow Social Security to function as it was originally intended: to prevent elderly poverty. Those most well-off in society need to acknowledge the guiding principle of the system is a social safety net. When you need the safety net, it will be there. When you do not, it will be there to protect those who do need it, and for future generations who are providing for the current retirees.

In conclusion, partial privatization of the Social Security is neither a magic potion nor an irresponsible beginning. It must, however, be just that: a beginning and not the only part of a plan to save the system. Without more fundamental changes in the Social Security system structure, it will not be able to meet the challenges that it faces over the next several decades. Any proposal to solve the problem must acknowledge the demographic and political realities of America. All Americans must be willing to sacrifice so that all can benefit. Some will be asked to sacrifice more than others. In the end, the system needs to be fixed; it cannot survive in its current manifestation. Only with honest political leadership can the steps be taken to ensure that one of the greatest programs in the history of the country can be saved, and one of the finest goals, to help our fellow American in his or her time of need, can be met. Social Security must be saved; the promise must be kept.

INSURING AGAINST THE SNAIL-DARTER: INSURANCE FOR LAND USE AND THE ENDANGERED SPECIES ACT

Jonathan F. Tross[*]

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INTRODUCTION

Although insurance[1] policies exist to guard against many possible risks, there is one area where coverage is noticeably lacking. There is an unexploited market segment in insurance for land use where there is the possibility of finding an endangered species on the property. The discovery of an endangered species on a property can profoundly impact on

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1. Insurance can be defined as "an agreement in which one party (the insurer), in exchange for a consideration provided by the other party (the insured), assumes the other party's risk and distributes it across a group of similarly situated persons, each of whose risk has been assumed in a similar transaction." ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 10 (2d ed. 1996).

the manner in which the property may be utilized.[2] The Endangered Species Act, which was enacted to afford listed species substantial protection, often restricts private landowners' use of their own land. At present, (and likely for the foreseeable future) no compensation is made to these disenfranchised landowners unless a regulatory taking is established. An attempt to establish a regulatory taking is a costly and lengthy process, which is often unsuccessful. Thus, it is not unreasonable to expect that many landowners would be interested in insuring against such a risk through this "endangered species insurance."

Endangered species insurance can, at least tangentially, be compared to insurance in the waste cleanup area. This insurance often sets a maximum (often in the form of a deductible) on a company's liability for a cleanup.[3] Likewise, I would anticipate that insurance for commercial land use where there is the possibility of discovering an endangered species would set a deductible that the landowner would incur before insurance coverage begins.[4] However, unlike insurance for waste cleanup, the maximum liability for insurance companies would be only up to the value of the property, rather than the total cost of cleanup (which may be well in excess of the value of the property).

Such endangered species insurance would have several foreseeable benefits. First, spreading the aforementioned risk across many possible policyholders would prevent any single landowner from bearing an abnormally heavy burden. Second, were this type of insurance to be made available, insurance companies would act as unwitting enforcers of environmental protection laws. This has the potential to be similar to improvements in fire safety resulting from preventative changes mandated

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2. Failure to comply with the Endangered Species Act has been determined to be grounds to enjoin a wide variety of proposed agency projects. *See, e.g.*, Portland Audubon Soc'y v. Lujan, 884 F.2d 1233 (9th Cir. 1989) (timber harvesting); Save the Yaak Comm. v. Block, 840 F.2d 714 (9th Cir. 1988) (road paving); Bob Marshall Alliance v. Hodel, 852 F.2d 1223 (9th Cir. 1988) (oil and gas leasing); Palila v. Haw. Dep't. of Land and Natural Res., 852 F.2d 1106 (9th Cir. 1988) (livestock grazing); Thomas v. Peterson, 841 F.2d 332 (9th Cir. 1988) (road construction); Defenders of Wildlife v. Andrus, 428 F. Supp. 167 (D. D.C. 1977) (hunting); and Tenn. Valley Auth. v. Hill, 437 U.S. 153 (1978) (dam construction).

3. Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942, 951-52 (1988) (discussing the importance of and difficulties associated with environmental liability insurance).

4. The requirement that a deductible or coinsurance be paid by the insured helps to lessen the moral hazard associated with the total elimination of risk. JERRY, *supra* note 1, § 10. This is due to the fact that an insured "might have less incentive to take measures that prevent the loss from occurring or minimize the effect of loss once it occurs. Thus, the existence of insurance can have the perverse effect of increasing the probability of loss." *Id.*

by fire insurance carriers. As fire insurance carriers mandate smoke detectors and sprinkler systems for their policyholders, carriers of this "endangered species" insurance would likely require that their policyholders carefully design and implement their Habitat Conservation Plan. Additionally, before issuing a policy, an insurance company would likely insist upon a thorough examination of the property in question, during which they would have the potential to detect any endangered species present on the property.[5] This, in turn, would likely lead to greater enforcement of endangered species protection statutes. Although such an examination would be difficult from an underwriting standpoint, it is not unreasonable to expect that insurance companies would become proficient at such a task. Third, this type of insurance would likely decrease the amount of negative publicity generated by the discovery of an endangered species on a private citizen's or corporation's property.[6] Finally, given that this endangered species insurance would compensate a landowner for his or her losses, it would help to reduce the possibility that many residential landowners would knowingly kill the endangered species on their land and then cover up the crime. Some describe this as the "Shoot it, Shovel it, and Shut up" mentality.[7] Endangered species insurance would enable such landowners to avoid the difficulty and expense associated with the discovery of an endangered or threatened species on their property. If property owners knew that they would be compensated for any alterations in the use of their land they would be less apt to kill or "cover up" the presence of the endangered species.

This Paper is organized as follows. Part I discusses the Endangered Species Act and subsequent endangered species jurisprudence. These cases will demonstrate the power of the Endangered Species Act and will help

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5. It should be noted, however, that such an examination may prove to be unfeasible should the number of potential insured become too great. As the number of properties to be examined increases, so do the costs (in terms of both time and money) associated with such examinations. It is likely that insurers would have to create less active metrics for assessing the potential risk a parcel of property posed (such as geographic location, proximity to land on which endangered species have been found, etcetera).

6. *See, e.g.*, Rone Tempest, *High Noon at the Blair Ranch: The Last Cattle Ranchers Face Pressure to Leave Mojave National Preserve, the Endangered Desert Tortoise May Drive Them Out*, L.A. TIMES, Feb. 9, 2003, at 1-2, *available at* 2003 WL 2383924 (discussing the difficulties the Blair family of ranchers experience in attempting to maintain their way of life subsequent to a federal court's decision to protect a desert tortoise in the Mojave National Preserve).

7. *See Ask Randy Weaver About That*, *available at* http://www.t137.com/archives/wwwboard49/messages/491496.html (last visited Apr. 9, 2005).

the reader obtain a better understanding of the risk that the act poses to landowners.

Part II considers takings jurisprudence, concentrating specifically upon regulatory takings. This section will assist the reader in assessing the probability of establishing a regulatory taking for a property. This is critical to determining the risk threshold a landowner is willing to bear.

Part III examines possible reasons for the current absence of endangered species insurance. In particular, the feasibility and practicality of this type of insurance will be considered. Additionally, the strengths and weaknesses of endangered species insurance will be discussed.

I. ENDANGERED SPECIES ACT AND SUBSEQUENT JURISPRUDENCE

A. THE ENDANGERED SPECIES ACT OF 1973

The Endangered Species Act of 1973[8] ("ESA") was enacted to "provide a program for the conservation of . . . endangered species and threatened species."[9] In contrast to many other environmental statutes that allow environmental gains to be evaluated relative to social and economic costs, the overarching import of the ESA is that species should be protected, whatever the cost. It is this focus which differentiates the ESA from its predecessor statutes, the Endangered Species Act of 1966[10] ("1966 Act") and the Endangered Species Conservation Act of 1969[11] ("1969 Act"). The 1966 Act gave the Secretary of the Interior the power to identify "the names of the species of native fish and wildlife found to be threatened with extinction."[12] It further directed all federal agencies to both protect these species and "*insofar as is practicable and consistent with the[ir] primary purposes* . . . preserve the habitats of such threatened species on lands under their jurisdiction."[13] Similarly, the 1969 Act empowered the Secretary to list species "threatened with worldwide extinction,"[14] and prohibited the importation of any such species into the

8. 16 U.S.C. §§ 1531-1544 (2000).

9. *Id.* § 1531(b).

10. Endangered Species Act of 1966, Pub. L. No. 89-669, 80 Stat. 926 (1966).

11. Endangered Species Conservation Act of 1969, Pub. L. No. 91-135, 83 Stat. 275 (1969).

12. Endangered Species Act of 1966, Pub. L. No. 89-669, § 1(c), 80 Stat. 926 (1966).

13. *Id.* § 1(b) (emphasis added).

14. Endangered Species Conservation Act of 1969, Pub. L. No. 91-135, § 3(a), 83 Stat. 275, 275 (1969).

United States.[15] The ESA's "pointed omission" of the "qualifying language" present in the prior endangered species statutes "reveals a conscious decision by Congress to give endangered species priority over the 'primary missions' of federal agencies."[16] Thus, both the 1966 Act and the 1969 Act afforded a far lesser degree of protection for endangered species and threatened species than the ESA.

Principal implementation responsibility for the ESA is assigned to the Secretary of the Interior[17] who, in turn, entrusts much of that authority to the Fish & Wildlife Service ("FWS"), an agency within the Department of the Interior. The ESA first provides a mechanism for identifying and "listing" threatened and endangered species that can benefit from the Act's protection.[18] Federal agencies have an obligation to preserve listed species and to ensure their recovery.[19] Agencies are also required to consult the FWS or the National Oceanic and Atmospheric Association (NOAA) Fisheries to ensure their actions neither jeopardize the continued existence of a species nor adversely modify its "critical habitat."[20] Federal and state governments, as well as private parties, are prohibited from killing, harming, or otherwise "taking" listed species.[21] To diminish the impact of the ESA and allow for accommodating implementation, under certain circumstances an incidental take permit can be issued to allow the taking of listed species.[22]

Because the ESA only protects species that are "listed," the formal listing of a species is vital to implementation. Section 4 of the ESA delineates the process and provides coverage only to species that are either "endangered" or "threatened."[23] A species is considered *endangered* if it is "in danger of extinction throughout all or a significant portion of its range,"[24] and *threatened* if it is "likely to become an endangered species in the foreseeable future."[25] The listing process may be initiated by anyone who files the appropriate petition. The agency then has 90 days to determine whether the petition is warranted.[26] If so, then it has up to a year

15. *Id.* § 2.
16. Tenn. Valley Auth. v. Hill, 437 U.S. 153, 185 (1978).
17. 16 U.S.C. § 1533 (2000).
18. *Id.*
19. *Id.* § 1536(a)(1).
20. *Id.* § 1536(a)(2).
21. *Id.* § 1538(a)(1)(B). *See also* 16 U.S.C. §1532(19) (2000).
22. 16 U.S.C. § 1539(a)(1)(B) (2000).
23. *Id.* § 1533.
24. *Id.* § 1532(6).
25. *Id.* § 1532(20).
26. *Id.* § 1533(b)(3)(A).

to determine whether to list the species.[27] Significantly, the agency may not consider economic costs or benefits in its listing decision.

The ESA also embodies the belief that a discrete habitat, a "critical habitat," could be identified and protected for each listed species. The ESA defines "critical habitat" to be *either* "the specific areas within the geographical area occupied by the species at the time it is listed . . . on which are found those physical or biological features (I) essential to the conservation of the species and (II) which may require special management considerations and protection;"[28] *or* "specific areas outside the geographical area occupied by the species at the time it is listed . . . upon a determination by the Secretary that such areas are essential for the conservation of the species."[29] Importantly, the focus on critical habitat in the ESA added a special dimension to species protection, allowing for the development of a map of critically important areas.

The EPA's designation of an endangered species' "critical habitat" has resulted in a significant amount of controversy. In *Northern Spotted Owl v. Lujan*[30] ("*Northern*"), environmental organizations brought an action to compel designation of critical habitat for the northern spotted owl. The ESA requires the Secretary of the Interior, "to the maximum extent prudent and determinable," to designate critical habitat *concurrently* with his or her decision to list a species as endangered or threatened.[31] In those instances where a critical habitat is not determinable at the time of the final listing of the endangered species, the Secretary of the Interior possesses the authority to allow for an additional twelve months to complete the designation.[32] The pertinent administrative regulations indicate that the Secretary of the Interior must specify his or her reasons for not designating critical habitat at the time of the final listing of the species.[33]

In *Northern*, the Secretary of the Interior chose to defer the designation of critical habitat in the final listing rule[34] indicating that it was not "determinable."[35] However, the Secretary of the Interior had not specified any reasons for the deferral other than the blanket statement that the critical

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27. 16 U.S.C. § 1533(b)(3)(B) (2000).
28. *Id.* § 1532(5)(A)(i).
29. *Id.* § 1532(5)(A)(ii).
30. 758 F. Supp. 621 (W.D. Wash. 1991).
31. 16 U.S.C. § 1533(a)(3)(A) (2000) (emphasis added).
32. *Id.* § 1533(b)(6)(C)(ii).
33. 50 C.F.R. § 424.12(a) (2004).
34. *See* Endangered and Threatened Wildlife and Plants; Determination of Threatened Status for the Northern Spotted Owl, 55 Fed. Reg. 26, 114 (June 26, 1990).
35. Northern Spotted Owl v. Lujan, 758 F. Supp. 621, 623 (W.D. Wash. 1991).

habitat was not "determinable."[36] The District Court for the Western District of Washington "reject[ed] as incongruous the federal defendants' argument that Section 4(b)(6)(C) authorizes an automatic extension of time merely upon a finding that critical habitat is not presently 'determinable,' even where no effort had been made to secure the information necessary to make the designation."[37] The court reasoned that "[t]o relieve the Secretary of any affirmative information gathering responsibilities would effectively nullify Congress' charge that the species listing and habitat designation occur concurrently, 'to the maximum extent . . . determinable.'"[38] The court went on to note that "[m]ore is required under the ESA and the Service's own regulations than the mere conclusion that more work needs to be done.[39] The FWS was ordered to provide a written plan for the completion of its review of the critical habitat for the northern spotted owl and was afforded forty-five days after such submission to publish the proposed critical habitat plan.[40]

Similarly, in *Forest Guardians v. Babbitt*,[41] environmental groups brought an action to compel the Secretary of the Interior to designate critical habitat for the Rio Grade silvery minnow, an endangered species. Due to several spending moratoria[42] that prohibited the FWS from listing species as endangered or threatened and similarly prohibited the designation of critical habitat, the FWS faced a backlog of 243 proposed species listings.[43] "Concluding that it could not feasibly complete all of its Section 4 duties in a timely manner, the Service, after notice and comment, published a rule establishing a priority system for eliminating its backlog."[44] This priority system, the Final Listing Priority Guidance

36. *Id.* at 627-28.

37. *Id.* at 626-27.

38. *Id.* at 627 (quoting 16 U.S.C. § 1533(a)(3)).

39. *Id.* at 628.

40. *Id.* at 629-30.

41. 174 F.3d 1178 (10th Cir. 1999).

42. The first such moratorium, the Emergency Supplemental Appropriations and Rescissions for the Department of Defense to Preserve and Enhance Military Readiness Act of 1995, Pub. L. No. 104-6, 109 Stat. 73, 86 (1995), stated in pertinent part: "Of the funds made available under this heading in Public Law 103-322—(1) $1,500,000 are rescinded from the amounts available for making determinations whether a species is a threatened or endangered species and whether habitat is critical habitat under the [ESA]; and (2) none of the remaining funds appropriated under that heading may be made available for making a final determination that a species is threatened or endangered or that habitat constitutes critical habitat (except a final determination that a species previously determined to be endangered is no longer endangered but continues to be threatened)."

43. Forest Guardians v. Babbitt, 174 F.3d 1178, 1183 (10th Cir. 1999).

44. *Id.*

("LPG"), was a three-tier system with critical habitat designations relegated to the third tier.[45] In reaching such a determination, the FWS reasoned that "critical habitat designation provided only a limited increase in protection to a species already listed as endangered or threatened."[46] The Court of Appeals for the Tenth Circuit framed the issue as "whether resource limitations can justify the Secretary's failure to comply with mandatory, non-discretionary duties imposed by the ESA."[47] The court concluded that they did not, and that the "Secretary violated his non-discretionary duty by failing to designate the critical habitat for the Rio Grande silvery minnow by the statutory deadline."[48] The court noted that the "inadequate resources defense could arise at the contempt stage, as a traditional impossibility defense at any subsequent contempt proceeding that may occur if the Secretary fails to comply with an order enjoining him to designate the critical habitat by a time certain."[49]

Once a species is listed in accordance with the requirements of the ESA, the primary goal is to prevent that species from going extinct. Additionally, it is the long-term goal of the ESA to restore populations to the point where a listing is no longer necessary. Section 7(a)(1) of the ESA requires federal agencies to "utilize their authorities in furtherance of the purposes of this chapter by carrying out programs for the conservation of endangered species and threatened species."[50] The conservation of protected species requires an agency to "use . . . all methods and procedures which are necessary to bring any endangered species or threatened species to the point at which the measures provided pursuant to this chapter are no longer necessary."[51]

There has also been a substantial amount of controversy, and litigation, concerning the listing of a species as endangered or threatened. For instance, in *Northern Spotted Owl v. Hodel*,[52] environmental groups brought an action against the FWS to challenge the decision not to list the northern spotted owl as an endangered or threatened species. These groups contended that the decision not to list the northern spotted owl, despite a review conducted by FWS biologists who advised the agency to list the

45. *Id.*

46. *Id.* (citing Endangered and Threatened Wildlife and Plants; Restarting the Listing Program and Final Listing Priority Guidance, 61 Fed. Reg. 24, 722-24 (May 16, 1996)).

47. *Id.* at 1184.

48. *Id.* at 1193.

49. 174 F.3d at 1192 (citing United States v. Rylander, 460 U.S. 752, 757 (1983)).

50. 16 U.S.C. § 1536(a)(1) (2000). *See also*, 16 U.S.C. § 1531(c)(1) (2000).

51. 16 U.S.C. § 1532(3) (2000).

52. 716 F. Supp. 479 (W.D. Wash. 1988).

species,[53] violated the "arbitrary and capricious" standard of the Administrative Procedure Act[54] ("APA"). An agency violates the arbitrary and capricious standard of the APA when it fails to "articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'"[55] The court in *Hodel* noted that the documents provided by the FWS "lack any expert analysis supporting its conclusion" and that, in fact, the expert opinion the agency commissioned was "entirely to the contrary."[56] Indicating that it would, "reject conclusory assertions of agency 'expertise' where the agency spurns unrebutted expert opinions without itself offering a credible alternative explanation,"[57] the court ordered the FWS to provide an analysis for its decision within ninety days.[58] In reaching this conclusion, the court reasoned that the FWS had "failed to provide its own or other expert analysis supporting its conclusions" and that "[s]uch analysis [would be] necessary to establish a rational connection between the evidence presented and the Service's decision."[59]

Section 4(f) of the ESA mandates that the FWS and National Marine Fisheries Service develop recovery plans "for the conservation and survival of threatened species," with priority given to those species "most likely to benefit" from a recovery plan, "particularly those species that are, or may be, in conflict with construction or other development projects or other forms of economic activity."[60] In laymen's terms, the plan provides a detailed map of how the species will recover, setting out necessary steps such as identification of important habitat and management of the habitat to ensure recovery.

Section 7(a)(2) of the ESA requires federal agencies to consult with the FWS before authorizing, funding, or carrying out any actions that would be likely to "jeopardize the continued existence" of a species or "result in the destruction or adverse modification of [the critical] habitat of such species."[61]

Section 9(a)(1) of the ESA provides that it is unlawful for all "persons"—federal, state or local government, corporation, or private

53. *See id.* at 481.

54. 5 U.S.C. § 706(2)(A) (2000).

55. Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins., 463 U.S. 29, 43 (1983) (citations omitted).

56. *Hodel*, 716 F. Supp. at 482.

57. *Id.* at 483 (citation omitted).

58. *Id.*

59. *Id.*

60. 16 U.S.C. § 1533(f)(1)(a) (2000).

61. *Id.* § 1536(a)(2).

entity—to take an endangered species of fish or wildlife.[62] Thus, absent a special permit, it is unlawful for any person to import or export, offer for sale, or take an endangered species. Specific intent is not required, nor is knowledge of the law a prerequisite for civil or criminal liability. Section 3(19) of the ESA, however, defines "take" more broadly than simply capture, killing, or attempting to do so: "[t]he term 'take' means to harass, harm, pursue, hunt, shoot, wound, kill, trap, capture, or collect, or attempt to engage in any such conduct."[63]

The Secretary of the Interior may issue an "incidental take permit" which would allow for "any taking otherwise prohibited by section 1538(a)(1)(B) of this title if such a taking is incidental to, and not the purpose of, the carrying out of an otherwise lawful activity."[64] However, the issuance of such a permit is contingent on the "applicant . . . submit[ting] to the Secretary a conservation plan."[65] This is commonly, although not statutorily, referred to as a "Habitat Conservation Plan."[66] Such a plan must contain:

> (i) the impact which will likely result from such taking; (ii) what steps the applicant will take to minimize and mitigate such impacts, and the funding that will be available to implement such steps; (iii) what alternative actions to such taking the applicant considered and the reasons why such alternatives are not being utilized; and (iv) such other measures that the Secretary may require as being necessary or appropriate for the purposes of the plan.[67]

Nonetheless, "[d]espite the potential benefits of habitat conservation planning, from 1982 to 1991 only eleven Habitat Conservation Plans ("HCPs") were approved by the Fish and Wildlife Service."[68] "Thus, in the first ten years of habitat conservation planning, the number of plans developed and implemented was wholly inadequate to alleviate the ever-burgeoning tensions created by the growing number of listed species."[69]

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62. *Id.* § 1538(a)(1)(B).
63. *Id.* § 1532(19).
64. *Id.* § 1539(a)(1)(B).
65. *Id.* § 1539(a)(2)(A).
66. Loggerhead Turtle v. Council of Volusia City, 148 F.3d 1231, 1238 n.8 (11th Cir. 1998).
67. 16 U.S.C. §1539(a)(2)(A) (2000).
68. Eric Fisher, *Habitat Conservation Planning Under the Endangered Species Act: No Surprises & the Quest for Certainty*, 67 U. COLO. L. REV. 371, 373 (1996).
69. *Id.* at 374.

In response to these concerns, Secretary of the Interior, Bruce Babbitt, promulgated the "No Surprises" policy, which was designed to afford landowners greater certainty about any HCP.[70] The "No Surprises" policy provides:

> [R]egulatory assurances to the holder of a Habitat Conservation Plan (HCP) incidental take permit issued under section 10(a) of the ESA that no additional land use restrictions or financial compensation will be required of the permit holder with respect to species covered by the permit, even if unforeseen circumstances arise after the permit is issued indicating that additional mitigation is needed for a given species covered by a permit.[71]

B. ENDANGERED SPECIES JURISPRUDENCE

The power of the ESA became readily apparent with the United States Supreme Court's decision in *Tennessee Valley Authority v. Hill*.[72] Along a portion of the Little Tennessee River, the Tennessee Valley Authority ("TVA") began construction of the Tellico Dam in 1967, soon after Congress appropriated funding for its development.[73] The ESA was enacted approximately six years after construction on the dam commenced. The Tellico Dam was to be located a short distance from where the Little Tennessee River intersects with the Big Tennessee River.[74] A University of Tennessee ichthyologist, Dr. David Etnier, discovered a new species of perch, the snail darter, seven miles from the mouth of the Little Tennessee River.[75] The snail darter was formally listed as an endangered species on October 8, 1975.[76] Additionally, "the Secretary [of the Interior] declared the area of the Little Tennessee which would be affected by the Tellico Dam to be the 'critical habitat' of the snail darter."[77] Environmental groups and an enterprising University of Tennessee law student, Hiram Hill, brought an action under the ESA to enjoin TVA from completing Tellico

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70. 63 Fed. Reg. 8859 (Feb. 23, 1998) (codified as amended at 50 C.F.R. pt. 17 and 50 C.F.R. pt. 222).

71. *Id.*

72. 437 U.S. 153 (1978).

73. *Id.* at 157 (citation omitted).

74. *Id.*

75. *Id.* at 158.

76. *Id.* at 161 (citations omitted).

77. *Id.* at 162 (citations omitted).

Dam and impounding that portion of the Little Tennessee River. The Court held that the ESA prohibited completion of Tellico Dam as this would extinguish the known population of the snail darter and destroy its critical habitat.[78]

Despite the fact that construction of the Tellico Dam commenced six years prior to the enactment of the ESA, that Congress had incurred approximately $53 million in "non-recoverable obligations,"[79] and even though Congress continued to appropriate millions of dollars for the project after the congressional appropriations committee had been informed of the project's anticipated impact on the snail darter,[80] the United States Supreme Court held that the ESA prohibited completion of the project. The Court noted that with the enactment of the ESA, "Congress intended endangered species to be afforded the highest of priorities."[81] The Court also emphasized that "[t]he plain intent of Congress in enacting this statute was to halt and reverse the trend toward species extinction, whatever the cost."[82]

The *Tennessee Valley Authority v. Hill* decision caused substantial congressional commotion and can be seen as the driving force behind the 1978 amendments to the ESA. These amendments required the Secretary of the Interior to consider the economic impact of a designation as critical habitat.[83] Additionally, these amendments enabled the FWS to decline to designate critical habitat if it is "not prudent" to do so or is not "readily determinable."

Another case which demonstrates the possible impact of the ESA is *Palila v. Hawaii Department of Land & Natural Resources*.[84] In this case, Hawaii's Department of Land & Natural Resources introduced mouflon sheep to the slopes of Mauna Kea on the Island of Hawaii for the "enjoyment of sport hunters."[85] These sheep fed on the shoots and seedlings of the mamane woodlands, the only trees in which the palila, an endangered species of bird, nest.[86] The "presence" of the sheep "harmed"[87]

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78. 437 U.S. at 172-73.
79. *Id.* at 166 (citation omitted).
80. *See id.* at 163-64.
81. *Id.* at 174.
82. *Id.* at 184.
83. 16 U.S.C. § 1533(b)(2) (2000).
84. Palila v. Haw. Dep't of Land & Natural Res., 852 F.2d 1106 (9th Cir. 1988).
85. *Id.* at 1107.
86. *Id.* at 1107 n.2.
87. The Secretary's then new definition of "harm" read: "'*Harm* in the definition of 'take' in the [Endangered Species] Act means an act which actually kills or injures wildlife. Such act may include significant habitat modification or degradation where it actually kills

the palila as the mamane woodland could not regenerate and the palila population "could not recover to the point where it could be removed from the Endangered Species list."[88]

Environmental groups brought an action seeking to require the State of Hawaii to remove the sheep from the habitat of the bird, arguing that the presence of the sheep was tantamount to a taking under §9 of the ESA.[89] Notably, there was no direct harm being inflicted on an identifiable bird. Rather, the breeding habits of the palila were being interrupted, limiting the number of new palila born. The court indicated that "[w]hile promulgating a revised definition of harm, the Secretary noted that harm includes not only direct physical injury, but also injury caused by impairment of essential behavior patterns via habitat modification that can have significant and permanent effects on listed species."[90] The court thus concluded that "[i]f the 'harassment' form of taking includes activities so remote from actual injury to the bird as birdwatching, then the 'harm' form of taking should include more direct activities, such as the mouflon sheep preventing any mamane from growing to maturity."[91]

In *Portland Audubon Society v. Babbitt*[92] ("*Babbitt*"), the Portland Audubon Society ("PAS") and other environmental groups brought an action seeking declaratory injunctive relief to protect the habitat of the northern spotted owl. Specifically, PAS challenged the Secretary of the Interior's "decision not to supplement Timber Management Plans ("TMPs") prepared between 1979 and 1983 with new information concerning the effect of those plans on the northern spotted owl."[93] PAS argued that the decision not to perform a new Environmental Impact Statement[94] ("EIS") while allowing Bureau of Land Management ("BLM") sales of timber from spotted owl habitat violated the National Environmental Policy Act[95] ("NEPA").[96] In reaching its decision, the

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or injures wildlife by significantly impairing essential behavioral patterns, including breeding, feeding, or sheltering." 50 C.F.R. § 17.3 (2003).

88. *Palila*, 852 F.2d at 1107 (citing Palila v. Haw. Dep't of Land & Natural Res., 649 F. Supp. 1070 (D. Haw. 1986)).

89. *Id.*

90. *Id.* at 1108 (citation omitted).

91. *Id.* at 1108-09.

92. 998 F.2d 705 (9th Cir. 1993).

93. *Id.* at 707.

94. *See* 42 U.S.C. § 4332(C)(i) (2000). *See also*, 40 C.F.R. § 1502 (2003).

95. 42 U.S.C. §§ 4321-47 (2000).

96. NEPA § 102 provides that "[t]he Congress authorizes and directs that, to the fullest extent possible: (1) the policies, regulations, and public laws of the United States shall be interpreted and administered in accordance with the policies set forth in the chapter, and (2) all agencies of the Federal Government shall— . . . (C) include in every recommendation or

Court of Appeals for the Ninth Circuit noted that "[a]t the very least, the body of scientific evidence available by 1987 concerning the effect of continued logging on the ability of the owl to survive as a species raised serious doubts about the BLM's ability to preserve viability options for the owl if logging continued at the rates and in the areas authorized by the TMPs."[97] The court determined that "[a] supplemental EIS should have been prepared because the scientific evidence available to the Secretary in 1987 raised significant new information relevant to environmental concerns, information bearing on the impact arising from the ongoing implementation of the land use decisions driven by the original TMPs."[98] Reasoning that "if we were to allow the BLM to continue to log in owl habitat pursuant to the old plans, pending finalization of the new Resource Management Plans, we would sanction the BLM's deliberate, protracted refusal to comply with applicable environmental laws, and countenance irreparable harm to plaintiffs," the Court of Appeals for the Ninth Circuit held that the decision not to order a new EIS was a violation of NEPA and that the district court's remedy of injunctive relief was proper.[99]

In *Seattle Audubon Society v. Espy*[100] ("*Seattle Audobon*"), filed concurrently with *Babbitt*,[101] the Seattle Audubon Society ("SAS") and other environmental groups brought an action to challenge the legality of an EIS issued by the United States Forest Service ("USFS") and the Record of Decision ("ROD") issued by the assistant secretary of agriculture with respect to the USFS proposal to sell logging rights in the national forest habitat areas of the northern spotted owl. The first hurdle faced by SAS was to establish standing to bring the action. In *Lujan v. Defenders of Wildlife*[102] ("*Lujan*"), the United States Supreme Court held that in order to establish standing a plaintiff must have suffered an "injury in fact"—an invasion of a legally-protected interest which is (a) concrete and

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report on proposals for legislation and other major Federal actions significantly affecting the quality of the human environment, a detailed statement by the responsible official on—(i) the environmental impact of the proposed action, (ii) any adverse environmental effects which cannot be avoided should the proposal be implemented, (iii) alternatives to the proposed action, (iv) the relationship between local short-term uses of man's environment and the maintenance and enhancement of long-term productivity, and (v) any irreversible and irretrievable commitments of resources which would be involved in the proposed action should it be implemented." *Id.* § 4332.

97. *Portland*, 998 F.2d at 708 (citation omitted).

98. *Id.* (multiple citations omitted).

99. *Id.* at 709-10.

100. 998 F.2d 699 (9th Cir. 1993).

101. *Portland*, 998 F.2d at 708.

102. 504 U.S. 555 (1992).

particularized; and (b) "actual or imminent, not 'conjectural' or hypothetical."[103] Additionally, there must be a "causal connection between the injury and the conduct complained of—the injury has to be fairly...trace[able] to the challenged action of the defendant, and not...th[e] result [of] the independent action of some third party not before the court."[104] Finally, it must be "'likely' as opposed to merely 'speculative' that the injury will be 'redressed by a favorable decision.'"[105] The USFS argued that as it had not yet authorized a specific timber sale pursuant to the plan, that its adoption of the spotted owl management plan was not ripe for review as there was no imminent injury to a SAS member as required under *Lujan*.[106] The Court of Appeals for the Ninth Circuit determined that:

> It is clear that the declarants have been using and will continue to use forest lands suitable for owl habitat on a regular basis. Moreover, absent an injunction, the Forest Service intends to develop and offer for auction timber sales throughout and around the old-growth forest ecosystem. There does not appear to be any dispute over whether further logging in old-growth forests will adversely affect the remaining owl population throughout its range. Thus the asserted harm SAS members complain of will occur if logging takes place.[107]

Thus, the Court concluded that SAS had standing to pursue its claims. The EIS of the USFS was deficient in that it "did not address in any meaningful way the various uncertainties surrounding the scientific evidence upon which the ISC [Interagency Scientific Committee Report] rested."[108] The court went on to note that "[i]t would not further NEPA's aims for environmental protection to allow the Forest Service to ignore reputable scientific criticisms that have surfaced with regard to the once "model" ISC Strategy.[109] Thus, the court held that "[b]ecause the Forest Service's EIS rests on stale scientific evidence, incomplete discussion of environmental effects vis-à-vis other old growth dependent species and

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103. *Lujan*, 504 U.S. at 560 (multiple citations omitted).
104. *Id.* (citation & internal quotations omitted).
105. *Id.* at 561 (citation omitted).
106. *Seattle Audobon*, 998 F.2d at 702.
107. *Id.* at 703.
108. *Id.* at 704 (citation omitted).
109. *Id.* (citation omitted).

false assumptions regarding the cooperation of other agencies and application of relevant law, the district court did not err in concluding that the Forest Service must re-examine its chosen alternative."[110]

In *Strahan v. Coxe*,[111] the plaintiff, Richard Strahan, filed suit against Trudy Coxe, the Secretary of the Massachusetts Executive Office of Environmental Affairs, among others, claiming that these state officers were violating the ESA and the Marine Mammals Protection Act (MMPA) by issuing licenses and permits authorizing gillnet and lobster pot fishing. Strahan argued that the fishing gear was entangling endangered Northern Right whales and killing them.[112] Strahan sought an injunction ordering Massachusetts to revoke said licenses and barring the state from issuing such licenses in the future unless it received "incidental take" and "small take" permits from the National Marine Fisheries Service ("NMFS") under the ESA and MMPA.[113] "The district court found, based on statements made by defendants as well as affidavits from three scientists, that Northern Right whales have been entangled in fixed fishing gear in Massachusetts coastal waters at least nine times."[114] The Court of Appeals for the First Circuit concluded that "the district court properly found that a governmental third party pursuant to whose authority an actor directly exacts a taking of an endangered species may be deemed to have violated the provisions of the ESA."[115] In so holding, the Court of Appeals for the First Circuit expressly indicated that the ESA not only prohibits the acts of those parties that directly exact a taking, but also bans the acts of a third party that bring about the acts that result in a taking. After the defendants attempted to analogize the licensure of this fishing gear to the licensure of a motorist (who has the potential to use this license as a means to rob a bank and make a "get away"), the court indicated that "whereas it is possible for a person licensed by Massachusetts to use a car in a manner that does not risk the violations of federal law suggested by the defendants, it is not possible for a licensed commercial fishing operating to use its gillnets or lobster pots in the manner permitted by the commonwealth without the risk of violating the ESA by exacting a taking."[116]

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110. *Id.* at 704-05.
111. 127 F.3d 155 (1st Cir. 1997), *cert. denied*, 525 U.S. 830 (1998).
112. *Id.* at 158.
113. *Id.*
114. *Id.* at 159 (citing Strahan v. Coxe, 939 F. Supp. 963, 984 (D. Mass. 1996)).
115. *Id.* at 163.
116. *Id.* at 164.

In *Loggerhead Turtle v. Council of Volusia City*,[117] Volusia County, Florida ("the County") was held to have violated ESA § 9 by providing "'harmfully' inadequate regulation of artificial beachfront lighting in the non-party municipalities."[118] The plaintiffs contended that artificial beachfront light sources were disorienting newly-hatched turtles who mistook the lights for moonlight reflecting off of the ocean. Instinctively heading toward the brightest light source which, on an undeveloped beach, is the moonlight, these turtles instead crawled inland to the artificial lights where they met certain demise.[119]

Although the County obtained an incidental take permit, it did not explicitly mention that the turtles may be taken as a result of beachfront lighting.[120] Reasoning that "the incidental take permission must be express and activity specific,"[121] the Court of Appeals for the Eleventh Circuit held that the incidental take permit obtained by the County did not authorize the taking of turtles by way of artificial beachfront lighting.[122]

Emphasizing that the County possessed "primary authority to regulate artificial beachfront lighting county-wide" the Court of Appeals for the Eleventh Circuit held that the plaintiffs displayed "a sufficient causal connection to seek to hold Volusia County liable for 'harmfully' inadequate regulation of artificial beachfront lighting in the non-party municipalities."[123] While the plaintiffs also contended that they also had standing to seek to hold the County liable for the inadequate enforcement of lighting regulations of two towns within the County, the Court of Appeals for the Eleventh Circuit held that they did not have such standing.[124] However, the Eleventh Circuit did emphasize that "[t]his absence of *enforcement* control on Volusia County's part, however, does not defeat the Turtles' standing to sue for inadequate *regulation*, the Turtles' core theory of causation in these two municipalities."[125] Thus, state and local governments may be determined to be liable under the ESA for their regulatory actions or inaction if it allows or enables the taking of an endangered species by a private party.

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117. 148 F.3d 1231 (11th Cir. 1998).
118. *Id.* at 1249.
119. *Id.* at 1235.
120. *Id.* at 1240.
121. *Id.* at 1242.
122. *Id.* at 1246.
123. *Loggerhead Turtle*, 148 F.3d at 1249.
124. *Id.* at 1250.
125. *Id.*

In *Babbitt v. Sweet Home Chapter of Communities for a Great Oregon*,[126] the plaintiffs were individuals who were allegedly dependent on the forest products industry. The plaintiffs brought an action against the Secretary of the Interior (the "Secretary") and the FWS director, challenging the Secretary's definition of "harm" within the meaning of the ESA provision defining "take." The Secretary promulgated a regulation defining "harm" to include "significant habitat modification or degradation where it actually kills or injures wildlife."[127] The plaintiffs contended that the Secretary should have limited the definition of "harm" to "direct applications of force."[128] The United States Supreme Court held that the Secretary's definition of "harm," within the meaning of the ESA provision defining "take," was reasonable.[129]

The Court considered there to be three reasons for this determination. First, the "ordinary understanding of the word 'harm' supports it."[130] The dictionary definition of "harm" did not include the suggestion of a direct application of force.[131] The Court reasoned that "unless the statutory term 'harm' encompasses indirect as well as direct injuries, the word has no meaning that does not duplicate the meaning of other words that § 3 uses to define 'take.'"[132] Second, the underlying purpose "of the ESA supports the Secretary's decision to extend protection against activities that cause the precise harms Congress enacted the statute to avoid."[133] Finally, "the fact that Congress in 1982 authorized the Secretary to issue permits for takings that § 9(a)(1)(B) would otherwise prohibit, 'if such taking is incidental to, and not the purpose of, the carrying out of an otherwise lawful activity,' 16 U.S.C. § 1539 (a)(1)(B), strongly suggests that Congress understood § 9(a)(1)(B) to prohibit indirect as well as direct takings."[134] The Court noted that "[n]o one could seriously request an 'incidental' take permit to avert § 9 liability for direct, deliberate action against a member of an endangered or threatened species, but respondents would read 'harm' so narrowly that the permit procedure would have little more than that absurd purpose."[135]

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126. 515 U.S. 687 (1995).

127. 50 C.F.R § 17.3 (2004).

128. Babbitt v. Sweet Home Chapter of Cmtys. for a Great Oregon, 515 U.S. 687, 697 (1995).

129. *Id.*

130. *Id.*

131. *See id.*

132. *Id.* at 697.

133. *Id.* at 698.

134. *Babbitt*, 515 U.S. at 700.

135. *Id.* at 700-01.

II. TAKINGS JURISPRUDENCE

The Takings Clause of the Fifth Amendment stipulates that private property may not be taken for a public purpose without "just compensation."[136] This is made applicable to the states through the Fourteenth Amendment.[137] The United States Supreme Court has been unable to develop any "set formula" for determining when "justice and fairness" require that economic injuries caused by public action be compensated by the government, rather than remain disproportionately concentrated on a few people.[138] In fact, on more than one occasion, the Court has observed that whether a particular restriction will be rendered invalid by the government's failure to pay for any losses proximately caused by it depends largely "upon the particular circumstances [in that] case."[139] However, the Court has identified some factors that have particular significance. Of particular importance are the economic impact of the regulation on the claimant and the extent to which the regulation has interfered with distinct investment-backed expectations.[140] However, "[g]overnment hardly could go on if to some extent values incident to property could not be diminished without paying for every such change in the general law."[141]

The notion of a regulatory taking was first heard by the United States Supreme Court in *Pennsylvania Coal Co. v. Mahon.*[142] In that case, a Pennsylvania statute, the Kohler Act, prohibited "the mining of anthracite coal in such a way as to cause the subsidence of, among other things, any structure used as a human habitation."[143] With respect to the facts of the case, the statute was "admitted to destroy previously existing rights of property and contract."[144]

Although the Court noted that "[a]s long recognized some values are enjoyed under an implied limitation and must yield to the police power."[145] The Court went on to note, however, that it was obvious that "the implied

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136. U.S. CONST. amend. V.

137. U.S. CONST. amend. XIV; *See* Chicago Burlington and Quincy R.R. Co. v. City of Chicago, 166 U.S. 226, 233-34 (1897).

138. *See* Goldblatt v. Hempstead, 369 U.S. 590, 594 (1962).

139. United States v. Cent. Eureka Mining Co., 357 U.S. 155, 168 (1958); *See* United States v. Caltex, Inc., 344 U.S. 149, 156 (1952).

140. *See Goldblatt*, 369 U.S. at 594.

141. Penn. Coal Co. v. Mahon, 260 U.S. 393, 413 (1922).

142. *Id.* at 412-13.

143. *Id.*

144. *Id.* at 413.

145. *Id.*

limitation must have its limits, or the contract and due process clauses are gone. One fact for consideration in determining such limits is the extent of the diminution. When it reaches a certain magnitude, in most if not in all cases there must be an exercise of eminent domain and compensation to sustain the act."[146] Consequently, the Court held that "while property may be regulated to a certain extent, if regulation goes too far it will be recognized as a taking."[147] The Court reasoned that when the protection against takings without just compensation was "found to be qualified by the police power, the natural tendency of human nature is to extend the qualification more and more until at last private property disappears."[148]

In *Penn Central Transportation Co. v. City of New York*,[149] the owner of Grand Central Terminal, Penn Central Transportation Co., brought suit against the city of New York following the refusal of the New York City Landmarks Preservation Commission to approve plans for the construction of a fifty-story office building over the terminal (which had been designated a "landmark"). The suit alleged, *inter alia*, that the application of the landmarks preservation law constituted a "taking" of the property without "just compensation" and "arbitrarily deprived [the owners] of their property without due process of law . . . ."[150]

The plaintiffs argued that the airspace above the terminal is a valuable property interest and the restrictions placed on the property by the "Landmarks Law has deprived them of any gainful use of their 'air rights' above the [t]erminal . . . ."[151] Ostensibly separating the "air rights" stick from their bundle of property rights, the plaintiffs contended that the City thus took their right to the airspace above the terminal, entitling them to just compensation. The Court, however, disagreed, noting that "'[t]aking' jurisprudence does not divide a single parcel into discrete segments and attempt to determine whether rights in a particular segment have been entirely abrogated."[152]

The plaintiffs also argued that the Landmarks Law effected a taking because its enforcement significantly diminished the value of the terminal.[153] The Court again disagreed, stating that the plaintiff's "position appears to be that the only means of ensuring that selected owners are not

146. *Id.*
147. *Penn. Coal*, 260 U.S. at 415.
148. *Id.*
149. 438 U.S. 104 (1978).
150. *Id.* at 119.
151. *Id.* at 130.
152. *Id.*
153. *Id.* at 131.

singled out to endure financial hardship for no reason is to hold that any restriction imposed on individual landmarks pursuant to the New York City scheme is a 'taking' requiring the payment of 'just compensation.'"[154] The Court concluded that "[a]greement with this would, of course, invalidate not just New York City's law, but all comparable landmark legislation in the Nation."[155] The Court was unwilling to do this.[156]

Reasoning that the present uses of the terminal were not affected by the Landmarks Law, the Court concluded that the law allowed the plaintiffs to profit from the terminal and to make a "reasonable return" on their investment.[157] The Court thus held that the Landmarks Law was not a "taking" of the plaintiff's property.[158]

In *Lucas v. South Carolina Coastal Council*,[159] the owner of beachfront property brought suit contending that the application of the South Carolina Beachfront Management Act to his property constituted a taking without just compensation. Lucas purchased two residential waterfront lots with the intention of erecting single family homes.[160] The Beachfront Management Act prevented him from undertaking such construction.[161] The trial court determined that this restriction "render[ed] [the parcels] valueless."[162]

The United States Supreme Court utilized a categorical rule to determine whether regulatory action has effected a "taking." Thus, the Court did not perform a "case-specific inquiry into the public interest advanced in support of the restraint."[163] The Court held that "where a regulation denies all economically beneficial or productive use of land," a taking has occurred.[164] The Court was unmoved by the argument that "'harmful or noxious uses' of property may be proscribed by government regulation without the requirement of compensation."[165] The Court stated that "the legislature's recitation of a noxious-use justification cannot be the basis for departing from our categorical rule that total regulatory takings

154. *Id.*
155. *Penn. Cent.*, 438 U.S. at 131.
156. *Id.*
157. *Id.* at 136.
158. *Id.* at 138.
159. 505 U.S. 1003 (1992).
160. *Id.* at 1008.
161. *Id.* at 1007 (citation omitted).
162. *Id.* at 1009 (citation omitted).
163. *Id.* at 1015.
164. *Id.* (multiple citations omitted).
165. *Lucas*, 505 U.S. at 1022.

must be compensated."[166] The Court reasoned that "[i]f it were, departure would virtually always be allowed."[167] The Court did create an exception, however, in which the state "may resist compensation only if the logically antecedent inquiry into the nature of the owner's estate shows that the proscribed use interests were not part of his title to begin with."[168]

In *Tahoe-Sierra Preservation Council, Inc. v. Tahoe Regional Planning Agency*,[169] the Tahoe-Sierra Preservation Council, an association of landowners, brought suit against the Tahoe Regional Planning Agency ("TRPA"). Land development around the Lake Tahoe Basin caused increased runoff into the lake and was turning the blue waters of the lake green.[170] Thus, the TRPA instituted a temporary moratorium on development around the lake while formulating a comprehensive land-use plan for the area.[171] The Tahoe-Sierra Preservation Council argued that this moratorium represented a taking without just compensation. The district court determined that the owners had been "temporarily deprived of 'all economically viable use of their land.'"[172] Although the Court had previously held that a regulation which permanently deprives an owner of all economically beneficial use of land is a categorical taking,[173] it had not yet made a ruling as to whether a temporary deprivation constituted a categorical taking as well.

The United States Supreme Court held that a temporary deprivation of all economically valuable use of a property by a regulation is not a categorical taking.[174] Thus, rather than establish a new categorical rule, the Court decided that "the better approach to claims that a regulation has effected a temporary taking 'requires careful examination and weighing of all the relevant circumstances.'"[175] The Court explained that "[a]n interest in real property is defined by the metes and bounds that describe its geographic dimensions and the term of years that describes the temporal aspect of the owner's interest."[176] Thus, "a fee simple estate cannot be

166. *Id.* at 1026.
167. *Id.*
168. *Id.* at 1027.
169. 535 U.S. 302 (2002).
170. *Id.* at 307-08.
171. *Id.* at 311-12.
172. *Id.* at 316 (citing Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency, 34 F. Supp. 2d 1226, 1245 (D. Nev. 1999)).
173. *See generally Lucas*, 505 U.S. at 1003.
174. *See Tahoe-Sierra Pres. Council, Inc.*, 535 U.S. at 342.
175. *Id.* at 335 (citing Palazzolo v. R.I., 533 U.S. 606, 636 (2001) (O'Connor, J., concurring)).
176. *Id.* at 331-32.

rendered valueless by a temporary prohibition on economic use, because the property will recover value as soon as the prohibition is lifted."[177] The Court further reasoned that "[a] rule that required compensation for every delay in the use of property would render routine government processes prohibitively expensive or encourage hasty decision-making."[178] Under such a "broad submission," compensation would be due in instances of "orders temporarily prohibiting access to crime scenes, businesses that violate health codes, [and] fire-damaged buildings . . . ."[179] The Court was unwilling to go to such an extreme.

III. ENDANGERED SPECIES INSURANCE OVERVIEW

An extensive search of products offered by insurance companies has resulted in no major carriers offering insurance for commercial or residential land use where there is the potential to discover an endangered species on the property. There are likely several reasons for this absence. First, and perhaps most logically, no one has thought to offer such a type of insurance. The ESA is a relatively recent statute and, hence, enforcement measures that affect private and corporate landowners are only recently receiving a substantial degree of notoriety. Second, it is likely that there would be difficulties predicting losses, so setting premiums would be very complicated. Specifically, it would be difficult to account for the determination that would be reached with a Habitat Conservation Plan (although the "No Surprises" Policy may reduce this uncertainty to some extent). Insurance companies would be justifiably apprehensive about offering coverage for a risk they could not properly account for. Third, many commercial land owners (such as paper companies) self-insure because they hold vast tracts of land and the premiums for all of this land would be astronomical. This indicates that the market for this type of insurance would be limited and, thus, cost-spreading would be significantly more difficult as there would not be a large enough population paying premiums. Fourth, it would be problematic to factor in the insurer's participation in the development of a Habitat Conservation Plan for commercial or residential property owners. Many people are only recently becoming aware of the power of the statute and the potential impact it can have on their intended use of their property. Similarly, reporting on how the ESA and similar statutes affect residential and commercial landowners

177. *Id.* at 332.
178. *Id.* at 335.
179. *Id.*

is only recently becoming more widespread. While the participation of an insurance company in the process of developing and implementing a Habitat Conservation Plan may be welcome news for unsophisticated property owners, it may also be seen as an uninvited intrusion by an outside party. Finally, it remains unsettled how the insurance policy would be impacted by a landowner's takings claim.

As mentioned above, the ESA is a relatively recent statute and its effects on land use are only now becoming a risk people feel they may need to insure against. Without a quantifiable or identifiable market to cater to, it would not be in an insurance company's best interest to incur the cost of developing and marketing such a product.

Insurance, like most other market segments, is a business.[180] An insurance company must generate revenues equal to or in excess of the expenses it incurs in order to remain in business over the long-term. Consequently, underwriting policies, accounting for risk, and predicting losses are critical factors for an insurance company's performance.[181] If there is a substantial degree of uncertainty or unpredictability associated with offering coverage for a particular type of risk or hardship, insurance companies would be justifiably apprehensive about offering a policy.[182] A company offering endangered species insurance would not only have to determine if there were listed species on the property, but also if there were any species on the property which have the potential to become listed. This is an exceptionally difficult assessment to make and, thus, accounting for and accurately predicting losses becomes complex. This problem is exacerbated by the difficulty associated with predicting how the eventual Habitat Conservation Plan would affect land use on the property. Due to the fact that each Habitat Conservation Plan is unique to the particular circumstances of a property and the endangered or threatened species on that property, it would be difficult to predict how a plan would affect land use until that plan was implemented. Additionally, the potential use of a "land swap" would also have to be factored into the eventual coverage equation.[183]

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180. *See generally,* JERRY, *supra* note 1, § 12, at 20 (discussing the regulation of the insurance industry as a business).

181. *See generally, id.* § 10 (discussing risk as it pertains to insurance).

182. It should be noted, however, that as "life is uncertain, calculating each person's expected loss with absolute precision is impossible." *Id.* at 15. Furthermore, were this absolute degree of precision possible on an "individual basis, insurance would not be necessary, since each person would know when loss would occur and then would take all necessary preventative measures, thereby eliminating the value of transferring risk." *Id.*

183. *See generally,* Evan Halper and Janet Wilson, *California Column One: A Sellout, or Just Practical?*, L.A. TIMES, Mar. 14, 2003, at A1 (discussing the controversy

As mentioned above, the potential market for endangered species insurance may be limited. Although recent jurisprudence suggests an increasing number of landowners may be affected by the ESA and the statutes and regulations passed to ensure compliance with its tenets, at the present moment most residential landowners are unaffected or unaware. This raises concerns about the potential for adverse selection.[184]

Adverse selection predicts that "[a]s the good risks begin to exit, the average quality of those insureds remaining falls and prices rise in a vicious circle, ending in a so-called 'death spiral' where no one is covered."[185] However, while concerns about adverse selection abound,[186] its importance to insurance markets appears to be "grossly exaggerated."[187] Specifically, evidence "strongly suggests that potential insureds—even if they have private information about factors that contribute to their riskiness—are unlikely to be able to turn that information into an accurate assessment of how much more or less risky than average they actually are."[188] "Individual insureds may perhaps have access to more information about themselves than their insurers do, but it is not the information itself that counts; it is the use to which it is put in making predictions about the future."[189] Furthermore, the "bald assumption" of the adverse selection model—that insurers cannot identify high-risk insureds from low-risk insureds[190]—is likely unrealistic as the insurance industry has been viable for a number of years and insurance companies continue to be profitable. "Propitious selection"[191] may also occur as those individuals who are highly risk averse take steps to reduce the risks they face and are more

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surrounding Dennis Murphy, the biologist who pioneered the use of land swaps that permit killing endangered species in one location in exchange for preservation elsewhere).

184. Adverse selection occurs when applicants for insurance possess substantially more information than insurers about the level of risk they pose. A disproportionate number of high-risk applicants then seek to obtain coverage (as they feel that the insurance is priced as a "bargain"), low-risk policy holders drop out of the pool (as they feel that the insurance is too expensive), and the cost of coverage rises. JERRY, *supra* note 1, §10, at 16.

185. Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1224 (2004).

186. *See id.*

187. *Id.* at 1274.

188. *Id.* at 1245.

189. *Id.* at 1247.

190. *Id.* at 1236.

191. "Propitious selection, as its name suggests, implies that insurance is most attractive to the lowest-risk individuals among those eligible to buy it, not to those with the highest risks. Of course, when only the best risks buy insurance, the profitability of insurers does not suffer, but is enhanced." *Id.* at 1266.

likely to insure against such risks.[192] Thus, it is reasonable to expect that insurance companies would develop the ability to predict and underwrite risk for endangered species insurance to the point where adverse selection is not a substantial economic concern.

Further diminishing the market for this insurance is the fact that many commercial land owners self-insure.[193] A prime example would be paper companies.[194] Although paper companies are greatly affected by the ESA, they own enormous tracts of land. Insuring this much land through a traditional insurance carrier would be quite expensive and, consequently, these companies self-insure rather than incur substantial premiums to insure against the risk of discovering endangered species on their property. Additionally, paper companies and large land holders tend to have substantial economic means and are more capable of absorbing losses than smaller landholders.[195] Without a sufficient number of policy holders over whom to spread the risk, insurance companies would often find themselves with substantial expenses for this insurance without commensurate revenues being generated. This scenario would bode poorly for the long-term viability of this type of insurance. However, due to the increasing attention that endangered species protection receives (as well as the hardships faced by property owners), it can reasonably be assumed that the market for endangered species insurance will expand as time passes. With an expansion in the potential number of policyholders, it would be possible to spread the risk efficiently. Additionally, as more and more people become covered under this type of insurance, it would help to reduce concerns about adverse selection.

As indicated above, if an endangered species is discovered on a policyholder's property, a Habitat Conservation Plan would be developed by both the landowner and the FWS. Given that the insurer would be liable

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192. *Id.* at 1266-67.

193. Rather than cope with a risk by transferring it to another entity (through insurance), a self-insured would assume the risk by themselves (likely taking measures to limit the probability of loss and limit the effects of loss). *See* JERRY, *supra* note 1, § 10, at 12.

194. *See* NEW JERSEY COMPENSATION RATING & INSPECTION BUREAU, 2003 ANNUAL REPORT (2004) (indicating in Table III that International Paper Company has been authorized to self-insure its obligations under the New Jersey Workers' Compensation Law since 1942) *available at* http://www.njcrib.com/annualreport/authorized2002.asp (last visited Apr. 9, 2005).

195. Given that "[a]n individual's attitude toward risk is influenced by several factors, including the probability of loss, the potential magnitude of the loss, and *the person's ability to absorb the loss*," it is reasonable to expect that the risk tolerance of paper companies and large landholders would be quite high. JERRY, *supra* note 1, § 10, at 13 (emphasis added). This would further increase their reluctance to purchase endangered species insurance.

for any losses associated with the implementation of such a plan, it is quite reasonable to expect that any insurance company would want to be intimately involved in the development of that plan. This would be relatively unexplored territory for the FWS and for the implementation guidelines under the ESA. As such, it would be difficult to determine when and how an insurance company would intervene and become a party to the development of a Habitat Conservation Plan. Likely, insurance companies would condition coverage upon allowing the insurance company to actively participate in the creation of a Habitat Conservation Plan. This would prevent landowners from attempting to block insurance company participation in the development process and would help to reduce moral hazard (as policyholders would have an incentive to diminish land use they did not particularly care about in an attempt to extract the maximum payment from the insurance company).

Finally, given the United States Supreme Court's holdings concerning regulatory takings, endangered species insurance would have to allow for the possibility of a constitutional takings claim. Although a successful takings claim would certainly be looked upon favorably by an insurance company, the delays associated with such litigation may pose a problem. Specifically, if a landowner is deprived of the use of his property for several years while the litigation is ongoing, that landowner is likely to immediately seek a payment from his insurer. If the insurer opts not to pay at this time, potential policyholders may be dissuaded from purchasing the insurance (as they would potentially have to wait years to receive the benefit of the policy). However, if an insurer pays immediately, it loses not only the value of that money, but also any investment income that money could have generated. Additionally, should the landowner fail to prevail in his or her regulatory takings claim, the insurance company would be faced with the very difficult task of reacquiring their money. The uncertainty associated with the fact specific, ad hoc inquiry of a takings claim[196] would be a tremendous roadblock for any insurance company looking to offer endangered species insurance.

196. Penn Cent. Trans. Co. v. City of New York, 438 U.S. 104, 124 (1978). *See also*, United States v. Cent. Eureka Mining Co., 357 U.S. 155, 168 (1958) (indicating that whether a particular restriction will be rendered a constitutional taking by the government's failure to pay for any losses proximately caused by it depends largely "upon the particular circumstances [in that] case.").

CONCLUSION

In conclusion, the above analysis indicates that endangered species insurance is a potentially beneficial form of risk spreading that is not currently offered by major insurance carriers. These benefits would be reaped by the federal government in the form of better enforcement measures and reduced intentional takes. This may reduce some of the litigation brought by environmental groups who claim that the enforcement measures are inadequate according to the ESA's standards (allowing them to allocate a greater percentage of their funding to actual enforcement measures instead of litigation). Furthermore, benefits would also accrue to policyholders who would not be unduly burdened by the "teeth" of the ESA. Finally, endangered species themselves would also benefit as the "Shoot it, Shovel it, and Shut up" mentality would be unnecessary as these landowners would be compensated for the reduction in their land use. Minimizing intentional takes is absolutely essential for the long-term success of the ESA and the long-term viability of endangered species.

While there are substantial public benefits to be reaped by the implementation of such an endangered species insurance plan, at the present moment insurance companies may consider there to be too much risk and uncertainty associated with underwriting such a policy. Without a more substantial degree of certainty regarding enforcement measures, Habitat Conservation Plans, and the discovery and listing of additional species, insurance companies would likely be apprehensive about offering endangered species insurance. However, given that the total value of an insured's property would represent the maximum potential liability for an insurer, the concerns about losses may be unfounded. Additionally, the ability of insurance companies to develop and implement successful assessment metrics for other forms of risk bodes well for the development of such metrics for endangered species insurance.

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

Edited by Matthew Fitzsimmons[*]

TERRORISM

Saul Levmore & Kyle D. Logue, *Insuring Against Terrorism -- And Crime*, 102 MICH. L. REV. 268 (2003).

This article analyzes the response of the United States government to the terrorist attacks of September 11, 2001 and examines the effects of the September 11th Victims' Compensation Fund and the Terrorism Risk Insurance Act of 2002. Initially, the authors recognize that the sheer enormity of the September 11th attacks created a political environment where compensation for the loss of human life was a necessity. The authors explain that the rebuilding of New York City's infrastructure and businesses, though an important and necessary undertaking, simply could not have been accomplished with at least some compensation for the loss of human life. As the authors posit, it would be politically impossible to justify expenditures to compensate for property loss but not the loss of human life. Thus, the authors agree that some sort of governmental intervention was needed after the terrorist attacks, but the particular type of subsidy chosen by Congress may not have been, according to the authors, the most effective approach.

The authors discuss the case for public and subsidized insurance covering terrorism risks and, ultimately, conclude that such a case is a particularly weak one. The authors assert that even if the United States were to adopt a permanent, routinized terror compensation system, the ad hoc response of the September 11th compensation regime would very likely materialize again (if indeed there were uninsured losses). The pressure to provide relief for large-scale terrorism losses, the authors contend, is simply too great to eschew the possibility of future compensation programs similar to the 9/11 Fund. Thus, the structure and permanency of terrorism-loss compensation will depend on whether there are serious changes in the war on terrorism.

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The authors next contrast the weak case for public and subsidized insurance covering terrorism risks, demonstrating the comparatively strong case for public insurance with respect to everyday crime. The authors note that many losses caused by crimes are uninsured, yet those losses are not generally subsidized or relieved by the government. The authors posit that, for a variety of reasons, governments more naturally internalize the costs of terrorism more than they do the costs associated with everyday crime. The main concern with government-subsidized crime insurance, according to the authors, is nothing more than a variation of the typical moral hazard problem: a crime insurance program would create an incentive to commit or tolerate crimes as payments for death or injury will result in increased deaths or injuries. The authors posit that the government may well be a better crime-fighter if it had a financial stake in crime-losses. Moreover, the authors assert that the underinsurance problem that seemed to have fueled the 9/11 Fund and terrorism insurance is greater for crime in impoverished areas than it is for terrorism in any area. However, the strong case for crime insurance has failed to gain political support, the authors state, and this is unsurprising. Victims of crimes are comparatively, if at all, sympathetic. The authors conclude that crime insurance is, for now, a thought experiment, though certainly one worth examining.

Richard R. Stedman, II, *Comment: Of Hurricanes and Airplanes: The Congressional Knee-Jerk Reaction to September 11*, 49 LOY. L. REV. 997 (2003).

In this comment, Stedman argues that Congress acted imprudently in passing the Terrorism Risk Insurance Act of 2002 ("TRIA"). Stedman asserts that, though TRIA was debated in Congress for over a year, the time for action had passed and their need for Congressional action had subsided by the time TRIA was passed. Stedman also argues that the taxpayer sees no direct benefit from the guarantee of indemnification on large construction projects that TRIA provides.

Stedman provides a brief overview of the insurance industry as background to the ultimate purpose of the paper, TRIA's inadequacy. Stedman next discusses the insurance industry's inadequate preparation for a disaster such as the September 11th attacks. Stedman posits there is simply a lack of data available for insurers to adequately estimate the likelihood and/or magnitude of a terrorist attack. As such, Stedman argues, insurers either exclude the threat losses related to terrorist attacks or charge excessive rates for coverage. All this, according to Stedman, served to stifle economic development because, after September 11th, banks would

not take on the risk of financing a potential terrorist target without insuring against potential loss due to a terrorist attack.

Stedman then discusses TRIA in detail, beginning with the first proposed bill and the ensuing debates. TRIA was signed by President Bush and enacted on November 26, 2002 and, Stedman argues, effectively designates the federal government as the re-insurer of the insurance industry against another catastrophic terrorist attack on the United States. Stedman relays that participation in the program by insurers is mandatory and that the bill invalidates all terrorism exclusions added to policies after September 11th. TRIA established a certification system whereby different officers within the federal government independently verify that a terrorist attack has in fact occurred. Once the certification is complete, federal funds become available once an insurer meets the minimum retention level, which acts almost like a deductible, Stedman states. There is also an aggregate retention level among all insurers, originally set at $10 billion, but increases throughout the life of the program. Stedman also states that the taxpayers pay for everything over the retention level, up to $100 billion, though this taxpayer money may be recouped by the Secretary of the Treasury utilizing his discretionary power under TRIA to recoup.

Stedman then examines the National Flood Insurance Program, which was intended to protect American citizens form the incalculable losses due to floods, and to aid the insurance industry by attempting to identify flood-prone areas and encourage insurers to create risk pools and diversify the risk posed by flooding. Stedman discusses the National Flood Insurance Program and asserts that its mitigation requirements are an active attempt to reduce the moral hazard of flood-prone new construction while at the same time providing the necessary insurance. Stedman then argues that one fatal flaw in TRIA is the complete lack of mitigation provisions similar to those in the National Flood Insurance Program. Stedman asserts that TRIA must include provisions requiring insurers, developers, or property owners to mitigate their risk exposure, as is required under the National Flood Insurance Program. Moral hazard and adverse selection are, according to Stedman, greatly increased because of TRIA's lack of mitigation provisions. Ultimately, Stedman concludes that TRIA will only benefit the insurance industry if the next catastrophic attack is comparable to September 11th. Thus, the addition of mitigation provisions would, according to Stedman, go a long way in making TRIA successful.

LIABILITY

Robert H. Jerry, II & Douglas R. Richmond. *The Insurance Aspects of Damages*, 2004 J. DISP. RESOL. 107 (2004).

The authors in this piece provide an examination of the insurance aspects of Barry Werth's *Damages: One Family's Legal Struggles in the World of Medicine* (1998). The story that *Damages* sets forth is that of Tony and Donna Sabia and their son Tony John Sabia ("Little Tony"). The story of the Sabias begins with Little Tony's birth and the discovery of his profound disabilities. The Sabias did not have health insurance and, the authors assert, had the family had health insurance, the events that Werth describes in *Damages* may never have occurred. That assertion notwithstanding, the authors relay that the Sabias, in order to pay for Little Tony's medical care, brought suit against the health care providers who attended Donna and Little Tony at the time of his birth. The central focus of this article was how insurance shaped and influenced the story of the Sabia family.

The authors begin their review of the Sabia story with the Sabias' lack of health insurance. The authors note that the United States is unlike most other industrialized nations in that the U.S. does not have universal health insurance and does not guarantee every citizen access to the health care system. The authors discuss the various routes through which an American citizen can acquire health insurance, noting that the Sabia family was unable to travel any of these routes. The authors state that Donna Sabia was one of the more than forty million Americans who do not have health insurance, which represents almost 20 percent of the United States' non-elderly population.

The authors next discuss different types of insurance (e.g., first-party and third-party insurance) and the relationships that are created with differing types of insurance. For example, the authors explore the relationship between liability insurers, such as malpractice insurers, and their insureds. The authors identify two distinct contractual duties owed an insured by their insurer: the duty to defend the insured against claims by third parties, and a duty to indemnify the insured with respect to claims covered by their policy. Upon setting forth these duties, the authors discuss how the relationship between the insurer and its insured plays out with regard to litigation. The authors note that liability policies typically give the insurer the right to control how the defense of a suit is conducted once the insurer undertakes the defense. The authors note that this gives the insurer the right to select counsel to defend the insured. This situation

thereby creates a conflict, the authors contend, because the defense counsel selected by the insurer often works at a discounted hourly rate in exchange for business volume, meaning that the insurer selects a particular defense attorney for many cases. The conflict lies in the defense attorney's duty to the insured, which is sometimes opposed to the interests of the fee-paying insurer. The contours of the debate as to whom defense counsel owes duties is left aside by the authors.

The authors next explain the various principles in insurance litigation and what interests each principle typically seeks to advance. After describing the underlying actors and their roles in the typical case, the authors turn to how the principles acted with respect to the Sabias story. Summarily, the authors state that the Sabias sued the attending physician for malpractice and when this happened, the physician wanted to retain her former counsel. The insurer selected one of its own preferred defense attorneys, which led the physician to hire her own personal lawyer of choice to monitor the case and assess the defense provided by the insurer's selected counsel. This, the authors point out, is not uncommon. Insurers often have the right to control the defense, but this right does not only affect the insured; it also affects the relationship between the insurer and defense counsel. The authors describe how defense counsel often serves, and in this case did serve, as a conduit for the insurer with counsel having little or no authority to perform various tasks, such as taking depositions without the insurer's consent. The authors state that the restrictions under which defense counsel operated in *Damages* are not atypical.

The authors also discuss the Sabias' claims against the hospital in which Little Tony's birth took place. The authors relay that the hospital was self-insured for $250,000, but had purchased an excess policy that provided financial protection beyond the self-insured retention. The excess policy provided a coverage limit of $15 million, while the physician's policy provided coverage up to $2 million. The authors state that the plaintiff offered to settle each claim for the respective coverage limits. The authors then discuss that this is a tactic often employed in litigation of this nature. The authors also discuss the tensions between the insured and the insurer and how those tensions affect settlement negotiations. Essentially, the authors posit that the excess insurer's exercise of its right to choose counsel led to a settlement in which the insured had no say over the settlement or its terms, which is also what occurred with respect to the physician.

The authors conclude that, as illustrated by Werth's *Damages*, insurance determines everything from whether tort claims are filed to how much plaintiffs ultimately recover. Insurance determined whom the Sabias

sued and, the authors contend, how much the Sabias recovered. The authors assert that had the physician and the hospital not had insurance, there is every reason to believe that no claim would have been filed by the Sabias. Thus, the authors conclude that, especially with respect to the Sabia family, insurance is important to an extent that simply cannot be overstated.

Anthony Heyes, Neil Rickman & Dionisia Tzavara, *Legal Expenses Insurance, Risk Aversion and Litigation*, 24 INT'L REV. L. & ECON. 107 (2004).

Legal expenses insurance is, the authors state, the dominant means of shifting risk in Europe. In this article, the authors analyze the effect of legal expenses insurance on litigation where the defendant is uninformed about the plaintiff's degree of risk aversion. Thus, the authors' analysis here is novel as it differs from previous studies where the setting was one of complete information and risk neutral. The authors observe that the procurement of legal expenses insurance has the effect of hardening plaintiffs' bargaining strategies, possibly leading to higher settlement offers. The authors find that plaintiffs will only purchase legal expenses insurance if they anticipate rejecting a settlement offer and, conversely, plaintiffs who plan to accept a settlement offer do not purchase the insurance.

The authors conclude that insurance brings about extra care by potential defendants. Additionally, the authors conclude that, although the effects of legal expenses insurance on the overall probability are ambiguous, there is a clear reduction if insurance increases settlement offers. In sum, the authors suggest that further research be done on legal expenses insurance because, admittedly, the authors clearly do not address all of the other issues involved. The authors identify conflicting forces when evaluating legal expenses insurance and indicate that further theoretical and empirical research be done to untangle these forces.

HEALTH

Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 205 (2004).

In this paper, Professors Marmor and Oberlander examine the state of health care reform in the United States. The authors state that, although the

issue of major health care reform fell off the political agenda after the failure of President Clinton's health plan, the familiar pressures of rising costs and growing numbers of uninsured have reopened the health care debate.

The authors next discuss the barriers to national health insurance, barriers not attendant to the passing of other legislation. The authors assert that simply having a President and a Congress share a party designation in no way guarantees the passing of health care legislation. If that were the case, the authors note, a national health insurance plan would have been enacted some fifty years ago. Another barricade to national insurance the authors identify is the structure of health politics in the United States. The authors note that there are several institutions that are heavily invested in maintaining the status quo. The institutions the authors describe are generally well-funded and well-organized while the forty-million uninsured and the numerous underinsured are generally disorganized and, as a result, certainly not well-funded. The third barrier the authors identify is public opinion. The authors contend that the public, though supportive of the general idea of national health insurance, is generally reluctant to support specific plans.

After discussing the health plans offered in the 2000 Presidential Election by George W. Bush and Al Gore, the authors offer and analyze three options for health reform, explaining both the benefits and problems with each option. The first option the authors identify is the "federalist option." In short, this option allows states to organize their own health care arrangements, thus allowing the emergence of multiple reform plans. The second option the authors offer is "the pincer strategy." This option is an incremental expansion of existing federal insurance sources for both children and working adults. The third and final option the authors analyze is the "single-payer plan." This plan is modeled after Canada's Medicare, which offers comprehensive coverage, accessible terms, public administration, and portability. Upon examining these three options, the authors move their discussion to the six lessons and strategies that they suggest should guide health reformers in 2004 and beyond. Ultimately, the authors concede that there is not a single plan that will invariably solve the health care problems in the United States, but the authors assert that the federalist option may prove to be the best choice.

Carolyn V. Juarez, Note, *Liberty, Justice and Insurance for All: Re-Imagining the Employment-Based Health Insurance*, 37 U. MICH. J.L. REFORM 881 (2004).

This article examines the history of employment-based health insurance and discusses the almost annual increase in the number of uninsured American citizens. Juarez contends that the number of uninsured Americans has reached crisis proportions. The American health insurance is primarily employment-based, but the number of uninsured still increases. Juarez argues that federal health insurance programs such as ERISA, Medicare, Medicaid, and S-CHIP have all failed to solve the problem. Though the United States spends an estimated $1.4 trillion on health care annually, which is about twice as much per person as any other industrialized nation, over 43 million people are still without health care coverage. Therefore, Juarez asserts, there needs to be an examination of the proposed reforms and a serious attempt made to remedy the predicament in which millions of American citizens find themselves.

After discussing the history of employment-based health insurance, which has been dominant since World War II, Juarez examines the failures of the federal government to fill the regulatory gaps and expand coverage. Juarez reviews the various federal attempts to cure the health insurance problem and sets forth the shortcomings of each attempt. Juarez notes that not only has each of the specific federal legislative attempts to close the regulatory gaps failed in its own right, but so has more comprehensive federal legislation, such as President Clinton's Health Security Act of 1993. Juarez then discusses state efforts to step in where the federal government has failed, namely the regulation of employment-based health insurance. Juarez notes that Hawaii is the only state that has enacted and implemented employer-mandated health care insurance. As a result of Hawaii's efforts, Juarez states that employment statistics worsened significantly in Hawaii and 60 percent of employers raised prices to offset the cost of the employer mandates. Thus, Juarez concludes, employer mandates are only part of an effective reform.

Hawaii's struggle with employer mandates notwithstanding, Juarez relays the attempt of California to address the growing number of uninsured in California. California's Health Insurance Act of 2003 will, according to legislative findings, help provide coverage to more than 80 percent of California's working uninsured and their families. The bill, however, has its flaws, Juarez argues. Though the California system has its upside and is a creative program, Juarez concludes that the system is flawed in much the same way as Hawaii's system, specifically that California's system only offers employer mandates. Juarez contends that any effective solution needs to combine these types of mandates with other programs an order to mitigate the detrimental effects that Juarez identifies. Thus, Juarez proposes that employer-based systems of health insurance, so

firmly rooted in American culture, need to be part of any health insurance reform. Juarez suggests a combination of employer mandates, refundable tax credits, and purchasing pools. Each of these parts of Juarez's proposal has been tried in various states and commentators have evaluated the potential of each, but Juarez advocates a combination of the three.

Robert Kaestner, *Publicly Provided Health Insurance for the Nonelderly Poor: Can We Save Money Safely?*, 2004 U. ILL L. REV. 91 (2004).

In this article, Kaestner examines publicly provided health care and, ultimately, offers policy recommendations to reduce spending on publicly provided health insurance for the nonelderly poor. In all, Kaestner estimates that his suggestions, if adopted by the government, can save $10 billion per year (and even more if his recommendations are applied to populations other than the nonelderly poor). Kaestner begins by discussing the positive and negative aspects of publicly provided health insurance. Kaestner notes publicly provided health insurance, though beneficial in many respects, engenders various negative consequences. The most important negative effect of publicly provided health insurance is the overuse of medical services because of an ex post moral hazard. Specifically, Kaestner asserts that since the cost to the publicly insured is zero, there is a great likelihood that insureds overuse medical care.

Kaestner next turns to estimating how much money can potentially be saved by addressing the problems he previously identified. Kaestner concludes that somewhere between $7.5 and $15 billion can be saved each year by reducing wasteful spending on inefficient care and limiting receipt of publicly provided insurance to truly needy families that would not otherwise be able to procure insurance. To achieve these savings, Kaestner offers several policy suggestions. First, to limit receipt of insurance to truly needy families, Kaestner proposes that the states set a maximum eligibility threshold of 200 percent of the Federal Poverty Level, with families between 150 and 200 percent paying monthly premiums and co-pays. Second, Kaestner recommends that states be able to cover a more limited range of services for groups where eligibility is not mandatory (such as near-poor children and adults), which would decrease the amount of inefficient care because demand for the limited services is elastic.

Additionally, Kaestner suggests the creation of medical savings accounts where 80 percent of current spending on outpatient services and prescription drugs would be allocated to these accounts and a portion of any unused funds would be returned to the family, thus creating an

incentive for recipients to use their funds wisely. Alternatively, Kaestner contends that a switch to federally mandated Medicaid managed care program will reduce costs without harmful effects. Kaestner also asserts that instituting medical savings accounts or switching to managed care would not adversely affect the physical and financial health of low-income families. Kaestner notes that both of these policy suggestions are based on providing incentives to ration the use of medical care. As a result, there are no adverse effects on the physical and financial health of low-income families because the savings come from the reduction in the consumption of marginally beneficial services. Thus, Kaestner concludes that the implementation of his policy suggestions would result in significant savings with insignificant to no adverse effects on low-income families.

Edwin Caldie, Note, *Medigap: Should Private Insurers Pay Public Rates and Who Should Make the Decision?*, 30 AM. J. L. & MED. 69 (2004).

In this article, Caldie examines the question of where to place the burden of rising healthcare costs with respect to Medigap policies. These policies, Caldie relays, are policies offered by private insurers to provide supplemental insurance to Medicare recipients who wish to expand their hospitalization coverage beyond the basic limits imposed by Congress. Caldie states that Medicare and Medigap insurers organize their payment systems by basing their per-day hospitalization payment rates on a particular patient's diagnosis. The diagnosis will fall into a category called a Diagnostic Related Group ("DRG"), which is a category that Medicare has established for certain diagnoses that have similar costs of treatment. Since Medicare has great leverage in negotiating the DRG rates because of the enormous amount of money Medicare pays to healthcare providers, the question often arises as to whether Medigap insurers should pay the low per diem rate that Medicare has negotiated, or negotiate their own rate. Caldie discusses the case of *Vencor Inc. v. Nat'l States Ins. Co.*, 303 F.3d 1024 (9th Cir. 2002), where the Ninth Circuit held that Medigap insurers are entitled to the low Medicare-negotiated rates, and posits that the Ninth Circuit's decision was legally and politically erroneous.

Caldie then sets the stage for his discussion of *Vencor* by discussing the current economic environment for health care, an environment where Americans are losing jobs and healthcare costs are continually rising. Caldie then discusses Medicare and Medigap policies, offering summaries of the origins and structure of each regime. Caldie next turns to a discussion of the *Vencor* case, beginning with the Ninth Circuit's analysis.

Caldie asserts that the Ninth Circuit was not alone in holding that a Medigap insurance provider was only obligated to pay the rates that Medicare would have paid for the same care. Caldie cites one case from the Eleventh Circuit Court of Appeals and one from the District Court for the Western District of Kentucky that have come to similar conclusions. As a contrast, Caldie discusses the analysis of the D.C. Circuit Court of Appeals in *Vencor, Inc. v. Physicians Mutual Ins. Co.*, 211 F.3d 1323 (D.C. Cir. 2000), where the D.C. Circuit held that Vencor could charge a patient more than the Medicare-negotiated rate for hospital care.

Caldie posits that the case before the 9th Circuit and the D.C. Circuit were factually similar, though the approach of the D.C. Circuit was superior. Caldie contends not only that the D.C. Circuit's legal analysis was superior, but also that, from a policy prospective, the D.C. Circuit's decision was sound while the Ninth Circuit's decision was dangerously uninformed and undemocratic. Primarily, Caldie contends that the federal court system is not the place to create new healthcare policy and allocate healthcare costs. The proper venue, Caldie stresses, is the legislature. Additionally, Caldie asserts that the D.C. Circuit recognized this basic assumption and for that reason, and others, the decision of the D.C. Circuit is superior to that of the Ninth Circuit in factually similar cases.

In sum, Caldie concludes that the Ninth Circuit's decision may have grievous consequences because of its erroneous analysis whereas the D.C. Circuit's decision rests on solid ground. The D.C. Circuit, according to Caldie, recognized that great care should be exercised in resolving the complex questions of healthcare policy and cost allocation. As such, the D.C. Circuit left certain historic assumptions in place: (1) that private insurers will negotiate their own rates; and (2) that Congress will make cost allocation decisions. A fatal flaw in the Ninth Circuit's analysis, Caldie sets forth, is the court's disregard of these two historic assumptions.

Ann Hilton Fisher, *Small Employers and the Health Insurance Needs of Employees with High Health Care Costs: A Need for Better Models*, 8 Employee RTS. & EMP. POL'Y J. 53 (2004).

In this article, Fisher examines the problem posed when employees with high cost health conditions seek health insurance from small employers. Fisher illustrates the problem presented with the story of Frank, a salesman for a family-owned printing company that has about forty-five full-time employees. When his employer's health plan came up for renewal, the employer learned that its monthly premiums would rise from $7,700 to $43,000 (from $171 per employee to $915 per employee per

month). The cause for the dramatic increase in insurance premiums, Fisher relays, was the fact that Frank had AIDS. Frank's costly health condition thus caused the insurance premiums for every employee to rise sensationally high. Fisher uses the story of Frank throughout the article to illustrate the problem that materializes when small employers are forced to decide how to handle an employee with a high cost condition.

Fisher provides a brief history of health insurance in the American workforce. Fisher traces the history of health insurance from before World War II, where most Americans lacked health insurance, through the 1970's, when multiple insurers offering an array of plans supplanted the once dominant local Blue-Cross/Blue-Shield plan. Fisher then briefly discusses how states regulate insurance, providing an overview of the discernible trends in insurance regulation. Fisher then turns to the federal laws that affect access to insurance. Fisher discusses ERISA, the ADA, the FMLA, COBRA, and HIPAA and examines how each federal initiative directly impacts the relationship between persons with disabilities, their employers, and insurance carriers.

Fisher next discusses the alternatives that are available when small employers like Frank's have confronted with radically increasing premiums caused primarily by an employee with high cost health conditions. One alternative Fisher identifies is creating larger groups to spread the risk and costs of the high health care cost employee across more than his own co-workers. Fisher discusses the efficacy of this alternative and examines various state programs that have attempted to accomplish such a spreading of risk. Fisher ultimately admits that, though attractive to small employers because of the assurance of stability, pool plans have not been proven to markedly increase the accessibility or affordability of insurance to employers. The second alternative Fisher discusses is regulating rates, which indirectly creates larger pools. Fisher asserts that regulating rates by, among other options, limiting the amount by which premiums can increase upon renewal may indirectly create larger risk pools, but this too has problems that ultimately have prohibited this alternative's widespread adoption. Finally, Fisher discusses the possibility of subsidizing the high health cost employee via government programs. Fisher discusses Medicaid buy-in programs and concludes that, mainly because of the strict cost-neutrality requirements of the federal buy-in laws, a relatively small number of states are including individuals that do not meet the very strict definition of a disabled individual for Medicaid.

Fisher concedes that none of the alternatives discussed do more than provide a small step towards ensuring access to health insurance for persons with high cost health conditions and their small employers. Fisher

also acknowledges that none of the programs would have helped Frank or his employer. Fisher stresses that the debate over health care must not continue to eschew the discussion of the issues of individuals with high health care costs working for small employers. Fisher argues that more attention needs to be paid to small employers and their high health care cost employees. Individuals like Frank and small employers, Fisher asserts, cannot be overlooked because the problems illustrated in Frank's story will only increase with time.

BAD-FAITH

Mark J. Browne, Ellen S. Pryor & Bob Puelz, *The Effect of Bad-Faith Laws on First-Party Insurance Claims Decisions*, 33 J. LEGAL STUD. 355 (2004).

The authors in this study examine how bad-faith laws affect insurers' claims settlement practices. The bad-faith laws essentially provide a cause of action in tort for an insurers' breach of the duty of good faith and fair dealing. Under this cause of action, the authors write, an insured can recover not only their economic losses caused by the breach, but also mental anguish and punitive damages. The authors here conduct an empirical study, one the authors say is the first of its kind, of the effect of bad-faith laws on claims decisions by insurance companies. The authors identified and controlled for identifiable and plausible variables in order to determine whether a bad-faith remedy played a role in the amount, timing, or allocation of payments made to the insured. The authors explain in detail the design of the study and the methodology they employed, carefully explicating the various parts of their study and how each element was treated.

The authors studied 38 jurisdiction and 2,223 insurance claims, with each claim containing an economic and non-economic component. The authors concluded that the presence of a bad-faith statute is evident in 78 percent of the sample claims, and an attorney was involved in 66 percent of the sample claims. The authors then present their findings and present a set of hypotheses which they explore by looking at the empirical association between bad-faith statutes and claim value. In sum, the authors conclude that higher overall settlement amounts are paid in states with a bad-faith remedy and that the higher settlement amounts are the result of higher payments for both economic and non-economic (mental anguish and punitive) damages. One aspect of the study the authors conducted was the effect of a claimant's representation by an attorney. The authors were

admittedly surprised when they found that the presence of a bad-faith law has the effect of higher settlement amounts for claimants who are not represented by counsel. As such, the authors identify a possible economic inefficiency with the tort of bad-faith, which the authors suggest should be the subject of further research.

AUTOMOBILE

Alma Cohen & Rajeev Dehejia, *The Effect of Automobile Insurance and Accident Liability Laws on Traffic Fatalities*, 47 J.L. & ECON. 357 (2004).

In this paper, the authors analyze the incentive effects of automobile insurance, compulsory insurance laws, and no-fault liability laws on driver behavior and, in turn, traffic fatalities. The authors note that traffic accidents claim over 40,000 lives each year in the United States. Additionally, the authors state that Americans spend over $100 billion on automobile insurance each year and Americans bear over $250 billion in uninsured accident costs annually. Thus, traffic accidents have significant costs, leading economists to ponder how the choices drivers make are influenced by agents' economic incentives and by various legal and policy measures. To this end, the authors analyze a panel of all 50 U.S. states and the District of Columbia for 1970-98, a period in which most states adopted compulsory automobile insurance and/or no-fault liability laws. The authors examine whether having automobile insurance has a moral hazard effect on traffic fatalities. The second, and related, issue the authors examine is the effect of the reduction in liability brought about by no-fault liability laws on traffic fatalities. The authors then lay out the details of their study and move to their analysis.

The authors conclude that compulsory insurance rules do indeed produce a significant reduction on the incidence of uninsured motorists, but the authors also find that increasing the incidence of insurance produces a concomitant increase in the number of fatalities. Thus, the authors conclude that automobile insurance had moral hazard costs that reflect up to a 2 percent increase in the number of fatalities for each percentage point decrease in the number of uninsured motorists. The authors also conclude that reductions in liability brought about by no-fault liability laws produce a significant increase in the number of fatalities. Thus, the move to a no-fault system brings with it the correlated moral hazard cost and increased traffic fatalities. The authors therefore suggest that this be taken into

account when assessing the rules governing accident liability and accident insurance.

INSURANCE-GENERAL

Peter Nash Swisher, *Insurance Binders Revisited*, 39 TORT TRIAL & INS. PRAC. L.J. 1011 (2004).

In this article, Swisher discusses binders, which are temporary insurance contracts that protect the insured against a specific loss during the period between completion of the insurance application and the issuance of the formal policy. Binders, though informal by their nature, are indeed enforceable insurance contracts. Swisher asserts that there are important differences between property and casualty insurance temporary binders and life and health insurance conditional receipt binders. The former are almost always temporary contracts of insurance while the latter are only deemed temporary contracts when certain conditions are met. The differences between the two provide the basis for Swisher's discussion.

Swisher first examines property and casualty insurance binders. Swisher notes that binders for property and casualty insurance may be oral or written, and established upon an agent's words or actions. As an example, Swisher discusses a case where the court found a valid and enforceable binder for temporary insurance coverage when the agent told a building contractor over the phone that he was covered and subsequently scribbled on a piece of paper instructions to cover the building. Swisher states that most property and casualty binders are based on standard contract forms. However, large corporate insureds often negotiate specific terms with the insurer, which results in what is known as a manuscript policy. Swisher posits that the distinction between manuscript and standard form binders and policies is important. Swisher explores the distinction using the September 11th attack on the World Trade Center. Swisher concludes that where parties contract through a manuscript form binder, the binder is invalid and unenforceable unless the parties agree upon some draft or model terms and conditions that may be inferred to be part of the policy.

Swisher then discusses life insurance conditional receipt binders. These binders differ significantly from property and casualty binders. One such difference is the fact that property and casualty binders can be written in the field after physical inspection of the property by an experienced agent. Life and health insurance binders, Swisher states, much greater expertise and judgment are required to determine a life or health insurance

risk. As a result, a life or health insurance binder is, Swisher asserts, a conditional receipt binder, rather than a temporary binding contract of insurance. Swisher identifies three categories of conditional receipt binders: (1) approval-type conditional receipts, where insurance coverage only comes into effect upon approval by the insurer's home office; (2) satisfaction-type conditional receipts, where insurance coverage comes into effect and relates back to the date of application after post-application physical examination of the applicant; and (3) unconditional temporary insurance during the time between application and issuance of coverage. Swisher ultimately concludes that satisfaction-type conditional receipts are the best approach because this category fairly balances the contractual language of a life or health insurance conditional receipt with the applicant's reasonable expectations of coverage, which is something the other two categories fail to accomplish.

Susan Lorde Martin, *Corporate-Owned Life Insurance: Another Financial Scheme that Takes Advantage of Employees and Shareholders*, 58 U. MIAMI L. REV. 653 (2004).

Martin analyzes in this article the existence and consequences of corporate-owned life insurance ("COLI") programs. In essence, COLI policies insure the lives of a corporation's key employees to protect the corporation from economic losses in the event of the employees' death. Martin indicates that insurance companies have adapted these COLI programs to respond to Congressional action curtailing the unintended benefits that corporations enjoyed. One alteration Martin discusses is the creation of "janitors' insurance." This type of insurance is life insurance purchased by corporations for rank-and-file employees with the corporation as the beneficiary. Janitors' insurance provides the basis for Martin's discussion of COLI programs as a whole.

Martin begins by explaining the notion of insurable interest. An insurable interest, in short, means that one must have a reasonable and well-grounded interest in the life of the insured so as to make the insurance a securing of that interest and not merely a wager upon human life. Martin explains that it was not uncommon in the past for people to buy life insurance policies for a celebrity whom they did not personally know, thus betting on the celebrity's early death. As a result, an insurable interest is now required to purchase life insurance, though the definition of an insurable interest is elusive. Martin then discusses statutes in various states that attempt to outline when an insurable interest exists. Martin also posits

that most states do not require an employee's consent for a corporation to take out a life insurance policy on that employees' life.

Martin next examines the employees' rights and consent with respect to COLI. Martin discusses a case against Wal-Mart by the estate of a former rank-and-file employee and its insurer to recover the proceeds of an insurance policy Wal-Mart had taken out on the life of the employee. The District Court for the Southern District of Texas held that an employee must be so essential to the success of the corporation that the death of the employee compromises that corporation's success. Wal-Mart had, to that point bought approximately 350,000 COLI policies, though the court's decision caused Wal-Mart to discontinue its COLI program for non-key employees. Martin uses this case as an example of the pervasiveness of COLI policies on the lives of non-key employees and explains how efforts are being made to require all employees' consent prior to the issuance of a COLI policy.

Martin then looks at the tax implications and profitability of COLI policies. Martin contends that the tax advantages of COLI plans have made the plans very attractive to corporations. For instance, Martin states that beneficiaries of life insurance policies, including corporations, receive the death benefits free of income tax. This is but one example of the tax benefits that Martin discusses, but it illustrates the enormous tax implications of COLI policies. Martin states that Congress has attempted to close some of the loopholes in the Tax Code in order to deter COLI policies on employees who are not essential to the corporation's success. Martin cites examples of Internal Revenue Service initiatives and lawsuits that also sought to prohibit corporations' improper tax deductions. In terms of profits, Martin states that one estimate has corporations earning up to 16 percent of their profits form janitors' insurance. Martin states that not only do these policies yield tax-free income, but the corporations use that income value as collateral for loans.

Ultimately, Martin sees the COLI policies as ways for corporations to hide financial data from shareholders and employees alike. COLI policies often make an ordinary employee worth more to the beneficiary dead than alive. Martin therefore suggests that, at the very least, every employer that wishes to insure the life of an employee with the employer as beneficiary must obtain the employee's informed consent. Martin also states that some states have responded to the public policy concern of employees being worth more dead than alive with exceptions when the purpose of the COLI plan is to fund employee benefit plans. Martin argues, however, that these exceptions merely shift the employer's responsibility for the benefit plans to the tax-payer. Finally, Martin suggests that the Securities and Exchange

Commission require disclosure of profits earned from COLI plans in order to inform the shareholder as to whether the strength of publicly traded companies comes from performance or manipulation of COLI plans.

Trisha Strode, Comment, *From the Bottom of the Food Chain Looking Up: Subcontractors are Finding that Additional Insured Endorsements are Giving them Much More than They Bargained For*, 23 ST. LOUIS U. PUB. L. REV. 697 (2004).

In this article, Strode examines additional insured endorsements in the context of construction contracts. Additional insured endorsements are essentially amendments to a subcontractor's insurance policy that adds the general contractor as an "additional insured." The general contractor, now an additional insured, enjoys the same coverage and rights as the purchaser of the policy (the subcontractor). Strode states that many general contractors require their subcontractors to include the general contractor as an additional insured on the subcontractor's policy. Strode notes that this seems beneficial to the general contractor but there has been little, if any, analysis of these agreements from the subcontractor's point of view. Thus, Strode analyzes additional insured endorsements from the subcontractor's point of view and examines how courts have been treating the endorsements.

Strode stresses that the initial purpose of additional insured endorsements was to cover the general contractor's costs should he be found vicariously liable for an act of his subcontractor. At first, Strode notes, courts interpreted these provisions to allow coverage only when the additional insured was held vicariously liable for the acts of the named insured. Over time, developers and general contractors began to assert that additional insured coverage is intended to protect them from their own liability as well, and the courts have endorsed this new interpretation. Strode analyzes the newer court interpretations and asserts that the courts' interpretations are overly broad and, in some instances, the courts are reaching to find coverage for the additional insured. Additionally, Strode contends that the courts are ignoring the impact on the subcontractors. Strode identifies several damaging affects on the subcontractor. Among the detrimental effects Strode describes are the dilution of the subcontractor's policy limits, increasing premiums, and a lack of accountability on the part of the defense lawyers. Moreover, Strode argues that the current trend in judicial interpretation is legally deficient because additional insured disputes are unique, yet courts continue to interpret the

endorsements in the same manner they would in a dispute over coverage for the named insured.

Strode concludes that the courts do not recognize the detrimental effects that their interpretations have on subcontractors because the subcontractor is very rarely before the court. Strode also stresses that there is no public policy justification for the courts' broad interpretation of the endorsements. As a result, Strode suggests that additional insured endorsements should be read with the original intent of such endorsements squarely in mind: vicarious liability only. Pushing all of the liability onto the subcontractor, as the courts are currently doing, is forcing the least able party to bear the cost of another's negligence and encourages no one to take any precautionary steps to prevent future incidents.

Gregory A. Goodman, Note, *Insurance Triggers as Judicial Gatekeepers in Toxic Mold Litigation*, 57 VAND. L. REV. 241 (2004).

In this Note, Goodman examines the current state of toxic mold litigation in the United States. Goodman states that toxic mold litigation, brought about by recognition of mold infestation as a cause of action for personal and property damage claims, has risen dramatically in recent years. Goodman sees the increase in toxic mold litigation as problematic because it has the potential to gravely affect various sectors of American economy. Goodman therefore focuses on managing the toxic mold docket so as to avoid a situation where toxic mold becomes the "next asbestos." Goodman examines how courts are dealing with the toxic mold litigation and offers suggestions as to which insurance trigger theory will accomplish his goals of providing a check on uncontrolled mold litigation and provide an equitable balance between injured plaintiffs and their insurers.

Goodman begins by providing a scientific and historical background of toxic molds. According to Goodman, toxic mold refers to the limited group of mold that can cause potentially serious health problems. Goodman traces the recognition of toxic molds in the United States to one family's ordeal in Chicago in 1986, though toxic mold had been recognized fifty years earlier in Europe. Goodman notes that the Center for Disease Control began a study of infant deaths in Cleveland in 1994, but the CDC did not state conclusively that toxic mold was the cause of the infant deaths. Goodman stresses that, though there are serious suspicions, the majority of the medical community has not yet acknowledged a firm link between toxic molds and human health problems.

Goodman next reviews and summarizes the case law on toxic mold litigation. Goodman identifies three basic categories of toxic mold cases:

(1) suits by home or building owners against builders for faulty construction or design; (2) suits by tenants against landlords for negligence in failing to maintain sanitary living conditions; and (3) suits by home or building owners against insurers for breach of contract or bad faith. Goodman notes here that many cases being in one of the first two categories, but often end up in the third category because defendants often seek indemnification from their insurers. Upon discussing various illustrative cases, Goodman notes that Congress has lagged behind the states in taking affirmative steps to confront toxic mold. Goodman also discusses here the impact of mold on the insurance markets, concluding that insurance companies will continue to argue that damage to persons or property resulting from toxic mold is not covered under the policies they issue.

Trigger of coverage theories are examined next. Goodman states that courts involved in toxic mold litigation will be forced to determine which policy has coverage obligations for a particular claim-coverage trigger. Goodman identifies trigger theories into four categories: the exposure theory; the manifestation theory or the first discovery theory; the triple trigger or continuous trigger theory; and the injury-in-fact theory. Goodman then defines and discusses each theory and its application in asbestos litigation, using case law to illustrate, which theories dominate in the different Federal Circuit Courts of Appeals. According to Goodman, the Fifth, Sixth, Ninth, and Eleventh Circuits favor the exposure theory in asbestos cases; the manifestation theory is generally disapproved of; the injury-in-fact theory is recognized by the Second and D.C. Circuits; and the continuous trigger theory has found its way into the opinions of the D.C. Circuit, as well as the Indiana Supreme Court.

Goodman argues that the appropriate trigger theory for toxic mold cases is the manifestation theory. In fact, Goodman posits that a strict application of the manifestation theory by all courts in toxic mold cases will avoid economic disaster, while at the same time providing equitable results for the parties involved. The application of the manifestation theory, and only the manifestation theory, Goodman argues, will provide much needed certainty in toxic mold litigation. Goodman also explains why each of the other trigger theories is ill-suited in dealing with toxic mold cases. Ultimately, Goodman argues that the manifestation theory accomplishes the goals of predictability and equity, goals that each of the other theories simply cannot achieve.

Representative Patrick J. Kennedy (D-R.I.), *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 HARV. J. ON LEGIS. 363 (2004).

In this Policy Essay, Representative Kennedy argues that the United States must end the insurance discrimination against the mentally ill that has plagued the country since colonial times. Kennedy notes that, although some 44 million adults have diagnosable mental illnesses, routine and potentially life-saving health care is persistently denied. Moreover, Kennedy asserts that the traditional distinction between mental and physical health and the historical notion that the two are unconnected is not only outdated, by patently inaccurate. To illustrate the pervasiveness of the distinction between mental and physical well-being, Kennedy cites a typical health insurance plan. According to Kennedy and the General Accounting Office, 87 percent of all health plans offer more favorable coverage to physical health care and more cost-sharing and more limitations on access for mental health care.

Kennedy states that he, along with Senator Domenici (R-N.M.) have introduced a bill, the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003. This legislation that would close the loopholes in the Mental Health Parity Act of 1996 that allow insurers to implement greater cost-sharing mental health care or impose additional limitations on access. The Mental Health Parity Act prohibits insurers from offering lower annual or lifetime benefits for mental health coverage than for physical health coverage, but does nothing to proscribe the cost-sharing or limitations on access that Kennedy argues is all too prevalent today. Kennedy asserts that his parity legislation would finally force the health care sector to recognize that the mind and the body are indeed inextricably intertwined.

In support of the parity legislation he has introduced in the House of Representatives, Kennedy offers both a principled and practical case for parity. Kennedy asserts that, as a matter of principle, discrimination against those with mental illnesses should be rejected just as other discriminatory policies have been repudiated. Kennedy stresses the social stigma attached to mental illnesses and contends that by increasing access to appropriate care, we also increase access to opportunity for success for those with mental illnesses. As a practical matter, Kennedy posits that parity is simply good health policy. Kennedy notes studies that show that the costs of mental illness add up to approximately $200 billion each year in the U.S. Kennedy notes that lost productivity due to a failure to treat mental illness is the largest component of this cost. Moreover, Kennedy

asserts, the lost productivity due to mental illness is invisible to employers because the loss occurs when employees are at work, as opposed to when they simply do not go to work. As a result, employers fail to recognize the significant savings that can be realized with parity legislation.

Thus, Kennedy supports the Wellstone Act with evidence that disparate treatment of mental illnesses in insurance is not only violative of civil rights, but is also inefficient and costly as a matter of health policy. Kennedy cites one example where a CEO exclaimed that the costs of mental health parity in employee health plans was more than offset by the savings in terms of productivity. In sum, Kennedy argues that parity legislation is desperately needed to close the gaps in our civil rights laws that allow the mentally ill to be cast outside the mainstream of American society and denied proper mental healthcare.

Angela K. Gore, Kevin Sachs & Charles Trzcinka, *Financial Disclosure and Bond Insurance*, 47 J.L. & ECON. 275 (2004).

In this study, the authors examine whether the regulation of accounting information affects the trade-off of public financial disclosures and bond insurance when trying to solve the problems that occur when buyers have less information than sellers. The authors note that regulators commonly presuppose that public disclosure is an indispensable aspect of an efficient capital market. However, economists recognize that public disclosure is only one of the ways to combat the asymmetric information problem. As such, the authors examine municipal insurers in two states, Michigan, where financial disclosure is required by the state, and Pennsylvania, where accounting information is unregulated. The authors examine municipal insurers because they are not covered by federal securities laws, thus allowing scrutiny of decisions by municipalities' to make efficient combinations and determine whether such decisions are related to the use of municipal bonds. Additionally, the authors select these two states because both states have city and township governments that do not have overlapping boundaries, which ensures that the responsibility for the financial reporting relationship is clear. The authors note that bond insurance, which is an insurer's guarantee to assume the principal and interest obligations of a bond in the event of default, has become common in the municipal sector generally, and there are no differences between the two states with regard to the bond insurance regulations.

The authors examine the empirical relationship between public financial disclosure and bond insurance and argue that if disclosure and bond insurance are substitutes, fewer bonds will be issued as a result of

regulating a minimum level of disclosure because insurance is therefore less beneficial in debt-cost-reduction. For this argument, the authors assume that municipal decision makers have incentives to lower municipal debt costs. The authors layout their research design and methods, explicating their hypotheses and how each hypothesis was tested, with each being tested at the municipality level and the bond level.

The authors conclude that their findings are strongly consistent with substitution. The authors ascertain that when financial disclosure is regulated, municipalities insure bonds less frequently and, conversely, when issuers are free to choose among combinations of debt-cost-reducing mechanisms (of which disclosure is but one mechanism), they substitute disclosure with bond insurance. The authors note that their findings suggest that regulation of accounting disclosure may force disclosures levels above an optimal level, which, in turn, makes bond insurance and other substitute mechanisms less beneficial at reducing debt costs. The authors also posit that pervasive, mandatory disclosure may actually prohibit the discovery of other capital-cost-reducing mechanisms. In their conclusion, the authors caution that the results of their study may be prudently extended beyond the market for municipal debt. Their caution notwithstanding, the authors suggest that if corporate issuers were allowed the same freedom as municipal issuers, similar results would be realized.

Michael M. Marick & Karen M. Dixon, *The Insurer's Contract "Right" to Defend: the "Tripartite" Relationship Reconsidered*, 39 TORT TRIAL & INS. PRAC. L.J. 1119 (2004).

This article discusses a liability insurer's contractual "right" to defend, which includes the insurer's right to select counsel. The authors note that much attention has been paid to an insurer's "duty" to defend its insured, but the examinations of the right to defend have been comparatively rare. The authors begin by analyzing a standard commercial general liability insurance policy to determine from where the insurer's contractual right to defend emanates. The authors posit that several provisions in the standard policy demonstrate that the insurer alone has the right to select defense counsel. The provisions the authors identify are: (1) the right to defend; (2) the supplementary payments clause; (3) the cooperation condition; and (4) the voluntary payments/obligations condition. Upon discussing these provisions, the authors conclude that standard general liability policies preclude coverage for the costs associated with defense attorneys not selected by the insurer. Moreover, the authors find no basis whatsoever for

the notion that these policies allow a policyholder to select its own counsel and, at the same time, demand payment from the insurer for that counsel.

The authors next discuss and explain the two theories of whom the assigned defense counsel owes his duties to the client or the common interest. The two-client or common interest theory holds that defense counsel represents two clients: the insurer and the policyholder. Under this theory, defense counsel represents and owes a duty of loyalty to both the insurer and the insured. The authors state that the courts that have adopted this theory hold that where the insurer agrees to provide a defense to the insured under a reservation of rights, and that reservation of rights creates a conflict of interest between the insurer and the insured, the insured has the right to present its own defense through counsel of its choice at the expense of the insurer. The second theory is the one-client theory. Under this theory, the insurer-appointed defense counsel represents only the insured and the insurer is not the attorney's client. Here, the insured is not entitled to select its own defense counsel because the attorney appointed by the insurer represents only the insured, thus no conflict of interest can arise.

The authors then identify and cogently discount eight "fallacies" or incorrect assumptions upon which the "policyholder chooses" argument rests. The erroneous assumption and arguments that the authors assert are advanced by proponents of the policyholder chooses position are: (1) the presumption of a close and harmonious relationship between insurers and the insurance defense bar; (2) an insurer-assigned attorney has an attorney-client relationship with the insurer as a matter of law, regardless of the facts surrounding the lawyer's retention; (3) the majority rule is that the insured can select counsel where the insurer asserts a reservation of rights; (4) policyholders should fear that insurance defense lawyers may not exercise independent professional judgment; (5) independent counsel means policyholder-selected counsel; (6) an insured's right to independent counsel is governed by the professional responsibility rules applicable to the insurer-assigned attorney; (7) the policyholder chooses rule is necessary to protect policyholders against inadequate lawyering by an insurance defense attorney; and (8) an insurer must be a client of the defense firm in order for the insurer to effectively conduct its claims handling.

The authors conclude by offering an alternative approach to the tripartite relationship between the insurer, the insured, and the assigned defense attorney. The authors contend that insurers can structure the engagement of defense counsel to fall within the one-client rule even in circumstances where the insurer has reserved rights and the two-client policyholder chooses theory might apply. The authors suggest that the insurer contact the attorney and inform the attorney that she is being

retained solely to represent the interests of the insured. In line with that suggestion, the authors recommend that the insurer obtain the attorney's acknowledgement that she is being retained for the sole purpose of representing the interests of the insured. Furthermore, the insurer should inform the insured that defense counsel was selected by the insurer pursuant to the insurer's contractual rights under the policy and, in the event the insured objects to the selection of counsel, the policyholder may retain counsel of his choice at his own expense. Finally, the authors suggest that the insurer inform defense counsel that counsel should not disclose any information about the insurance coverage or any privileged matters without the insured's consent, thus reinforcing the notion that the attorney represents only the policyholder. This approach, the authors assert, ensures that the insurer cannot be reasonably thought to be a client of the defense attorney and also makes certain that defense counsel understands that the only client is the policyholder. Thus, the insured should have no rights to select her own defense counsel.

Susan J. Stabile, *Religious Employers and Statutory Prescription Contraceptive Mandates*, 43 CATH. LAW. 169 (2004).

In this article, Stabile attacks mandatory prescription contraceptive coverage statutes that either contain no clause exempting churches and other religious organizations or that do exempt such organizations, but define the term "religious employer" very narrowly. Stabile notes that at least twenty states have passed laws mandating the coverage of prescription contraceptives for employees when an insurance plan provides any prescription drug coverage. Stabile identifies two states, New York and California, that do exclude religious employers from such statutes, but define religious employer very narrowly, requiring religious entities to meet the following four-fold test: (1) the purpose of the organization must be to teach religious values; (2) the organization must primarily employ persons of the same faith; (3) the organization must primarily serve persons of the same faith; and (4) the organization must be non-profit under specific sections of the Internal Revenue Code. Stabile argues that this four-part test may set dangerous precedent for further incursions on religion because it facially, and in no way substantively, gives respect for religion. Accordingly, Stabile discusses how the four-part test ignores the realities of the Catholic religion.

Stabile explains the Catholic religious mission as one in which worship and acts of charity and social justice are inseparable. Stabile asserts that the Catholic religious organizations that provide care for the elderly or the

sick, provide education, or provide meals for the hungry do so as acts that are as religious as those that take place within the church itself. As such, the statutes' definition represents a fundamental misunderstanding of what it means to be Catholic and what constitutes Catholic religious activity. The statutes would, Stabile argues, force Catholic hospitals, Catholic Churches, and Catholic institutes of higher learning to provide coverage for something the Catholic religion unambiguously denounces. Stabile asserts that these statutes, with their narrow definitions of religious employer, fail to recognize the reality that Catholic religious activity encompasses far more than prayer and other activities within the church building.

Stabile next discusses the statutes' requirement that an organization hire members of its own faith in order to be considered a religious employer. Stabile asserts that there are indeed situations where the Catholic nature of the employer causes it to act in a way that is incompatible with the employee's non-Catholic preferences. The statutes, in Stabile's view, attempt to balance these competing interests and ask that the Catholic interests of the organization heed to the non-Catholic interests of the employee. The better balance is, in Stabile's judgment, in favor of the Catholic employer's basic moral beliefs and not forcing the organization to act contrary to what it believes to be a grave sin. Stabile argues that, on the other end of the balance, asking a non-Catholic employee to procure prescription contraceptives via other means is at most inconvenient and possibly more expensive. The added cost and inconvenience to the non-Catholic employee do not, Stabile asserts, justify forcing a religious organization to act contrary to their core beliefs.

Stabile then discusses the options that religious organizations have if they wish to adhere to their beliefs and not provide prescription contraceptive coverage, all of which have undesirable consequences. One option Stabile discusses is forgoing all prescription drug coverage. However, Stabile notes that the Catholic Church firmly believe that employers have a moral obligation to consider the well-being of its employees. Moreover, Catholic organizations do not pay particularly high salaries, thus, Stabile notes, such organizations will be less competitive in the hiring of competent staff. A second option for a Catholic employer that Stabile suggests is ceasing operations completely. This obviously drastic step has manifold detrimental effects, which Stabile discusses.

In sum, Stabile argues that these statutes fail to properly understand religion. Stabile recognizes this failure not only for its current troubling consequences, but for the threat of further incursions on religious freedom in the future. Stabile sees these statutes as a dangerous first step toward even greater infringement on the Catholic Church and its core beliefs.

Stabile stresses that many of these statutes speak in terms of contraceptives, but also blur the line between birth control and abortion, a situation certainly repulsive to the Catholic Church. Thus, Stabile urges legislatures to rethink their approach if indeed they deem prescription contraceptives are a basic health need.

Dayna H. Kamimura, *Punishment and Deterrence: Merely a Mantra; A Casenote on* State Farm v. Campbell, 26 U. HAWAII L. REV. 229 (2003).

This article examines the decision of the United States Supreme Court in *State Farm Mutual Automobile Insurance Co. v. Campbell*, wherein the Court struck down a Utah jury's award of punitive damages as arbitrary and excessive in violation of the Due Process Clause of the Fourteenth Amendment. Kamimura argues that the Court incorrectly decided this case by erroneously applying prior Court precedent and misconstruing the facts of this case.

Kamimura begins by discussing the Court's prior holdings with regard to the alleged excessiveness of punitive damages awards. Primarily, Kamimura focuses on the Court's 1996 decision in *BMW of North America, Inc. v. Gore*, 517 U.S. 559 (1996). In *Gore*, the Court held that a $2 million punitive damages award was grossly excessive because it was not justified by the three guideposts that the Court established in that case: reprehensibility, ratio, and comparable liability. The Court in *Gore* explained the guideposts and their application, as Kamimura relays. The *Gore* Court declared that the reprehensibility guidepost was perhaps the most important factor in determining whether a punitive damages award is unreasonable.

Kamimura then discusses the factual and procedural background of *State Farm*. Summarily, the plaintiffs in *State Farm* sought damages from their insurer, State Farm, for bad faith, fraud, and intentional infliction of emotional distress. The plaintiffs alleged that State Farm's handling of their insurance claim and State Farm's handling of the defense of the original lawsuit against the plaintiffs following an automobile accident. State Farm assured their insureds (the *State Farm* plaintiffs) that they did not need to obtain independent counsel and that they had no liability for the accident. When a jury found the insureds liable for more than three times their policy limit, State Farm refused to pay the liability in excess of the $50,000 limit. State Farm ultimately paid the entire judgment, but the insureds subsequently sued State Farm. A Utah jury awarded the insureds $2.6 million in compensatory damages and $145 million in punitive damages. The Utah Supreme Court ultimately set the damages at $1

million compensatory and $145 million punitive damages. The United States Supreme Court analyzed the case by utilizing the *Gore* guideposts. Kamimura argues, however, that the Court merely purported to follow *Gore* and in fact ignored substantial evidence in the trial court's opinion that illustrated the reprehensibility of State Farm's conduct.

Kamimura asserts that the Court dismissed State Farm's reprehensible conduct in one short paragraph and failed to properly consider all of the factors that determine reprehensibility. Kamimura argues that, as the trial court found, State Farm's conduct was not only reprehensible in this specific case, but was part of a nationwide policy to deny claimants fair benefits by, *inter alia*, destroying materials and adding false facts so as to alter assessment values. Additionally, Kamimura asserts that State Farm had engaged in a repeated course of illegal conduct, thus evincing reprehensibility, though the Court, erroneously according to Kamimura, held that the repeated conduct did not justify the punitive damages awarded by the jury. With regard to the "ratio" guidepost, Kamimura contends that the Court failed to take into account the vast wealth of State Farm, which Kamimura argues justifies a large punitive damages award. As for comparable liability, Kamimura concludes that this guidepost could not have played a decisive role in the Court's opinion because the award the Court approved was 100 to 200 times the relevant civil sanction identified.

Kamimura concludes that the Court entirely failed to repudiate State Farm's reprehensible conduct and, in fact, seemed to condone State Farm's national policy of denying claimants benefits. Kamimura posits that the state has a legitimate interest in punishing State Farm for conduct deemed reprehensible by a state jury and the U.S. Supreme Court in *State Farm* repressed that interest and interjected the Court's own idea of what a fair punitive damages award would be in the case.