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SAFEGUARDING STATE INTERESTS IN HEALTH INSURANCE EXCHANGE ESTABLISHMENT

CHRISTINE H. MONAHAN*

This Article documents how, contrary to popular narratives, the states were given and took advantage of numerous opportunities to weigh in on health insurance exchange implementation under the Affordable Care Act. This engagement was driven by frequent informal consultation with federal officials, although states were also regular participants in regular notice-and-comment rulemaking. This Article identifies four factors that appear to have affected how much influence states were able to exercise over federal decision-making, and concludes by discussing how changing dynamics may encourage states to push for a more formal seat at the table in future exchange policy deliberations.

I. INTRODUCTION

News reporters and academic experts alike have heaped significant attention on the fact that the vast majority of states rejected the opportunity to run their own health insurance exchange under the Affordable Care Act (ACA), and instead opted for a federally operated exchange.¹ While states

* Yale Law School, J.D. expected 2016. I am indebted to the officials who shared their time and insights with me. I would also like to thank Professor Abbe Gluck for her supervision and guidance on this project, and my former colleagues at Georgetown's Center on Health Insurance Reform for inspiring my research into state implementation of the Affordable Care Act.

¹ See, e.g., Sarah Dash et al., *Health Policy Brief: Health Insurance Exchanges and State Decisions*, HEALTH AFFAIRS, July 18, 2013, available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=96; SARAH DASH ET AL., IMPLEMENTING THE AFFORDABLE CARE ACT: STATE DECISIONS ABOUT HEALTH INSURANCE EXCHANGE ESTABLISHMENT (Geo. Univ. Health Pol'y Inst. Ctr. on Health Ins. Reforms ed., Apr. 2013); Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST, Feb. 18, 2013, <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/18/its-official-the-feds-will-run-most-obamacare-exchanges/>; David Morgan, *Only 15 States Opt to Run Obamacare Exchanges*, CNBC (Dec. 13, 2012), <http://www.cnbc.com/id/100311739>; Alex Wayne, *Obama to Run Most Health Marketplaces as States Opt*

likely considered many factors as they came to this decision,² many ultimately were driven by partisan politics,³ and their vocal objections to these exchanges contributed to the popular conservative characterization of ACA implementation as a “federal takeover.”⁴ In light of state decisions to default to the federally run exchange, it is indisputable that the federal government has taken a larger role in the operation of exchanges than expected.⁵

Yet, arguably as important as who is responsible for day-to-day operation of health insurance exchanges is *who makes the rules* governing health insurance exchanges, for they control the extent of flexibility states

Out, BLOOMBERG BUS. (Dec. 14, 2012), <http://www.bloomberg.com/news/2012-12-14/obama-to-control-most-health-exchanges-as-states-opt-out.html>.

² Dash et al., *Implementing the Affordable Care Act*, *supra* note 1.

³ See, e.g., Jessica Bulman-Pozen, *From Sovereignty and Process to Administration and Politics: The Afterlife of American Federalism*, 123 YALE L.J. 1920, 1948 (2014); David K. Jones et al., *Pascal’s Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. HEALTH POL. POL’Y & L. 97 (2014); Elizabeth Weeks Leonard, *The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation*, 46 U. RICH. L. REV. 781, 796–803 (2012); Brendan W. Williams, *A Better “Exchange”: Some States, Including Washington, Control Their Health Care Markets While Most Surrender Autonomy to Resist Reform*, 48 GONZ. L. REV. 595, 610–615 (2013); *GOP States Offer Little Help to Health Care Exchanges*, CBS ATLANTA (Oct. 1, 2013), <http://atlanta.cbslocal.com/2013/10/01/gop-states-offer-little-help-to-health-care-exchanges/>; Elizabeth Hartfield, *Health Care Law: GOP Govs Opt Out of State Exchanges*, ABC NEWS (Nov. 15, 2012), <http://abcnews.go.com/blags/politics/2012/11/health-care-law-gop-govs-opt-out-of-state-exchanges/>.

⁴ See, e.g., *10 Reasons ObamaCare is a Government Takeover of Health Care*, GALEN GUIDE NO. 2 (Galen Inst., Alexandria, Va.), Fall 2012, at 1 (“States are being treated like contractors to the federal government, not sovereign entities empowered by the Constitution. They are ordered to set up new exchange bureaucracies lest the federal government sweep in and do it for them.”); Michael F. Cannon, *ObamaCare: A Federal Takeover, No Matter Who Runs the Exchanges*, CATO INST. (March 15, 2011), <http://www.cato.org/blog/obamacare-federal-takeover-no-matter-who-runs-exchanges> (“[U]nder ObamaCare the feds will write all the rules governing health insurance, so who administers the Exchanges is well-nigh irrelevant. ObamaCare is a federal takeover of health care, no matter who runs these new government bureaucracies that we call health insurance Exchanges.”).

⁵ For example, originally all states but Alaska applied for and received federal grants to support planning for exchange establishment. DASH ET AL., *IMPLEMENTING THE AFFORDABLE CARE ACT*, *supra* note 1, at 15.

running their own exchanges can have. Here, Congress put the federal government in the driver's seat by assigning the Secretary of the Department of Health and Human Services (HHS) responsibility for issuing regulations regarding, among other things, the "establishment and operation of Exchanges," "the offering of qualified health plans through such Exchanges," and "such other requirements as the Secretary determines appropriate."⁶ Reflecting the same federalism values that led to state-run exchange default,⁷ however, Congress also provided for a consultation role for state officials in the federal rulemaking process.⁸

This Article describes how this consultation provision was implemented in the four years that followed enactment of the ACA, as the initial policies and operational decisions governing health insurance exchange establishment were made. Given that Congress did not elaborate on how frequently the Secretary should consult with state representatives, the Secretary likely has discretion to keep her consultations largely pro forma and thus minimized state influence over federal policies. Yet complicating the traditional "federal takeover" narrative that has accompanied exchange implementation, this Article demonstrates that states actually played an active and influential role in federal decision-making processes.⁹

⁶ Patient Protection and Affordable Care Act § 1321(a)(1), 42 U.S.C. § 18041(a)(1) (2012).

⁷ See Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 *FORDHAM L. REV.* 1749, 1757 (2013) ("[E]xchange governance was the key question that divided the House and Senate versions of the legislation, with the Senate invoking 'federalism' values to insist on the state-leadership default preference that ultimately carried the day."); see also Gillian E. Metzger, *Federalism Under Obama*, 53 *WM. & MARY L. REV.* 567, 576 ("This reliance on state-run exchanges marks a significant difference between the Senate bill that became the ACA and the earlier House version. The latter had assigned primary responsibility for operating a national uniform exchange to the federal government, with states allowed to opt in to operate state-based exchanges if they met federal requirements. State officials lobbied strongly for state-based exchanges and for states to retain broad regulatory authority over insurance." (footnotes omitted)).

⁸ Patient Protection and Affordable Care Act § 1321(a)(2), 42 U.S.C. § 18041(a)(2) (2012).

⁹ This Article complements other work questioning descriptions of the ACA as a "federal takeover" of insurance regulation. Of note, Professors Brendan Maher and Radha Pathak have argued that the ACA provides "an opening for state actors to exploit and reclaim their historic preeminence with respect to health insurance

In doing so, this Article contributes to a growing field of literature regarding whether states should have a special role in or access to federal deliberations that impact their interests and, if so, how this should be manifested in administrative procedures and/or judicial review.¹⁰ The normative arguments most frequently proffered in favor of a special role for states, as summarized in a recent article by Professor Miriam Seifter, include: advancing federalism interests,¹¹ enhancing agency expertise,¹² and maintaining or enhancing democratic accountability.¹³ Critics do not necessarily challenge the desirability of these interests, but rather question the extent to which special procedural rules for states, in their current form or as proposed reforms, actually advance these interests in practice.¹⁴

regulation” by “incorporat[ing] state preferences, grow[ing] state regulatory markets, and provid[ing] possibilities for state regulators to attract millions more to their spheres of influence.” Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL’Y REV. 275, 306, 307 (2013).

¹⁰ See, e.g., Gillian E. Metzger, *Administrative Law As the New Federalism*, 57 DUKE L.J. 2023 (2008) (arguing that administrative law can be used to advance federalism); Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1 (2011) (arguing for judicial deference to agency interpretations that are born from bilateral intergovernmental bargaining); Miriam Seifter, *States, Agencies, and Legitimacy*, 67 VAND. L. REV. 443 (2014) (arguing that a robust state role in administrative decision-making could imperil administrative legitimacy without reform); Catherine M. Sharkey, *Federalism Accountability: “Agency-Forcing” Measures*, 58 DUKE L.J. 2125 (2009) (contending that, despite poor performance in the past, agencies can protect federalism interests if existing procedural rules are meaningfully enforced).

¹¹ Miriam Seifter, *States As Interest Groups in the Administrative Process*, 100 VA. L. REV. 953, 957 (2014) (“The most oft-cited goal of involving states in federal administration, mirroring a prevailing goal of contemporary federalism scholarship, is the protection of state power from federal excess.”).

¹² *Id.* (“[T]he idea is that state consultation will improve agencies’ decisions by conveying states’ local knowledge and experience as regulatory ‘laboratories.’”).

¹³ *Id.* (The idea “that states can be trusted with privileged access to agency decision making because, unlike private groups, states are ‘co-regulators’ and represent public constituencies themselves.”)

¹⁴ For example, in the same article, Professor Seifter argues that state interest groups frequently serve as state representatives to federal agencies, but that their involvement “inevitably requires tradeoffs among the core goals at the intersection of administrative law and federalism.” *Id.* at 956. In an earlier work, Professor Seifter has argued that there is no basis for assuming that states will advance expertise- or public-interest-based agendas, or that their demands will necessarily

Ultimately, many underlying assumptions behind positive and negative assessments of state influence turn on largely un-tested empirical questions, such as: What formal and informal channels do states use to engage in federal administrative decision-making? How frequently do states engage in federal decision-making processes? Who, in fact, represents states in these processes (executive or legislative branch officials, or state interest groups, e.g., the National Governors Association and National Conference of State Legislatures)? How much influence are any of these representatives able to exert?¹⁵

Relatively little work has been done to answer these questions to date.¹⁶ This Article intends to fill this gap by documenting state

reflect Congressional intent as others have opined. Seifter, *supra* note 10, at 491–501; *cf.* Nina A. Mendelson, *A Presumption Against Agency Preemption*, 102 NW. U. L. REV. 695, 718 (2008) (arguing that “[a]n institution with a specialized focus, an agency is not likely to possess the broader institutional mission, or the expertise necessary, to consider the appropriate balance of authority between the federal government and the states or the benefits of preserving some degree of state autonomy.”); Ryan, *supra* note 10, at 10–11 (arguing that the outcomes of bargaining between states and federal agencies should be considered a legitimate interpretation of federalism so long as the negotiations are based on mutual consent and federalism values, including the maintenance of checks and balances, accountability and transparency, preference for local innovation and competition, and problem-solving).

¹⁵ *Cf.* Metzger, *supra* note 10, at 2085 (referencing Nina A. Mendelson, *Chevron and Preemption*, 102 MICH. L. REV. 737, 758–59 (2004)) (“Professor Nina Mendelson has correctly insisted that the ability of states to protect their regulatory interests through notice-and-comment rulemaking is largely an empirical question, as are claims about the extent of state influence on federal agency decision-making.”).

¹⁶ Seifter, *supra* note 10, at 445 (“Scholars of the administrative process . . . have scarcely studied the state role in federal regulation.”). Notable exceptions include Professor Seifter’s subsequent article documenting state interest group engagement in federal administrative processes, Seifter, *supra* note 11; Catherine M. Sharkey, *Inside Agency Preemption*, 110 MICH. L. REV. 521 (2012) (examining five agencies’ efforts to comply with Executive Order 13,132 following issuance of President Obama’s Memorandum on Preemption); and JOHN D. NUGENT, *SAFEGUARDING FEDERALISM: HOW STATES PROTECT THEIR INTERESTS IN NATIONAL POLICYMAKING* (2009) (demonstrating how states promote their interests in both federal legislative and administrative processes). Additionally, for examples of work in the overlapping field of environmental law and administrative federalism, see Heather Gerken, *Federalism as the New Nationalism: An Overview*, 123 YALE L.J. 1889, 1902 n.86 (2014).

engagement in federal decision-making with respect to health insurance exchanges. In so doing, this Article relies on both formal written records evidencing state engagement in rulemaking and interviews with a number of state officials and state interest group representatives. While the interviews are not representative of every state or every state official's experience and perspective, they help cast light on informal state-federal agency relationships that are not captured as part of any lasting public record.¹⁷ And, while this Article cannot definitively say that state engagement was the "but-for" cause of final decisions by federal officials,¹⁸ the interviews herein provided insight into factors that likely affected how much influence states were able to exert.

Before proceeding into the research findings, Part II briefly describes the administrative procedural rules by which state and federal officials interacted. Given that the ACA did not elaborate on how federal officials should consult with states, federal officials were only legally constrained by pre-existing framework laws and orders governing administrative interactions with states. As Part II shall explain, despite multiple Executive Orders expounding the importance of considering state interests in federal rulemaking, existing law sets few formal requirements on agencies that appear to have any great impact on their actions. Indeed, perhaps most important to state-federal interactions is a provision of the Unfunded Mandates Reform Act of 1995, which facilitates off-the-record communication between federal officials and state officials.

Part III begins to fill the aforementioned research gap by examining actual state engagement in federal decisions governing exchange implementation. As mentioned above, it is informed by a review of publicly available materials, including public comments on federal rulemaking, and interviews with state officials and representatives of state interest groups, as well as two former federal officials, all of whom were active in exchange policymaking deliberations.¹⁹

This research suggests that states were given and took advantage of numerous opportunities, both formal and informal, to weigh in on exchange implementation.²⁰ In fact, state officials frequently spoke positively of the

¹⁷ Cf. Seifter, *supra* note 10, at 465.

¹⁸ Indeed, it has been observed that "measuring regulatory influence in any context is notoriously difficult." *Id.* at 473–74.

¹⁹ For a detailed discussion of methodology and limitations, see *infra* App. A.

²⁰ For clarity sake, this Article departs from the technical meanings of "formal" and "informal" under the Administrative Procedure Act (APA). Formal

federal government's willingness to work with them and accommodate their needs and preferences. The Center for Consumer Information and Insurance Oversight (CCIIO)—the office within the U.S. Department of Health and Human Services (HHS) charged with implementing the ACA's insurance reform provisions—received particular praise from states. Notably, state participation and positive experiences extended beyond the states that ultimately chose to operate their own exchanges: many states that may be commonly perceived as critics or opponents of exchanges because they chose to default to a federally run exchange and/or signed on to anti-ACA litigation nonetheless actively engaged in both formal and informal lobbying and developed close working relationships with federal officials.

Part IV discusses multiple factors that appeared to affect how much influence states could exert over federal decision-making. First, state officials frequently described how their ability to influence the federal government was connected to the extent to which the federal government perceived that the state shared the ACA's goals of increasing access to health coverage and expanding consumer protections in the insurance market. Second, restraints on federal financial resources and capacity appeared to both encourage and limit state influence in different ways. Third, institutional characteristics of the federal agencies and their different sub-components appeared to make them more or less amenable to state influence. Fourth, and finally, states could enhance their influence when they were able to act as first-movers.

Part V briefly discusses changing dynamics in health insurance exchange policy and politics and suggests that a continued reliance on informal processes could imperil state interests going forward. It concludes the Article by finding that while informality has arguably served state officials well to date, any gains acquired through informal processes can also be taken away without the federal government having to turn to any formal procedures. Accordingly, to the extent states want to secure any advances they have made, they may want to consider pushing for a more formal seat at the table in the future.

proceedings, as used here, generally refer to informal notice-and-comment rulemaking procedures under the APA. Informal proceedings refer to off-the-record communications between state and federal officials, which may occur by telephone or in-person at meetings.

II. THE ROLE OF STATES IN CURRENT ADMINISTRATIVE RULEMAKING PROCEDURES

The primary mechanism for stakeholders to engage in federal policymaking decisions is participation in notice-and-comment rulemaking. Stakeholders, including states, can learn of pending action, provide written comments either supporting or opposing the proposed rule, and encourage other parties who may share their interests, such as their congressional delegation, to weigh in as well.²¹ In light of the arguably special role of states, federal policymakers have also adopted various federalism-promoting procedural requirements to try to give special attention or access to state interests. Generally, though, these efforts are heavy on rhetoric regarding the importance of respecting state interests, while continuing to leave decisions about when and how to consult with states to the discretion of administrative officials.

Executive Order 12,372, Intergovernmental Review of Federal Programs (1982), broadly requires federal agencies to provide “opportunities for consultation” by state elected officials when they would be directly affected by proposed federal financial assistance or development programs.²² To effectuate this consultation requirement, federal agencies are told to communicate with state officials “as early in the program planning cycle as is reasonably feasible to explain specific plans and actions” and “make efforts” to accommodate any concerns states raise.²³

Executive Order 12,866, Regulatory Planning and Review (1993), expands the command to federal agencies to consult with state officials beyond federal programs (and beyond the limit that such officials be “elected”), providing that “[w]herever feasible, [federal] agencies shall seek views of appropriate State, local, and tribal officials before imposing regulatory requirements that might significantly or uniquely affect those governmental entities.”²⁴ Executive Order 12,866 also encourages agencies to consider using “consensual mechanisms for developing regulations,

²¹ Metzger, *supra* note 10, at 2086.

²² Exec. Order No. 12,372 § 1, 3 C.F.R. 197, 197 (1983) (as amended by Exec. Order No. 12,416, 3 C.F.R. 186 (1984)), *reprinted as amended in* 31 U.S.C. § 6506 (2012).

²³ *Id.* § 2(b), (c), 3 C.F.R. at 197.

²⁴ Exec. Order No. 12,866 § 1(b)(9), 3 C.F.R. 638, 640 (1994), *reprinted as amended in* 5 U.S.C. § 601 app. at 802—06 (2012).

including negotiated rulemaking.”²⁵ Negotiated rulemaking occurs when an advisory committee is convened to “consider and discuss issues for the purpose of reaching a consensus in the development of a proposed rule.”²⁶ An outside facilitator leads the process and any consensus is ultimately incorporated into a proposed rule that then goes through normal notice-and-comment rulemaking.²⁷ While not limited to such purposes, Professor Erin Ryan has argued that negotiated rulemaking “holds promise for facilitating sound administrative policymaking in disputed federalism contexts”²⁸ by ensuring “that agency personnel will be unambiguously informed about the full federalism implications of a proposed rule by the impacted state interests.”²⁹

Executive Order 13,132, Federalism (1999), goes another step further to state that “[t]he national government should be deferential to the States when taking action that affects the policymaking discretion of the States and should act only with the greatest caution where State or local governments have identified uncertainties regarding the constitutional or statutory authority of the national government.”³⁰ Specifically with respect to consultation, Executive Order 13,132 generally requires federal agencies to refrain from promulgating any rules that have “federalism implications” unless the federal government consults with state officials while developing the proposed rule and publishes a “federalism summary impact statement” describing such consultation and discussing any concerns raised by state officials.³¹

Finally, the Unfunded Mandates Reform Act of 1995 (UMRA) both limits federal imposition of financial burdens on states and strengthens the relationships between federal and state governments. While many of UMRA’s directives are targeted at Congress, the law also addresses federal

²⁵ *Id.* § 6(a)(1), 3 C.F.R. at 645.

²⁶ 5 U.S.C. § 562(7) (2012).

²⁷ *Id.* § 566.

²⁸ Ryan, *supra* note 10, at 51.

²⁹ *Id.* at 53. Ryan further notes that “state-side federalism bargainers” consistently reported a preference for negotiated rulemaking over traditional notice-and-comment rulemaking for this reason. *Id.* at 54.

³⁰ Exec. Order 13,132 § 2(i), 3 C.F.R. 206, 207 (2000), *reprinted as amended in* 5 U.S.C. 601 app. at 807–809 (2012).

³¹ *Id.* § 6, 3 C.F.R. at 209–10. However, if the regulation imposes substantial direct compliance costs on states but does not preempt state law, federal agencies may bypass these requirements if, instead, the federal governments pays such costs on behalf of the states. *Id.* § 6(b)(1), 3 C.F.R. at 209.

agencies in two ways. First, building on Executive Order 12,866, UMRA requires agencies to provide written statements detailing the costs and benefits of any “significant” federal mandate that may result in the expenditure by state, local, or tribal governments of at least \$100 million (adjusted annually for inflation) in any one year.³² Second, to promote free-flowing communication, UMRA requires agencies to develop an “effective process” for state elected officers, among others, to “provide meaningful and timely input in the development of regulatory proposals containing significant Federal intergovernmental mandates,”³³ and exempts meetings between federal officials and state elected officers and/or their designated employees from the requirements of the Federal Advisory Committee Act (FACA), such as notice and disclosure rules.³⁴

While these Executive Orders and UMRA give lip service to accommodating state interests and concerns, they arguably offer little by way of hard requirements. The rulemaking agency is generally given discretion regarding whether consultation is necessary or feasible. The rulemaking agency also is the entity to determine what the process of consultation should look like when it occurs, with minimal oversight of their decisions or practices.³⁵ Empirical research supports a finding that, at least historically, these requirements have had little teeth. For example, a study by Professor Nina Mendelson found that only six out of 600 proposed or final rules issued during one quarter of 2003 included or referred to a completed federalism impact analyses; an updated sampling in May 2006 delivered similar results. She further noted that, when federalism impact analyses were prepared, “[n]early all were of low quality, failing to analyze state interests in providing additional protection for residents, state autonomy, or any [other federalism values].”³⁶ Similarly, use of negotiated rulemaking by federal agencies remains rare:

³² Unfunded Mandates Reform Act of 1995 (UMRA), 2 U.S.C. § 1532 (2012).

³³ *Id.* § 1534(a).

³⁴ *Id.* § 1534(b).

³⁵ For example, under Executive Order 13,132, an agency must include a certification of compliance with the federalism requirements in a final rule that the agency has determined has federalism implications when such rule is otherwise subject to review prior to promulgation by the Office of Management and Budget under Executive Order 12,866. Exec. Order 13,132 § 8(a), 3 C.F.R. at 210; *see also* Sharkey, *supra* note 10, at 2177–78 (criticizing executive enforcement of Executive Order 13,132).

³⁶ Mendelson, *supra* note 14, at 718–19 (2008) (referencing Mendelson, *supra* note 15, at 771, 782–83).

according to Professor Erin Ryan, “in the first thirteen years surrounding passage of the Negotiated Rulemaking Act, only fifty federal rules were produced through negotiated rulemaking—as little as one percent of the total number of rules promulgated over this period.”³⁷

The tide may have begun to turn, at least temporarily, under President Obama, however. Shortly after taking office, he issued a memorandum to his agency heads encouraging precaution when regulations could preempt state law and careful compliance with Executive Order 13,132.³⁸ The memorandum reportedly “led to serious internal review” and policy changes within at least some federal agencies, including the National Highway Traffic Safety Administration and the Consumer Product Safety Commission.³⁹

Additionally, the potential impact of UMRA’s exception of state officials from FACA should not be dismissed. While it does not require state engagement in federal policymaking, it can give state officials privileged access to federal policymakers as rules are being developed. Based on in-depth studies of state interactions with the Environmental Protection Agency, Professor Miriam Seifter has observed that state influence largely “appears to come through states’ informal and largely subterranean consultations with agencies--through agency-state ‘workgroups,’ meetings, and regular conference calls arising from states’ status as ‘co-regulators’ in federal programs.”⁴⁰

Outside the scope of formal rules, states may also use their unique public position and authority to sway federal regulators. For example, state officials may attempt to leverage their congressional delegations to gain influence. Federal agencies are particularly responsive to members of Congress and, given legislators’ responsiveness to their home state governments, “[a]gency officials’ desire to please important constituencies in Congress thus will lead them to seek to please the governments of the states with home they deal.”⁴¹ Similarly, state officials may “adopt public

³⁷ Ryan, *supra* note 10, at 55.

³⁸ Preemption: Memorandum for the Heads of Executive Departments and Agencies, 74 Fed. Reg. 24,693 (May 20, 2009).

³⁹ CATHERINE M. SHARKEY, ADMIN. CONFERENCE OF THE U.S., FEDERAL AGENCY PREEMPTION OF STATE LAW: EXECUTIVE SUMMARY 2, *available at* <http://www.acus.gov/sites/default/files/documents/Sharkey-Executive-Summary.pdf>.

⁴⁰ Seifter, *supra* note 10, at 461.

⁴¹ Samuel R. Bagenstos, *Federalism by Waiver After the Health Care Case*, in PUBLIC LAW AND LEGAL THEORY RESEARCH PAPER SERIES 6 (2012).

relations campaigns to draw attention to their disagreements with proposed or existing federal policies, exhorting policymakers to act in a more state-friendly way.”⁴² State and federal officials also may vie for policymaking control over a given area and put out competing regulations. When facing a state that has already taken action in an area, the federal government may simply acquiesce to their policy decisions rather than attempt to preempt them.⁴³

III. STATE ENGAGEMENT IN FEDERAL DECISION-MAKING ON EXCHANGES

This Part discusses different channels and methods states used to influence federal rules and guidance on or related to exchange implementation. It finds that states, including those that did not elect to operate state-based exchanges, were actively involved in this process through both formal and informal channels. The federal government provided numerous opportunities for states to weigh in through notice-and-comment rulemaking and other solicitations published in the *Federal Register*, and states frequently responded with detailed letters expressing their preferences and concerns. Of even greater value to states was the near constant informal communications between states and federal officials. States also regularly relied on state interest groups, like the National Association of Insurance Commissioners (NAIC), and informal cross-state collaboration to amplify their voices through both formal and informal communication channels.

A. FORMAL ENGAGEMENT: NOTICE-AND-COMMENT RULEMAKING

The federal government has engaged in frequent rulemaking with respect to health insurance exchanges between March 23, 2010 and May 30, 2014. The following sections discuss this process as well as the response from states to opportunities to provide comments.

⁴² NUGENT, *supra* note 16, at 58.

⁴³ Professor Erin Ryan has referred to this as “intersystemic signaling.” Ryan, *supra* note 10, at 70.

1. Federal Use of Notice-and-Comment Rulemaking

Since enactment of the ACA, the federal government has published more than forty actions in the *Federal Register* directly or tangentially related to the establishment or operation of exchanges.⁴⁴ The Centers for Medicare & Medicaid Services (CMS), within HHS, is the most frequent publisher, although some actions have come out of the Internal Revenue Service (IRS) or directly from HHS.⁴⁵

Prior to engaging in any rulemaking related to exchanges, the federal government issued a request for comments soliciting input on twelve topics: state exchange planning and establishment grants, implementation timeframes and considerations, state exchange operations, qualified health plans (QHPs), quality, an exchange for non-electing states, enrollment and eligibility, outreach, rating areas, consumer experience, employer participation and risk adjustment reinsurance, and risk corridors.⁴⁶ While all stakeholders were invited to respond, many of the questions were either explicitly targeted at soliciting state views on their

⁴⁴ See *infra* App. A.

⁴⁵ The first action, requesting comments regarding exchanges, was published by the Office of Consumer Information and Insurance Oversight, within HHS. Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 45,584 (Aug. 3, 2010) (to be codified at 45 C.F.R. pt. 170). This independent office was subsequently converted into the Center for Consumer Information and Insurance Oversight (CCIIO) and placed under CMS's jurisdiction. Arthur D. Postal, *HHS Overhauls Consumer Office*, LIFEHEALTHPRO (Jan. 6, 2011), <http://www.lifehealthpro.com/2011/01/06/hhs-overhauls-consumer-office>.

⁴⁶ Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 45,586–90.

needs and preferences,⁴⁷ or requested information about state policies and operations.⁴⁸

Subsequently, the federal government solicited formal comments twenty-seven times on issues broadly related to exchange implementation.⁴⁹ Most (eighteen) of these opportunities were in the form of proposed rules or notices of proposed rulemaking, allowing interested parties to provide comments before anything was finalized. One was a request for information regarding health care quality standards for plans offered through exchanges. In an additional two cases, CMS issued notices in the *Federal Register* soliciting comments on potential action it was considering (specifically, recognizing a new organization as an accrediting entity for the purpose of QHP certification and developing a sound framework for rating the quality of QHPs).

In five cases, the government solicited comments on interim final rules.⁵⁰ While the public had an opportunity to provide comments, the interim final provisions (which in some cases encompassed the whole rule, and in others were just sections of a rule that otherwise was being finalized without an additional comment opportunities) were finalized and scheduled to go into effect before consideration of any comments. In many of these instances, the federal government departed significantly from an approach raised in the proposed rule, but found cause to finalize the new language without going through another round of notice-and-comment rulemaking.⁵¹

⁴⁷ *E.g., id.* at 45,586 (“What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014?”); *id.* at 45,587 (“What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment?”); *id.* at 45,588 (“What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?”).

⁴⁸ *E.g., id.* at 45,588 (“To what extent do States currently have similar requirements or standards for plans in the individual and group markets?”); *id.* at 45,589 (“To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)?”); *id.* (“To what extent do States currently offer reinsurance in the health insurance arena (e.g., Medicaid, State employee plans, etc.) or in other arenas?”).

⁴⁹ *See infra* App. B.

⁵⁰ *Id.*

⁵¹ For example, in the final and interim final rules on exchange establishment, HHS notes, “Based on the comments that we received on the Exchange

In one instance, the IRS issued a final regulation but solicited additional written comments on subject matter to be addressed through future rulemaking.⁵²

The comment periods for actions released in 2010 and 2011 were all at least sixty days in length, while many of the later rules provided much shorter comment periods (Table 1). At the most extreme, one interim final rule provided for only a six-day comment period.⁵³ More common were comment periods between twenty-one and thirty days in length.⁵⁴ Rules would often also come out in batches, with multiple rules published on or around the same day.⁵⁵ While this provided the public a more comprehensive understanding of the issues under development, it also increased the amount of work for respondents in that time period. Indeed, after the federal government released five major exchange-related regulations over a one-month time period in the summer of 2011, it bowed

establishment and eligibility proposed rules, we believe that there are new options and specific standards that should be implemented in connection with eligibility determinations.” Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,434 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155,156, 157). However, citing timing constraints and concerns that “it would be contrary to the public interest to delay issuing new eligibility determination and timeliness standards,” HHS chose to waive proposed rulemaking. *Id.*

⁵² Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,380 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602) (“The final regulations authorize the Commissioner to publish additional guidance, see § 601.601(d)(2), to address the effect on affordability of wellness incentives that increase or decrease an employee’s share of premiums. Comments are requested on types of wellness incentives, how these programs affect the affordability of eligible employer-sponsored coverage for employees and related individuals, and how incentives are earned and applied.”).

⁵³ Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76,212, 76,212 (Dec. 17, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156). This rule, published on December 17, 2013 (although available for review online briefly beforehand), changed the effective coverage date for any QHP purchased through a federally facilitated exchange between December 15, 2013 and December 23, 2013 from February 1, 2014 to January 1, 2014. The rule provided states operating their own exchanges with the authority to make a similar change as well. *Id.* at 76,213–14.

⁵⁴ See *infra* App. B.

⁵⁵ *Id.*

to public pressure and extended the comment period on the initial rules from seventy-five to 108 days.⁵⁶ Sometimes comments were due over major holidays. For example, in the winter of 2012, deadlines for two proposed rules and one request for information fell on or between December 26, 2012 and December 31, 2012.⁵⁷

Table 1. Length of Exchange-Related Comment Periods by Year

Solicitation and Issuing Agency*	Action	Days
2010		
OCIO: Exchange-Related Provisions in Title I of the ACA	RFC	62
2011		
CMS/Treas: Application, Review, & Reporting Process for Waivers for State Innovation	PR	60
HHS: Establishment of Exchanges & QHPS	PR	108^
HHS: Standards Related to Reinsurance, Risk Corridors, & Risk Adjustment	PR	108^
HHS: Exchange Functions in the Indiv. Market; Elig. Determinations; Standards for Employers	PR	75
CMS: Medicaid Program; Elig. Changes Under the ACA	PR	75
IRS: Health Insurance Premium Tax Credit	NPRM	75
2012		
CMS: Medicaid Program; Elig. Changes Under the ACA	FR/IF R	45
HHS: Establishment of Exchanges & QHPs; Exchange Standards for Employers	FR/IF R	45
IRS: Health Insurance Premium Tax Credit	FR	90
HHS: Recognition of Entities for the Accreditation of QHPs	PR	30
HHS: Standards Related to Essential Health Benefits, Actuarial Value, & Accreditation	PR	30
CMS: Health Care Quality for Exchanges	RFI	30

⁵⁶ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Extension of Comment Period, 76 Fed. Reg. 60,788, 60,788–89 (Sept. 30, 2013) (to be codified at 45 C.F.R. pts. 153, 155, 156). Notably, this extension was announced mere days before the original due date for comments on the exchange establishment and risk adjustment proposed rules.

⁵⁷ See *infra* App. B.

Solicitation and Issuing Agency*	Action	Days
CMS: HHS Notice of Benefit & Payment Parameters for 2014	PR	24
2013		
CMS: EHB in Alternative Benefit Plans, Elig. Notices, Fair Hearing & Appeal Processes for Medicaid & Exchange Elig. Appeals & Other Provisions	PR	22
CMS: Exchange Functions: Elig. for Exemptions; Misc. Min. Essential Coverage Provisions	PR	45
CMS: Amdts. to the HHS Notice of Benefit & Payment Parameters for 2014	IFR	50
CMS: Establishment of Exchanges & QHPs; Small Business Health Options Program	PR	21
CMS: Exchange Functions: Standards for Navigators & Non-Navigator Assistance Personnel	PR	31
IRS: Min. Value of Eligible Employer-Sponsored Plans & Other Rules	NPRM	60
CMS: Program Integrity: Exchange, SHOP, Premium Stabilization Prgms & Market Standards	PR	30
IRS: Information Reporting for Affordable Insurance Exchanges	NPRM	63
CMS: AAAHC App. To Be a Recognized Accrediting Entity for the Accreditation of QHPs	N	32
CMS: Exchanges & QHPs, Quality Rating System, Framework Measures & Methodology	N	63
CMS: HHS Notice of Benefit & Payment Parameters for 2015	PR	24
CMS: Maximizing January 1, 2014 Coverage Opportunities	IFR	6
2014		
CMS: Third Party Payment of QHP Premiums	IFR	60
CMS: Exchange & Insurance Market Standards for 2015 & Beyond	PR	31

* Regulation names are shortened for brevity. A full list of exchange-related solicitations and rulemaking is available in Appendix B.

^ The original comment period for this proposed rule was seventy-five days. However, the federal government subsequently extended it to 108 days. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Extension of Comment Period, 76 Fed. Reg. 60,788, 60,788–89 (Sept. 30, 2011) (to be codified at 45 C.F.R. pts. 153, 155, 156).

FR = Final Rule

IFR = Interim Final Rule

N = Notice (with comment)

NPRM = Notice of Proposed Rulemaking

PR = Proposed Rule

RFC/RFI=Request for Comments/Information

The federal government has conducted an immense amount of rulemaking in the past four years—as one state official commented in an interview, “the speed with which [CMS] get[s] out regulations is astonishing . . . it took them five years to issue some of the interim final regulations for HIPAA.”⁵⁸ However, as much if not more information has been released only as sub-regulatory guidance documents. Guidance documents listed under the “Health Insurance Marketplaces” (the federal government’s term for health insurance exchanges) and “Plan Management” sections of CCIIO’s “Regulations and Guidance” webpage vastly outnumber regulations, which include both proposed and final versions of many rules,⁵⁹ and hundreds if not thousands of additional resources targeted towards states and insurance companies are only available on password protected websites.⁶⁰ While a few guidance documents include solicitations for comments,⁶¹ transparency-and-deliberation-forcing rules in the Administrative Procedure Act (APA) do

⁵⁸ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

⁵⁹ Ctr. for Consumer Info. & Ins. Oversight, *Regulations and Guidance*, CMS.GOV, <http://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html> (last visited May 14, 2014).

⁶⁰ See COLLABORATIVE APPLICATION LIFECYCLE TOOL (CALT), <https://calt.cms.gov/> (last visited May 21, 2015); REGISTRATION FOR TECHNICAL ASSISTANCE PORTAL (REGTAP), <https://www.regtap.info> (last visited May 22, 2015) (unlike CALT and SERVIS, members of the public can register to access REGTAP); STATE EXCHANGE RESOURCE VIRTUAL INFORMATION SYSTEM (SERVIS), <https://servis.cms.gov/resources/> (last visited May 14, 2014).

⁶¹ See, e.g., CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES (May 16, 2012), *available at* <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf>; Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Mar. 1, 2013), *available at* <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-3-1-2013.pdf>.

not apply, so the federal government is under no obligation to consider or publish feedback.⁶²

2. Federalism Analyses in Rulemaking

In the majority (thirty) of *Federal Register* publications, the federal government has included an explicit Federalism Impact Statement.⁶³ Examining federalism discussions in final and interim final rulemaking specifically, however, demonstrates some inconsistency in how the requirements of Executive Order 13,132 are met (Table 2). First, while CMS and HHS addressed the federalism implications of its rules either in an explicit Federalism Impact Statement or briefly within a more general Regulatory Impact Statement, the IRS did not include any references to federalism generally or Executive Order 13,132 specifically in any of its exchange-related rulemaking, including regulations enacting information reporting requirements on state-run exchanges.⁶⁴

Table 2. Federalism Impact Statements and Related Findings in Exchange-Related Final and Interim Final Rules

Rule*	FIS	EO 13132 Compliance Certified or Attested	EO 13,132-Related Findings		
2012					
CMS/Treas: App., Review, & Reporting Process for Waivers for State Innovation	N	--	N	--	--
CMS: Medicaid Program; Elig. Changes Under the ACA (Final Rule/IFR)	Y	Neither	Y	--	--
HHS: Standards Related to	N	--	--	--	--

⁶² 5 U.S.C. § 553(b)(3)(A) (2012).

⁶³ See *infra* App. B.

⁶⁴ Information Reporting for Affordable Insurance Exchanges, 79 Fed. Reg. 26113 (May 7, 2014) (to be codified at 26 C.F.R. pt. 1).

Rule*	FIS	EO 13132 Compliance Certified or Attested	EO 13,132-Related Findings		
Reinsurance, Risk Corridors & Risk Adjustment					
HHS: Establishment of Exchanges & QHPS; Exchange Standards for Employers (Final Rule/IFR)	Y	Cert'd	N^	--	Y
IRS: Health Insurance Premium Tax Credit (2012)	N	--	--	--	--
HHS: Data Collection to Support Standards Related to EHBs; Recognition of Entities for the Accreditation of QHPs	Y	Cert'd	N	N	N
2013					
IRS: Health Insurance Premium Tax Credit (2013)	N	--	--	--	--
HHS: Standards Related to EHBs, Actuarial Value, and Accreditation	Y	Neither	N	Y	Y
CMS: HHS Notice of Benefit & Payment Parameters for 2014	Y	Attested	N	--	Y
CMS: Amdts. to the HHS Notice of Benefit & Payment Parameters for 2014 (IFR)	N	--	N	N	Y
CMS: Establishment of Exchanges & QHPs; Small Business Health Options Program	Y	Cert'd	N	N	N
CMS: Exchange Functions: Elig. for Exemptions; Misc. Min. Essential Coverage Provisions	Y	Cert'd	N	--	Y
CMS: EHB in Alternative Benefit Plans, Elig. Notices, Fair Hearing & Appeal Processes, & Premiums & Cost	Y	Cert'd	N	--	Y

Rule*	FIS	EO 13132 Compliance Certified or Attested	EO 13,132-Related Findings		
Sharing; Exchanges: Elig. & Enrollment					
CMS: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel	Y	Both	--	Y	--
CMS: Program Integrity: Exchange, SHOP, & Elig. Appeals	Y	Both	Y	Y	Y
CMS: Program Integrity: Exchange, Premium Stabilization Programs, & Market Standards	Y	Both	Y	Y	Y
CMS: Maximizing Jan. 1, 2014 Coverage Opportunities (IFR)	Y	Cert'd	N [^]	N	N
2014					
CMS: HHS Notice of Benefit & Payment Parameters for 2015	Y	Attested	N	--	Y
CMS: Third Party Payment of QHP Premiums (IFR)	Y	Cert'd	N [^]	N	N
IRS: Info. Reporting for Exchanges (2014)	N	--	--	--	--
CMS: Exchange and Insurance Market Standards for 2015 & Beyond	Y	Both	--	Y	--
Totals	15	13	3	5	9

* Unless otherwise noted, all rules were issued as final. Regulation names are shortened for brevity. A full list of exchange-related solicitations and rulemaking is available in Appendix B.

[^] In these rules, the drafters limited their finding by noting that the rule does not impose any costs on state or local governments not otherwise imposed by already-finalized provisions of the regulations implementing the Affordable Care Act.

Second, even when CMS and HHS frequently included a discussion of federalism concerns, they did not appear to apply consistent processes for confirming that they were complying with the Executive Order. For example, federalism was usually discussed in a Federalism Impact Statement, but on two instances regulators only briefly dismissed any federalism concerns within the Regulatory Impact Statement.⁶⁵ In addition, where a Federalism Impact Statement was included, HHS usually attested or certified that CMS had complied with the requirements of the Executive Order in a meaningful and timely manner. On two instances, however, compliance was not confirmed despite findings that the rule either imposed direct costs on states⁶⁶ or that it had preemption and other federalism implications.⁶⁷

Third, CMS and HHS frequently did not address all three prongs of the standard used to determine whether certain requirements of the Executive Order applied to a given rule. The standard, as interpreted by HHS, asks whether a rule 1) imposes substantial direct costs on State and local governments; 2) preempts State law, or 3) otherwise has federalism implications.⁶⁸ Most frequently, the federal government would find that a rule had federalism implications “due to direct effects on the distribution of power and responsibilities among the State and Federal governments.”⁶⁹ Sometimes, this finding was accompanied by a statement that the rule did not impose substantial costs on states or preempt state law, but frequently one or the other (most often, the preemption analysis) was not addressed

⁶⁵ Application, Review, and Reporting Process for Waivers for State Innovation, 77 Fed. Reg. 11,700, 11,714–15 (Feb. 27, 2012) (to be codified at 45 C.F.R. pt. 155); Patient Protection and Affordable Care Act, Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,541, 15,550 (Mar. 11, 2013) (to be codified at 48 C.F.R. pts. 153, 156).

⁶⁶ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144, 17,202 (Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 437).

⁶⁷ Patient Protection and Affordable Care Act, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,864 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

⁶⁸ See, e.g., Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,443–44 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155–57).

⁶⁹ *Id.*

one way or another. On two instances, the rules only addressed the preemption analysis and ignored the other two prongs.

Notably, the federal government more frequently acknowledged the preemptive effects and costs of rules that were issued later in the implementation process. In at least some cases, these later rules found such implications even though earlier rules on the same topics had not.⁷⁰ For example, while the 2012 final rule on standards related to reinsurance, risk corridors, and risk adjustment (collectively referred to as “premium stabilization programs”) did not include any discussion of federalism,⁷¹ the Federalism Impact Statement in the October 2013 final rule on these programs found that the rule would impose direct costs on states as “State-operated reinsurance and risk adjustment programs are required to undertake oversight, record maintenance and reporting activities.”⁷² Similarly, while the March 2012 rule on exchange establishment included standards for navigator programs,⁷³ the potential preemptive effect of these rules was not discussed until subsequent rulemaking in July 2013 and May 2014.⁷⁴

⁷⁰ The statements, however, were largely consistent from proposed to final rules, in contrast to earlier research documenting that agencies often only acknowledged any preemptive effects in final rather than proposed rules. Sharkey, *supra* note 32, at 2139.

⁷¹ Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220 (Mar. 23, 2012) (to be codified at 45 C.F.R. pt. 153).

⁷² Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 65,046, 65,091 (Oct. 30, 2013) (to be codified at C.F.R. pts. 144, 146, 147).

⁷³ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,330–34, 18,443 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156, 157).

⁷⁴ Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors; Final Rule, 78 Fed. Reg. 42,824, 42,858–59 (July 17, 2013) (to be codified at 45 C.F.R. pt. 155); Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 Fed. Reg. 30240, 30,333–35 (May 27, 2014) (to be codified at 45 C.F.R. pts. 144, 146, 147).

3. State Participation in Notice-and-Comment Rulemaking

In the case of exchange implementation, many states were in fact fairly active in the commenting process.⁷⁵ Discounting five rules or notices for which no states submitted comments,⁷⁶ an average of between thirteen and fourteen states submitted either individual or joint comments on each exchange-related action. This, however, glosses over significant variability across solicitations.

The action on which the greatest number of states (forty-one, including the District of Columbia) submitted comments was a proposed rule titled, “Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing.”⁷⁷ As indicated by the name, this was an “omnibus” rule covering a wide range of issues and it elicited comments from a number of state agencies or offices that did not normally participate in the exchange rulemaking process, such as administrative hearing

⁷⁵ See *infra* App. B.

⁷⁶ Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,380 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602); Patient Protection and Affordable Care Act, Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,541 (Mar. 11, 2013) (to be codified at 45 C.F.R. pts. 153, 156); Patient Protection and Affordable Care Act, Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 15,553 (proposed Mar. 11, 2013) (to be codified at 45 C.F.R. pts. 155, 156); Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans, 78 Fed. Reg. 56,711 (Sept. 13, 2013); Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76,212 (Dec. 17, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

⁷⁷ Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; 78 Fed. Reg. 4,594 (proposed Jan. 22, 2012) (to be codified at 42 C.F.R. pts. 430, 431, 433, 435, 440, 447, 457, 45 C.F.R. pt. 155).

offices.⁷⁸ Other highly commented on rules included the initial exchange establishment proposed rule⁷⁹ (thirty-five states, including the District of Columbia) and the Medicaid eligibility proposed rule⁸⁰ (thirty-eight states, including the District of Columbia) (which states sometimes responded to with a single set of joint comments⁸¹), and the recent proposed rule Exchange and Insurance Market Standards for 2015 and Beyond⁸² (twenty-five states, including the District of Columbia). Twenty states responded to the initial request for comments on exchanges,⁸³ which as discussed above, was largely targeted towards soliciting state-specific responses. Curiously, only six states responded to the proposed rule on the application, review, and reporting process for state innovation waivers.⁸⁴

⁷⁸ See, e.g., Comments of the D.C. Office of Admin. Hearings on Proposed 45 CFR Part 155, Subpart F (Feb. 21, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0511>; Comments of Michael Zimmer, Exec. Dir., Mich. Admin. Hearings Sys., on Proposed 42 CFR Parts 430, 431, 433, 435, 440, 447, and 457, and 45 CFR Part 155 (Feb. 21, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0397>; Comments of Tracy L. Henry, Chief A.L.J., Penn. Dep't of Pub. Welfare, Bureau of Hearings & Appeals (BHA) on Proposed Rule on Medicaid, CHIP and Exchanges (Feb. 21, 2013), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0522>.

⁷⁹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866 (proposed July 15, 2011) (to be codified at 45 C.F.R. pts. 155, 156).

⁸⁰ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg. 51,148 (proposed Aug. 17, 2011) (to be codified at 42 C.F.R. pts. 431, 433, 435, 457).

⁸¹ See, e.g., The State of Utah's Comments on Proposed Federal Rules Relating to the Implementation of Exchanges Under the Affordable Care Act (Oct. 31, 2011), available at <http://www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0020-2287> (responding to five distinct proposed rules issued between July 15 and Aug. 17, 2011).

⁸² Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 Fed. Reg. 15,808 (proposed Mar. 21, 2014) (to be codified at 45 C.F.R. pts. 146, 147, 149, 153, 155, 156, 158).

⁸³ Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 75 Fed. Reg. 45,584 (Aug. 3, 2010) (to be codified at 45 C.F.R. pt. 170).

⁸⁴ Application, Review, and Reporting Process for Waivers for State Innovation, 75 Fed. Reg. 13,553 (proposed Mar. 14, 2011) (to be codified at 45 C.F.R. pt. 155).

Based on their response rates, this Article classifies twenty-one states as “infrequent participants” in rulemaking, submitting comments four or fewer times (Table 3). Of these, only one state (Delaware) did not respond to any solicitations, however. Sixteen states and the District of Columbia may be classified as “moderate participants,” responding to between five and nine solicitations, while thirteen states may be classified as “frequent participants,” responding to ten or more solicitations. Unsurprisingly, states operating state-based exchanges (New York and Oregon) were the most frequent commenters, responding to sixteen and fifteen solicitations, respectively. An additional six states operating state-based exchanges—California (fourteen), Colorado (eleven), Maryland (eleven), Massachusetts (twelve), Minnesota (twelve), and Washington (twelve)—commented on ten or more publications. Utah, which is operating its own state-based small business exchange, also commented on ten actions. Perhaps more surprisingly, some states that opted to defer to take no part in exchange operation were also actively engaged throughout the notice-and-comment process, including Louisiana (eleven), Oklahoma (eleven), Tennessee (ten), and Wisconsin (eleven). In addition, some states that either operated their own exchanges or formally partnered with the federal government largely opted out of formal commenting process, including Delaware (zero), Hawaii (two), Idaho (four), Kentucky (two), and New Hampshire (three).

Table 3. State Responses to Federal Exchange Solicitations

State (Frequency of Participation)	
Frequent Commenter	CA (14x), CO (11x), LA (11x), MD (11x), MA (12x), MN (12x), NY (16x), OK (11x), OR (15x), TN (10x), UT (10x), WA (12x), WI (11x)
Moderate Commenter	AL (7x), AZ (7x), AR (6x), DC (7x), IL (6x), IN (7x), IA (5x), ME (6x), MI (8x), NE (5x), NV (9x), NM (6x), OH (7x), RI (6x), TX (8x), VT (6x), WV (5x)
Infrequent Commenter	AK (3x), CT (3x), DE (0x), FL (2x), GA (4x), HI (2x), ID (4x), KS (4x), KY (2x), MS (2x), MO (2x), MT (1x), NH (3x), NJ (4x), NC (2x), ND (3x), PA (3x), SC (2x), SD (4x), VA (2x), WY (1x)

State-Based Exchange

State Partnership Exchange

Federally Facilitated Exchange (including Marketplace Plan Management States)

Bifurcated Exchange

In interviews, officials from states that were moderate or frequent commenters noted that they primarily submitted comments to establish a

formal record of their opinion.⁸⁵ State officials doubted, however, that the commenting would be enough to change an outcome on its own.⁸⁶ One official from a state with a federally run exchange appraised things by noting that, “[o]ur comments are lumped in with hundreds, if not thousands, of others, so it is probably not the most effective way of influencing the process, but it is one way and we certainly took advantage of that avenue.”⁸⁷ Some state officials noted that they would often rely on the NAIC to represent their interests—as one related, “I think they pay attention to NAIC. From individual states, it depends on what they’re saying.”⁸⁸ Capacity also presented a barrier to commenting for some states: “it was all we could do to operationalize our exchange and keep up with the federal rules as best we could We didn’t have time to be concerned about providing comments.”⁸⁹

State officials quickly pivoted from discussion of their approach to rulemaking to the other avenues they used to weigh in and often found to be more effective direct interaction with federal officials, whether over the

⁸⁵ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

⁸⁶ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld). *But see* Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld) (“[T]hey would seriously consider our comments and they would take the comments whenever they could.”); Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld) (“[T]he comments are taken very seriously by the feds. . . . Unless something goes in in formal comments it doesn’t get counted.”).

⁸⁷ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

⁸⁸ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

⁸⁹ Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld).

phone, in person, or by email.⁹⁰ A former federal official echoed their sentiments: “The comments are important, and we would always ask for thoughts in writing. But the more interactive process was more important.”⁹¹ A formal comment letter from Tennessee on the initial health insurance premium tax credit proposed rule reflects the idea that the direct interactions are where the action is as well as states’ interest in establishing a formal record of those interactions.⁹² Specifically, regulators included copies of letters and email communications sent between state and federal officials regarding, among other things, negotiations over whether and how to allow Medicaid Managed Care Organizations (MCOs) to offer products on exchanges.⁹³ Putting these conversations in the *formal* public record may be seen as a way to hold federal officials accountable to their off-the-record commitments.

⁹⁰ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

⁹¹ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

⁹² Darin J. Gordon, TennCare Dir. & Deputy Comm’r, Div. of Health Care Fin. & Admin., State of Tennessee’s Comments on Proposed Rules about Eligibility for Premium Tax Credits and Cost-Sharing Subsidies (Oct. 28, 2010), *available at* <http://www.regulations.gov/#!documentDetail;D=IRS-2011-0024-0072>.

⁹³ *Id.* at 14, 16–17, 19–32.

B. INFORMAL ENGAGEMENT: DIRECT AND INDIRECT COMMUNICATION

In this section, the Article discusses additional channels used by states to informally influence federal decisions on exchange implementation. Direct communication between state and federal officials—in person, over the phone, and by email—was common and valued by state officials. Some states also chose to bring in third parties, including members of Congress and the media, to pressure the federal government when state officials felt they were not making headway. In some cases, states were also able to take advantage of their first-mover status: having acted on an issue before the federal government had finalized its decision-making, states were able to ensure that any subsequent federal action accommodated their preferences.

1. Direct Communication

On July 29, 2010, the first allotment of federal grant funding for the planning and establishment of exchanges (known as “section 1311 funds”) was opened to states.⁹⁴ According to a former federal official, HHS began holding forums with state officials shortly thereafter.⁹⁵ Every state, except Alaska, subsequently applied for, at least some, exchange grant funding,⁹⁶ and the grant application and monitoring process has provided a critical opportunity for state-federal interaction. Before each grant cycle, states could participate in pre-application conference calls, during which federal officials would provide information about the project and offer policy and budgetary guidance.⁹⁷ Grant recipients were assigned a state

⁹⁴ OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE ACT’S EXCHANGES (July 29, 2010), *available at* https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/exchange_planning_grant_foa.pdf.

⁹⁵ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

⁹⁶ Ctr. for Consumer Info. & Ins. Oversight, *Creating a New Competitive Health Insurance Marketplace*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Marketplace-Grants/index.html> (last visited May 22, 2015).

⁹⁷ *See, e.g.*, OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., COOPERATIVE AGREEMENT TO SUPPORT ESTABLISHMENT OF STATE-OPERATED HEALTH INSURANCE EXCHANGES 13–14

officer to track their progress and provide technical assistance as needed,⁹⁸ and CCIIO held at least two multi-day meetings in Washington, D.C. with grantees during which federal officials would review policy and operational issues.⁹⁹

State officials from both states operating state-based exchanges and states with partnership and fully federally run exchanges reported that their state officers became their primary contact point at HHS.¹⁰⁰ Depending on the proximity to the initial open enrollment period beginning in October 2013, state officials would be interacting with their state officer on a daily or weekly basis.¹⁰¹ As needed, state officers would funnel questions or

(Jan. 20, 2011), *available at* http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/foa_exchange_establishment.pdf.

⁹⁸ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., COOPERATIVE AGREEMENT TO SUPPORT ESTABLISHMENT OF THE AFFORDABLE CARE ACT'S HEALTH INSURANCE EXCHANGES 43 (Dec. 6, 2013), *available at* <http://www.cms.gov/CCIIO/Resources/FundingOpportunities/Downloads/amended-spring-2012-establishment-foa.pdf>.

⁹⁹ *See, e.g.*, Ctr. for Consumer Info. & Ins. Oversight, *Affordable Insurance Exchanges: State Exchange Grantee Meeting: September 19–20, 2011*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Presentations/hie-fall-2011-grantee-meeting.html> (last visited May 22, 2015); Ctr. for Consumer Info. & Ins. Oversight, *Affordable Insurance Exchanges: System-Wide Exchange Meeting: May 21–23, 2012*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Presentations/hie-spring-2012-conference.html> (last visited May 22, 2015).

¹⁰⁰ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰¹ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity

concerns to policy and legal staff within CCIIO, CMS, or IRS, or set up calls so they could directly communicate with states.¹⁰² One state official also noted that their state officer would tip them off on when to escalate an issue to a higher level because they were not getting traction.¹⁰³

As implementation moved forward, higher-level officials at CCIIO and CMS would also hold regular calls with state officials, including weekly meetings with the directors of state-based exchanges.¹⁰⁴ The federal government also continued to hold or attend multi-state meetings where states could schedule “office hours” visits with federal officials to discuss different policy options.¹⁰⁵ According to one state official, “states that wanted to be involved took advantage [of these meetings]. We wanted to interact with HHS as much as we could.”¹⁰⁶

State officials indicated that the informal nature of these interactions was valuable, particularly with respect to operational questions. According to one official, “it is much easier to talk about things informally rather than put in writing that you can’t complete a legal requirement . . . CMS played an important advisory role and problem solving role that wouldn’t have been possible through formal rules.”¹⁰⁷ Another official noted that they appreciated the ability to form a close

and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

¹⁰² *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰³ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹⁰⁴ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with former federal official (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld).

¹⁰⁵ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰⁶ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁰⁷ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

relationship with their federal partners and engage in dialogue about issues rather than just submitting written comments.¹⁰⁸

The informal nature of communications also drew concern from states, however. In particular, states felt that they did not always hear from the federal government about policy decisions when they felt they should have. For example, one official from a state with a partnership exchange noted that they first learned through the *New York Times* that the federal government was going to delay implementing employee choice (a functionality whereby a single employer can allow their employees to choose from multiple different health plans offered by different insurers) in federally run small business exchanges.¹⁰⁹ The delays resulted, in part, from the rulemaking process itself, as federal staff was barred from answering questions while they were drafting rules.¹¹⁰ At most, states might have learned the gist of a rule a few hours before it was released.¹¹¹ Other times, state officials felt the delays were more strategic: “The press was hungry to point out any flaws. That created some hesitancy on the part of the feds to share things with the states.”¹¹² For example, state officials reported not getting advance notice before the administration announced that it was adopting a transitional policy whereby health insurers could continue to renew policies that do not meet the ACA’s requirements beyond January 1, 2014,¹¹³ and that it would be changing the coverage effective date for plans purchased through the federally facilitated exchange between December 15th and 23rd and that it encouraged state-based exchanges to do the

¹⁰⁸ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹⁰⁹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹¹⁰ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹¹¹ Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld).

¹¹² Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld).

¹¹³ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld). The policy was announced in a public letter to insurance commissioners released on November 14, 2013. Letter from Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ins. Comm’rs (Nov. 14, 2013), *available at* <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf>.

same.¹¹⁴ Many state officials also commented that their primary contacts were not always kept up to date on policy or operational changes.¹¹⁵

State officials also perceived that the federal government was reluctant to put anything in writing due to political pressure, and reported getting different answers to the same questions from one week to the next as different people would join their discussions: “It was hard to get real consistent answers.”¹¹⁶ One state official expressed particular frustration that they were never allowed to speak to the HHS Office of the General Counsel (OGC), describing OGC as a “mysterious entity, like the Wizard of Oz.”¹¹⁷ Messages would be channeled between intermediaries who did not necessarily have legal expertise or an understanding of health insurance, opening the door for miscommunications and misunderstanding.¹¹⁸

¹¹⁴ Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld). This policy was announced in a fact sheet released on December 12, 2013. *Taking Steps to Smooth Consumers' Transition into Health Coverage Through the Marketplace*, CMS.GOV (Dec. 12, 2013), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-12-12.html>. This proposal was published in interim final rule five days later. Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76,212 (Dec. 17, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156).

¹¹⁵ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹¹⁶ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); *see also, e.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

¹¹⁷ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

¹¹⁸ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld). This frustration particularly arose with respect to questions regarding sub-regulatory guidance, which, unlike rules issued through notice-and-comment rulemaking, are not required to cite the legal authority under which they are being issued. *See* William Funk, *A Primer on Nonlegislative Rules*, 53 ADMIN. L. REV. 1321, 1322 (2001)

2. Indirect Communication

State officials offered differing opinions on the value of using third parties, including members of Congress and the press, to influence federal decision-making. In some cases, state officials implied that going to the press or other third parties would be a breach of the trust and bonds they had with federal officials. According to one official from a state with a federally run exchange, “[o]ur feeling was that we can [sic] take care of our own issues. We had established relationships not only with our project officer but other people within CCIIO If I needed to, I would elevate issues up to [the senior staff level].”¹¹⁹ Another framed it politically, “[o]ur governor wants to support the Obama Administration and exchange implementation. There have been times when we could have gone out of our way to point out problems, and we haven’t done that.”¹²⁰ Others simply rejected the option as unnecessary¹²¹ or expressed concern that it would not benefit them to go to the press.¹²²

States appeared more willing to use their congressional delegation to escalate an issue than the press.¹²³ One official characterized this as a “more muted” option than going public with concerns.¹²⁴ However, this option was only available to the extent state officials perceived their

(“These rules . . . are not ‘law’ in the way that statutes and substantive rules that have gone through notice and comment are ‘law,’ in the sense of creating legal obligations on private parties.”).

¹¹⁹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹²⁰ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²¹ Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²² Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²³ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹²⁴ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

congressional delegation to be supportive of their requests, which was not the case in every state.¹²⁵

Among states that were more willing to use third parties, most reported only doing so as a last resort. According to a state-based exchange official, “[i]t’s a stronger option that we only turn to if no movement and it’s not needed very often. But there have been times when they’ve been involved.”¹²⁶ Some states would be willing to pull the trigger more quickly than others, though. As one official from a state with a state partnership exchange reported, “[a]ny time we had a problem, we felt like we could go to [our Senator]. And we did. And we felt we could use the press if we were having trouble If there wasn’t communications [sic] with us, we’d make it known.”¹²⁷

C. THE ROLE OF THE STATE INTEREST GROUPS AND CROSS-STATE COLLABORATION

The NAIC played a particularly active role in exchange implementation. Congress recognized the potential value of NAIC (self-described as, “the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories”¹²⁸) in the ACA. The statute calls on the Secretary of HHS to consult with NAIC on numerous occasions,¹²⁹ including multiple provisions closely to exchange implementation.¹³⁰ HHS has since not merely consulted with NAIC, but in

¹²⁵ Compare Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld) (noting supportive relationship), with Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld) (noting unsupportive relationship).

¹²⁶ Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld).

¹²⁷ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹²⁸ Senator Ben Nelson, *About the NAIC*, NAT’L ASS’N OF INS. COMM’RS, http://www.naic.org/index_about.htm (last visited May 22, 2015).

¹²⁹ See, e.g., Patient Protection and Affordable Care Act §§ 1333(a)(1), 1341(b)(1), 42 U.S.C. §§ 18053(a)(1), 18061(b)(1) (2012).

¹³⁰ See, e.g., Patient Protection and Affordable Care Act §§ 1311(c)(1)(F), 1321(a)(2), 42 U.S.C. §§ 18031(c)(1)(F), 18041(a)(2) (2012).

fact relied on it to write first drafts of key regulations¹³¹ and templates of a uniform summary of benefits and coverage.¹³²

Particularly early on, before it had developed relationships with individual states, the federal government relied on state interest groups to convey messages to and from the states.¹³³ HHS acknowledged this important convening role of state interest groups early on when it sent a letter to the presidents of NAIC, the National Conference of State Legislatures (NCSL), and the National Governors Association (NGA) accompanying its first guidance document on exchanges.¹³⁴ The letter states:

As we look ahead to the establishment of the Exchanges and other reforms, it is essential that we work closely with states every step of the way.

The enclosed guidance is another sign of our commitment to provide states with timely, useful information and assistance in response to the priorities and needs states have communicated to us. It provides transparency in our efforts and offers states interested in acting in the coming year input into the structure and function of Exchanges.¹³⁵

The letter also acknowledges NAIC's work to draft model exchange legislation, adding that the "preliminary drafts currently under review are in

¹³¹ Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 563–64 (2011) (noting that HHS adopted NAIC's draft medical loss ratio regulations).

¹³² Sutherland Asbill & Brennan LLP, *New Rules for Summaries of Health Benefits and Coverage*, LEXOLOGY (Aug. 23, 2011), <http://www.lexology.com/library/detail.aspx?g=55f86fb0-247e-4ff4-87b5-884aba08f4b6>.

¹³³ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹³⁴ Letter from Kathleen Sebelius, Sec'y of Health & Human Servs., to Christine Gregoire, Governor of Wash., Jane L. Cline, President, Nat'l Ass'n of Ins. Comm'rs, and Senator Richard T. Moore (Nov. 18, 2010), *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_guidance_cove_r_letter_101118.pdf (regarding initial guidance on Health Insurance Exchanges).

¹³⁵ *Id.* at 1.

accordance with the statute and will serve as a helpful model for states to establish authorizing legislation for their Exchanges.”¹³⁶

Since then, all three organizations have been active in exchange-related activities. NCSL and NAIC were moderate to frequent participants in notice-and-comment rulemaking,¹³⁷ and NAIC, as well as NGA, has sent public letters to HHS, the White House, and members of Congress outside of commenting periods to emphasize points of concerns.¹³⁸ In addition, the

¹³⁶ *Id.* at 2.

¹³⁷ *See, e.g.*, Letter from Susan E. Voss, Iowa Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Kevin M. McCarty, Fla. Ins. Comm’r & President-Elect, Nat’l Ass’n of Ins. Comm’rs, James J. Donelon, La. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Adam Hamm, N.D. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n. of Ins. Comm’rs, to Donald Berwick, Adm’r, Ctrs. for Medicare & Medicaid Servs. (Oct. 5, 2011), *available at* http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services2.pdf; *see also Special Section: Patient Protection and Affordable Care Act & State Insurance Regulation*, NAT’L ASS’N. OF INS. COMM’RS, http://www.naic.org/index_health_reform_section.htm (last visited May 22, 2015). Additional comment letters include NCSL on the Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (OCIIO-9989-NC); Establishment of Exchanges and Qualified Health Plans Proposed Rule (CMS-9989-P); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 Final and Interim Final Rules (CMS-2349-F); and Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule (CMS-9980-P). Letters are available by searching the respective file code (in parentheses) on nctl.org.

¹³⁸ *See, e.g.*, Letter from Terry Branstad, Governor of Iowa & Chair, Health & Human Servs. Comm., Nat’l Governors Ass’n, and Pat Quinn, Governor of Ill. & Vice Chair, Health & Human Servs. Comm., Nat’l Governors Ass’n, on behalf of the Nat’l Governors Ass’n, to Kathleen Sebelius, Sec’y, Dep’t of Health & Human Servs. (Nov. 2, 2011), *available at* <http://www.nga.org/cms/home/federal-relations/nga-letters/health--human-services-committee/col2-content/main-content-list/november-2-2011-letter---health.html>; Letter from Susan E. Voss, Iowa Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Kevin M. McCarty, Fla. Ins. Comm’r & President-Elect, Nat’l Ass’n of Ins. Comm’rs, James J. Donelon, La. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Adam Hamm, N.D. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to Kathleen Sebelius, Sec’y, Dep’t of Health & Human Servs. (Nov. 7, 2011), *available at* http://www.naic.org/documents/index_health_reform_111107_naic_letter_sec_sebeilus_exchange_partner_guide.pdf;

groups have convened numerous in-person meetings and calls where states can meet with each other and with federal officials. For example, in 2011, NGA hosted a two-day meeting entitled, “Timelines, State Options, and Federal Regulations,” that was attended by more than 120 state officials and ended with a group meeting with federal officials from HHS and the Department of Treasury on exchange implementation.¹³⁹ A year later, NGA again convened a two-day meeting at which participants compiled a lengthy list of questions for federal officials on exchanges and Medicaid

Letter from James J. Donelon, La. Ins. Comm’r & President, Nat’n Ass’n of Ins. Comm’rs, Adam Hamm, N.D. Ins. Comm’r & President-Elect, Nat’l Ass’n of Ins. Comm’rs, Monica J. Lindeen, Mont. Comm’r of Sec. & Ins. & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Michael F. Consedine, Pa. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to John Boehner, Speaker, U.S. House of Representatives, Harry Reid, Majority Leader, U.S. Senate, Nancy Pelosi, Minority Leader, U.S. House of Representatives, and Mitch McConnell, Minority Leader, U.S. Senate, (Nov. 6, 2013), *available at* http://www.naic.org/documents/index_health_reform_comments_131106_naic_letter_to_congress_aca_implementation.pdf; Letter from Adam Hamm, N.D. Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Monica J. Lindeen, Mont. Comm’r of Sec. & Ins. & President-Elect, Nat’n Ass’n of Ins. Comm’rs, Michael F. Consedine, Pa. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, and Sharon P. Clark, Ky. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to Dr. Mandy Cohen, Interim Dir., Ctr. for Consumer Info. & Ins. Oversight (Apr. 23, 2014), *available at* http://www.naic.org/documents/index_health_reform_comments_140423_naic_letter_cciio_network_adequacy.pdf; Letter from Adam Hamm, N.D. Ins. Comm’r & President, Nat’l Ass’n of Ins. Comm’rs, Monica J. Lindeen, Mont. Comm’r of Sec. & Ins. & President-Elect, Nat’n Ass’n of Ins. Comm’rs, Michael F. Consedine, Pa. Ins. Comm’r & Vice President, Nat’l Ass’n of Ins. Comm’rs, Sharon P. Clark, Ky. Ins. Comm’r & Sec’y-Treasurer, Nat’l Ass’n of Ins. Comm’rs, and Senator E. Benjamin Nelson, Chief Exec. Officer, Nat’l Ass’n of Ins. Comm’rs, on behalf of the Nat’l Ass’n of Ins. Comm’rs, to President Barack Obama (Apr. 30, 2014), *available at* http://www.naic.org/documents/index_health_reform_comments_140501_naic_letter_wh_followup_letter.pdf.

¹³⁹ KRISTA DROBAC, NGA CENTER FOR BEST PRACTICES ISSUE BRIEF: STATE PERSPECTIVES ON INSURANCE EXCHANGES: IMPLEMENTING HEALTH REFORM IN AN UNCERTAIN ENVIRONMENT (Sept. 16, 2011), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/1109NGAEXCHANGESSUMMARY.PDF>.

expansion.¹⁴⁰ Federal officials also regularly attend NAIC's bi-annual conferences.¹⁴¹

All three organizations have also published materials to assist states. NAIC's efforts are particularly noteworthy and include a model law on exchange establishment,¹⁴² a chart of federal ACA FAQs,¹⁴³ summaries of clear or potential preemptions on state authority with respect to qualified health plans and health plans sold outside exchanges,¹⁴⁴ a summary of decisions to be made by states with a federally run exchange,¹⁴⁵ and white papers on topics including accreditation and quality,¹⁴⁶ marketing and

¹⁴⁰ NAT'L GOVERNORS ASS'N, HEALTH CARE: DECISION POINTS FOR STATES MEETING SUMMARY (July 26, 2012), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/HealthCareDecisionPointsforStates.pdf>. An appendix with the full list of questions from states is available at <http://www.nga.org/files/live/sites/NGA/files/pdf/AppendixQuestionsfromStates.pdf>.

¹⁴¹ *See, e.g., Health Insurance Exchanges Focus of Governors Session*, NAT'L GOVERNORS ASS'N (July 16, 2011), http://www.nga.org/cms/home/news-room/news-releases/page_2011/col2-content/main-content-list/health-insurance-exchanges-focus.html; Nat'l Ass'n of Ins. Comm'rs, 2014 NAIC Spring National Meeting Final Registration List; Nat'l Ass'n of Ins. Comm'rs, 2013 NAIC Fall National Meeting Final Registration List.

¹⁴² AM. HEALTH BENEFIT EXCH. MODEL ACT (2010), *available at* http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

¹⁴³ NAT'L ASS'N OF INS. COMM'RS, ALL ACA-RELATED FEDERAL FAQs AS OF OCTOBER 9, 2013, *available at* http://www.naic.org/documents/index_health_reform_faq.pdf.

¹⁴⁴ NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: QUALIFIED HEALTH PLANS (June 27, 2013), *available at* http://www.naic.org/documents/committees_b_130627_preemption_analysis_qhp.pdf; NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: HEALTH PLANS OUTSIDE EXCHANGES (June 27, 2013), *available at* http://www.naic.org/documents/committees_b_130627_preemption_analysis_outside_market.pdf.

¹⁴⁵ NAT'L ASS'N OF INS. COMM'RS, STATE DECISIONS: FEDERALLY FACILITATED EXCHANGE (FFE) STATES (June 27, 2013), *available at* http://www.naic.org/documents/committees_b_130627_ffestate_decisions.pdf.

¹⁴⁶ NAT'L ASS'N OF INS. COMM'RS, EXCHANGES PLAN MANAGEMENT FUNCTION: ACCREDITATION AND QUALITY WHITE PAPER (2012), *available at* http://www.naic.org/documents/committees_b_related_wp_accred_quality.pdf.

consumer assistance,¹⁴⁷ and network adequacy.¹⁴⁸ In addition, NCSL has maintained up-to-date resources on state action on exchanges¹⁴⁹ and NGA has published issue briefs on exchange implementation.¹⁵⁰ State officials expressed particular gratitude for their help interpreting the sea of regulations and guidance coming out of the federal government.¹⁵¹

More recently, a fourth state interest group comprised specifically of state exchange directors and staff has formed. The State Health Exchange Leadership Network, also known informally as “Exchangers,” is convened by the National Academy of State Health Policy (NASHP).¹⁵² It is led by an eleven-person steering committee of state and exchange officials representing all exchange models,¹⁵³ and currently has over 400 members representing all fifty states and the District of Columbia.¹⁵⁴

¹⁴⁷ NAT’L ASS’N OF INS. COMM’RS, MARKETING AND CONSUMER INFORMATION WHITE PAPER: NAVIGATORS, AGENTS AND BROKERS, MARKETING AND SUMMARY OF BENEFITS AND COVERAGE (2012), *available at* http://www.naic.org/documents/committees_b_related_wp_marketing_consumer_info.pdf.

¹⁴⁸ NAT’L ASS’N OF INS. COMM’RS, PLAN MANAGEMENT FUNCTION: NETWORK ADEQUACY WHITE PAPER (2012), *available at* http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

¹⁴⁹ Richard Cauchi, *State Actions to Address Health Insurance Exchanges*, NAT’L CONFERENCE OF STATE LEGISLATURES (May 1, 2015), <http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx>.

¹⁵⁰ *See, e.g.*, TOM DEHNER, NGA CENTER FOR BEST PRACTICES ISSUE BRIEF: STATE HEALTH INSURANCE EXCHANGES AND CHILDREN’S COVERAGE: ISSUES FOR STATE DESIGN DECISIONS (Aug. 29, 2011), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/1108CHILDRENHEALTHEXCHANGES.PDF>.

¹⁵¹ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

¹⁵² NAT’L ACAD. FOR STATE HEALTH POL’Y, STATE HEALTH EXCHANGE LEADERSHIP NETWORK: 2013 ANNUAL REPORT 3 (2014), http://nashp.org/sites/default/files/Exchangers_Annual_Report_FINAL.pdf.

¹⁵³ As of April 2014, Steering Committee Members represented the following states: Arizona, Colorado, Connecticut, Idaho, Illinois, Kansas, Kentucky, New Mexico, Oregon, Washington, and West Virginia. Nat’l Acad. for State Health Pol’y, State Health Exchange Leadership Network: Steering Committee Membership (Apr. 2014), *available at* http://www.nashp.org/sites/default/files/Steering_Committee_membership_list_4-2014.pdf.

¹⁵⁴ NAT’L ACAD. FOR STATE HEALTH POL’Y, *supra* note 152, at 4–5.

Unlike NAIC, NCSL, and NGA, the “Exchangers” is not formed as an association and does not conduct official lobbying itself.¹⁵⁵ It does, however, facilitate regular calls between state exchange directors and staff and online information sharing between states,¹⁵⁶ and is currently building relationships with federal officials.¹⁵⁷ One state official noted that this group filled an important gap, as much of exchange implementation, such as building call centers and eligibility systems, fell beyond the scope of the existing groups’ expertise.¹⁵⁸

Outside of these formal networks, collaboration between states in terms of advocating the federal government appears to have been irregular (information sharing, in contrast, was much more common). On only three instances did states come together to submit multi-state comment letters in response to formal notice-and-comment rulemaking independent of the NAIC, NGA, or NCSL,¹⁵⁹ and, in interviews, state officials often reported that they did not typically band together for lobbying purposes. There were some exceptions, however. For example, an official from a state with a partnership exchange noted that they coordinated with other states to successfully discourage CCIIO from requiring partnership states from entering into formal memoranda of understanding (MOUs).¹⁶⁰ In addition, officials reported that a handful of states defaulting to federally run

¹⁵⁵ Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld).

¹⁵⁶ NAT’L ACAD. FOR STATE HEALTH POL’Y, *supra* note 152, at 4.

¹⁵⁷ Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld).

¹⁵⁸ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹⁵⁹ Pam Bondi, Fla. Attorney Gen., et al., Comments from the States of Florida, Alabama, Georgia, Kansas, Michigan, Nebraska, North Dakota, South Carolina, Texas, and West Virginia on Consumer Protection Issues Raised by HHS’s Proposed Rule (CMS-9949-P) (Apr. 21, 2014), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2014-0036-0163> (including comments on consumer protection issues raised by HHS’s proposed rule); Caroline M. Brown & Philip J. Peisch, Joint Comments on Behalf of Nine States and State Agencies Regarding Proposed Rules for Alternative Benefit Plans (Feb. 21, 2013), *available at* <http://www.regulations.gov/#!documentDetail;D=CMS-2013-0012-0453>; Gordon, *supra* note 92 (reprinting a letter to federal officials from officials from Arizona, Tennessee, and Utah).

¹⁶⁰ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

exchanges joined forces to ensure they could maintain authority over the regulation of qualified health plans. Their collective advocacy ultimately resulted in the creation of the “marketplace plan management option” by which states could conduct plan management on behalf of the federally run exchange, which seven states—Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia—ultimately took part in for 2014.¹⁶¹ According to one participant in the group: “It worked out really well for us. At some point HHS acknowledged that there was this core group of states [that wanted to be engaged in exchange implementation] and started reaching out to us collectively.”¹⁶²

IV. FACTORS AFFECTING STATE INFLUENCE OVER FEDERAL DECISION-MAKING

Objectively assessing how much influence state officials ultimately had over exchange implementation is difficult.¹⁶³ Rather than attempt to tally victories and losses and speculate over whether a state’s input, versus other factors, drove any given decision, this Part more broadly identifies four factors that appear to have affected how much influence states were able to hold over federal decision-making. These factors include the extent to which the federal government perceived states to share their goals for ACA implementation, limits on federal resources and capacity for exchange implementation, institutional characteristics of the different federal agencies involved and their relevant sub-components, and the ability of states to take “first-mover” advantage.

Prior to proceeding, however, it is worth noting that while the federal government appeared to put more effort into conducting federalism impact analyses than research has found it to in the past, it appears to be a largely pro forma practice. It seems unlikely that the inclusion of federalism impact statements served any public notice function as states were closely monitoring the rulemaking process and were aware that the rules, whether acknowledged by the federal government or not, would

¹⁶¹ DASH ET AL., IMPLEMENTING THE AFFORDABLE CARE ACT, *supra* note 1, at 3.

¹⁶² Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁶³ Seifter, *supra* note 11, at 473–74 (“Empirical studies [of state influence over federal agency decision-making] are scarce, and measuring regulatory influence in any context is notoriously difficult.” (footnote omitted)).

directly impact their interests. In fact, rather than rely on the federal government's federalism analysis, states turned to the NAIC to conduct a comprehensive preemption review.¹⁶⁴ In addition, while it is possible that federal officials were inspired to conduct additional outreach to states and/or revise their decisions in light of Executive Order 13,132, there was no suggestion that this was in fact the case. Any increase in attentiveness to state interests may be just as readily explained by the previously mentioned command in the ACA that the Secretary of HHS consults with state insurance regulators.¹⁶⁵

A. STATE INTERESTS AND THE COMPETING GOALS OF THE ACA

The ACA embodies multiple and sometimes competing goals. Broadly speaking, one of its primary purposes is to reduce the number of people who are uninsured by promoting access to more affordable coverage through Medicaid expansion, financial support for low-to-moderate income families purchasing private coverage, and reforming the private health insurance market so companies can no longer deny coverage to those who need it.¹⁶⁶ The law is also intended to strengthen consumer rights and protections for people who are already or become insured.¹⁶⁷ At the same time, Congress specifically rejected a national model for exchange implementation in favor of the state-led approach.¹⁶⁸ Thus, while the

¹⁶⁴ NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: HEALTH PLANS OUTSIDE EXCHANGES, *supra* note 144; NAT'L ASS'N OF INS. COMM'RS, ACA IMPACT ON STATE REGULATORY AUTHORITY: QUALIFIED HEALTH PLANS, *supra* note 144.

¹⁶⁵ Patient Protection and Affordable Care Act § 1321(a), 42 U.S.C. § 18041(a) (2012) (establishment of standards for state flexibility in operation and enforcement of exchanges and related requirements).

¹⁶⁶ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2612–14, 2629 (2012) (Ginsburg, J., dissenting).

¹⁶⁷ *Id.* at 2626 (2012) (Ginsburg, J., dissenting) (“Recall that one of Congress' goals in enacting the Affordable Care Act was to eliminate the insurance industry's practice of charging higher prices or denying coverage to individuals with preexisting medical conditions.”).

¹⁶⁸ Gluck, *supra* note 7, at 1757 (“[E]xchange governance was the key question that divided the House and Senate versions of the legislation, with the Senate invoking ‘federalism’ values to insist on the state-leadership default preference that ultimately carried the day.”); *see also* Metzger, *supra* note 7, at 576 (“This reliance on state-run exchanges marks a significant difference between the

federal government was asserting new control over an area traditionally regulated by the states by setting broad consumer protection rules, it continued to value at least some state flexibility.¹⁶⁹ As Professor Gillian Metzger has commented in light of similar approaches by the Obama Administration in other areas of the law, this represents “federalism in service of progressive policy, not a general devolution of power and resources to the states.”¹⁷⁰

Indeed, some academics have characterized HHS’s approach to implementation as reflecting a “general policy of flexibility toward states’ efforts to carry out their obligations under the ACA,”¹⁷¹ or, more strongly, a “policy of ‘maximum flexibility’ to the states on a number of the key implementation points involving the health exchanges and other variables.”¹⁷² And, in interviews, officials widely acknowledged that the federal government has provided states significant independence in most areas.¹⁷³ However, there appears to be a limit to this flexibility if the federal government perceives that state flexibility or accommodation may be

Senate bill that became the ACA and the earlier House version. The latter had assigned primary responsibility for operating a national uniform exchange to the federal government, with states allowed to opt in to operate state-based exchanges if they met federal requirements. State officials lobbied strongly for state-based exchanges and for states to retain broad regulatory authority over insurance.” (footnotes omitted).

¹⁶⁹ Gluck, *supra* note 131, at 579. (“[T]he ACA’s text itself mentions ‘state flexibility’ six times in the context of the exchange provisions.”).

¹⁷⁰ Metzger, *supra* note 7, at 569–70.

¹⁷¹ Bagenstos, *supra* note 41, at 230.

¹⁷² Theodore W. Ruger, *Health Policy Devolution and the Institutional Hydraulics of the Affordable Care Act*, in *THE HEALTH CARE CASE: THE SUPREME COURT’S DECISION AND ITS IMPLICATIONS* 359, 362 (Nathaniel Persily, Gillian E. Metzger & Trevor W. Morrison eds., 2013).

¹⁷³ See, e.g., Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state interest group (Mar. 25, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

perceived to threaten the ACA's primary goal of coverage expansion. As a former federal official described:

If you look at the regulation we put out in July 2011 [on exchange establishment]—which was mostly about plan management and consumer outreach functions of the exchange—the watchwords were state flexibility. We almost needed synonyms for flexibility because we used it too much. . . . But when the next regulation came out in August—on eligibility and enrollment—the watchwords were seamless consumer experience and not state flexibility. If anything, it was supposed to be totally regimented. Determinations should come out exactly the same for consumers answering questions in different states. . . . We didn't want states innovating around determining if someone is eligible for a tax credit or not.¹⁷⁴

A striking example of this comes from Utah's negotiations with the federal government over which exchange model to pursue. In December 2012, Utah Governor Gary Herbert submitted a declaration letter indicating interest in pursuing a state-based exchange.¹⁷⁵ However, he noted that his willingness to move forward was contingent on having “flexibility to stay true to Utah principles.”¹⁷⁶ Around this time, the Utah small business exchange was frequently compared to Massachusetts' exchange.¹⁷⁷ These comparisons primarily focused on the two exchanges' differing approaches to plan management: Utah had adopted a take all comers approach to insurer participation, while Massachusetts established more stringent

¹⁷⁴ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

¹⁷⁵ Letter from Gary R. Herbert, Governor of Utah, to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Dec. 14, 2012), *available at* <http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ut-declaration-letter.pdf>.

¹⁷⁶ *Id.*

¹⁷⁷ *See, e.g.,* SABRINA CORLETTE ET AL., GEO. U. HEALTH POL'Y INST., THE MASSACHUSETTS AND UTAH HEALTH INSURANCE EXCHANGES: LESSONS LEARNED (Geo. Univ. Health Pol'y Inst. Ctr. for Children & Families ed., 2011), *available at* http://ccf.georgetown.edu/wp-content/uploads/2012/03/Health-reform_exchanges.pdf.

standards for which insurers could participate and what they could offer.¹⁷⁸ This, however, was not an issue as the federal exchange rules gave states significant leeway in this area,¹⁷⁹ and, in fact, the federal government opted to pursue an approach that looked more like the Utah model than the Massachusetts model for federally run exchanges.¹⁸⁰ Instead, the sticking point was over whether Utah would administer Medicaid eligibility determinations or assessments or offer premium tax credits through the exchange. In a speech to the American Enterprise Institute in February 2012, Governor Herbert stated:

We want to maintain clear separation between private insurance options in our market based exchange and the welfare based public programs such as Medicaid. In order to preserve the market-based principles behind Utah's unique exchange, it is critical that the exchange remain focused on the core mission of creating competition and choice in insurance markets. Those who are in need

¹⁷⁸ See, e.g., Sharon Silow-Carroll et al., *Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection*, STATES IN ACTION: INNOVATIONS IN STATE HEALTH POL'Y (Commonwealth Fund, New York, N.Y.), Mar. 17, 2011, available at <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Feature/Feature.aspx>.

¹⁷⁹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule, 77 Fed. Reg. 18,310, 18,406 (Mar. 27, 2012) ("As we noted in the preamble to the Exchange establishment proposed rule, we believe that an Exchange's certification approach may vary based upon market conditions and the needs of consumers in the service area. Accordingly, in this final rule, we offer flexibility to Exchanges on several elements of the certification process, including the contracting model, so that Exchanges can appropriately adjust to local market conditions and consumer needs. An Exchange could adopt its contracting approach from a variety of contracting strategies, including an any qualified plan approach, a selective contracting model based on predetermined criteria, or direct negotiation with all or a subset of QHPs.").

¹⁸⁰ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., GENERAL GUIDANCE ON FEDERALLY-FACILITATED EXCHANGES, *supra* note 61 ("To ensure a robust QHP market in each State where an FFE operates, and to promote consumer choice among QHPs, at least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards.").

should have the opportunity to get assistance, but that determination and effort should be done separately.¹⁸¹

The federal government would not accommodate Utah's requests. However, HHS revised its regulations to create a middle ground, allowing Utah to continue to operate its small business exchange while the federal government stepped in to run the individual market exchange.¹⁸²

More generally, a state official from a state-based exchange state acknowledged that they were given flexibility "so long as what we are doing contributes to the goal of getting as many people enrolled as possible, with as few gaps as possible If we were trying to go the other direction, we would have seen more pushback."¹⁸³ Officials from states with partnership exchanges reported sometimes being constrained even though they shared the same goals with the federal government, because the flexibility or authority that would apply to them would also apply to states that strongly opposed implementation of health insurance exchanges.¹⁸⁴

It is important to note that there was not always a clear line between states that shared the administration's goals and those that did not. At least some state officials from states defaulting to federally run exchanges went out of their way to work with the federal government to ensure that implementation went smoothly. In some cases, this reflects divisions within states over the ACA. One official commented, "[b]ecause I do show up at face-to-face meetings and to talk [to federal officials] personally, and because the [state insurance] commissioner is trying to support health reform, when I call them or send them an email or tell them there is a problem with something, it usually gets responded to."¹⁸⁵ Yet,

¹⁸¹ Gov. Gary R. Herbert, Remarks at American Enterprise Institute, Utah's Vision for Healthcare Reform (Feb. 6, 2013), *available at* <http://www.utah.gov/governor/docs/Speech-HealthcareSpeechToAmericanEnterpriseInstitute.pdf>.

¹⁸² Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule, 78 Fed. Reg. 54,070, 54,075-76 (Aug. 30, 2013) (to be codified at 45 C.F.R. §§ 155.100, 155.105, 155.140).

¹⁸³ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

¹⁸⁴ Interview with senior official, federally run health insurance exchange state (Mar. 7, 2014) (interviewee identity and affiliation withheld).

¹⁸⁵ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

another state official found that even though their boss personally disagreed with certain things, they were willing to make things work.¹⁸⁶

B. FEDERAL FINANCIAL RESOURCES AND CAPACITY

Limitations on federal resources and capacity appeared to play a meaningful role in determining if and when the federal government would accommodate state preferences. In interviews, both state and former federal officials noted that the federal government did not anticipate that so many states would opt out of running their own exchanges.¹⁸⁷ One state official added that “once there got to be so many [states opting out], federal officials were at the mercy of being much more flexible and were willing to give as much as they could to any state participating having a dialogue with them.”¹⁸⁸ Particularly pressing was the difference in financial resources available to states versus the federal government. While states can continue to apply for an unlimited amount of section 1311 establishment funds through the end of 2014,¹⁸⁹ the ACA dedicated no funds to federal exchange operations. Instead, it only appropriated \$1 billion to HHS for federal administrative expenses related to implementing the ACA writ large.¹⁹⁰ HHS has been forced to scrape together resources from existing appropriations funds, including HHS’s General Departmental Management

¹⁸⁶ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

¹⁸⁷ *E.g.*, Interview with senior official, state with state-run health insurance exchange (March 18, 2014) (interview identity and affiliation withheld); Interview with former senior federal official (March 24, 2014) (interviewee identity and affiliation withheld).

¹⁸⁸ Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld).

¹⁸⁹ Patient Protection and Affordable Care Act § 1311(a), 42 U.S.C. §18031(a) (2012) (providing assistance to states to establish American Health Benefit Exchanges).

¹⁹⁰ Health Care and Education Reconciliation Act of 2010 § 1005, 42 U.S.C. § 18121 (2012) (“(a) IN GENERAL. There is hereby established a Health Insurance Reform Implementation Fund (referred to in this section as the “Fund”) within the Department of Health and Human Services to carry out the Patient Protection and Affordable Care Act and this Act (and the amendments made by such Acts). (b) FUNDING. There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, \$1,000,000,000 for Federal administrative expenses to carry out such Act (and the amendments made by such Acts).”).

Account, CMS's Program Management Account, the Prevention and Public Health Fund, and HHS's Nonrecurring Expenses Fund, to support its activities.¹⁹¹ In contrast, as of January 2014, more than \$4.6 billion in federal grant dollars has been awarded to states (with nearly one quarter of state grant dollars going to California).¹⁹²

The most obvious development coming out of this dynamic has been the introduction of novel exchange models. The idea of a hybrid "partnership" model where functionalities would be shared between a state and the federal government was first introduced publicly in the July 2011 proposed rule on exchange establishment in response to state pressure for more options.¹⁹³ Many states, however, bridled at the "partnership" label

¹⁹¹ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-601, STATUS OF CMS EFFORTS TO ESTABLISH FEDERALLY FACILITATED HEALTH INSURANCE EXCHANGES 1, 12 (2013), *available at* <http://www.gao.gov/assets/660/655291.pdf>.

¹⁹² *Total Health Insurance Exchange Grants*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/total-exchange-grants/> (last visited May 22, 2015).

¹⁹³ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866, 41,870 (proposed July 15, 2011) ("HHS has pursued various forms of collaboration with the States to facilitate, streamline and simplify the establishment of an Exchange in every State. These efforts have made it clear that for a variety of reasons including reducing redundancy, promoting efficiency, and addressing the tight implementation timelines authorized under the Affordable Care Act, States may find it advantageous to draw on a combination of their own work plus business services developed by other States and the Federal government as they move toward certification. Some States have expressed a preference for a flexible State partnership model combining State-designed and operated business functions with Federally designed and operated business functions. Examples of such shared business functions might include eligibility and enrollment, financial management, and health plan management systems and services. We note that States have the option to operate an exclusively State-based Exchange. HHS is exploring different partnership models that would meet the needs of States and Exchanges."). Over time, the federal government elaborated on how responsibilities and authority would be divided: while legally, state partnership exchanges would be federally facilitated exchanges, states entering into partnerships could conduct plan management responsibilities and/or certain consumer assistance functions, including operating an in-person assistance program funded by § 1311 exchange establishment grants to supplement the statutorily mandated navigator program, which could not be supported by such funds. Letter from Ctr. for Consumer Info. & Ins. Oversight, Affordable Insurance Exchanges Guidance: Guidance on the State Partnership Exchange (Jan. 3, 2013), *available at* <http://www.cms.gov/>

and the formal application process the federal government required states to follow to enter into a partnership.¹⁹⁴ In February 2013, the Kansas Insurance Commissioner sent a letter to the director of CCIIO explaining that while there was “no political support for a partnership arrangement,” the state would like approval to perform plan management functions (such as certifying that health plans met state and federal statutory and regulatory requirements) on behalf of the federally run exchange.¹⁹⁵ Five days later, CCIIO issued a FAQ allowing for states to conduct plan management so long as they submitted a letter from their governor or insurance commissioner attesting to their legal authority and operational capacity to do so and agreed to participate in a one-day review session with the federal government.¹⁹⁶

Over time, the federal government also expanded the scope of activities for which states could use exchange establishment and planning grants. For example, in June 2012, guidance generally provided that states with federally facilitated exchanges could use funds to support a transition to a state-based or state partnership exchange or to cover the costs of state activities to establish interfaces with the federal exchange.¹⁹⁷ Ten months later, the federal government clarified that states with federally run exchanges could use section 1311 funds to conduct statewide marketing

CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf.

¹⁹⁴ According to one state official, state insurance regulators stressed to HHS that they “cannot use the word partnership. That would immediately turn off our governor’s offices.” Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

¹⁹⁵ Letter from Sandy Praeger, Comm’r of Ins., Kan. Ins. Dept., to Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, Re: Proposal to Perform Plan Management Functions for Federally Facilitated Exchange (Feb. 15, 2013), available at <http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ks-exchange-letter-2-15-2013.pdf>.

¹⁹⁶ Letter from Ctr. for Consumer Info. & Ins. Oversight, Frequently Asked Questions: State Evaluation of Plan Management Activities of Health Plans and Issuers (Feb. 20, 2013), available at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/plan-management-faq-2-20-2013.pdf>.

¹⁹⁷ Ctr. for Consumer Info. & Ins. Oversight, *Exchange Establishment Cooperative Agreement Funding FAQs*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-est-grant-faq-06292012.html> (last visited May 22, 2015).

activities to promote the exchange.¹⁹⁸ More guidance was provided just a few weeks after that, allowing federally run exchange states to use section 1311 funds for activities including, among other things, participating in stakeholder consultations with HHS; compiling and sharing with HHS information on state licensure requirements for navigators, agents, and brokers; gathering and sharing state-specific content for the federal web portal; and conducting other policy analysis and research to support exchange operations.¹⁹⁹ Similarly, an official from a state with a partnership exchange noted that they had originally been told they would need to rely on the federal call center, but later they and other states were able to get approval to operate their own,²⁰⁰ thus expanding state responsibilities to take pressure off the federal government.

Resource limitations at the federal level did not always lend itself towards increased flexibility for states, however. To the extent certain functions stayed within the federal government, limited resources and capacity necessitated greater uniformity—a “one-size-fits-all” model.²⁰¹ As one state official noted, “CMS was supposed to head implementation in the states, but became the implementation body for the nation It’s hard working with three or four different states, let alone thirty-six with different interests.”²⁰² Another informant felt that the federal government had the “attitude that if they were running the exchange for states, the states would

¹⁹⁸ Ctr. for Consumer Info. & Ins. Oversight, *Using Section 1311(a) Funding for Marketing Activities in a Plan Management State Partnership Marketplace or Federally-facilitated Marketplace FAQs*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketplace-funding-marketing-faq.html> (last visited May 22, 2015).

¹⁹⁹ Ctr. for Consumer Info. & Ins. Oversight, *Frequently Asked Questions on Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace*, CMS.GOV, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html> (last visited May 22, 2015).

²⁰⁰ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²⁰¹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²⁰² Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld).

need to take it. CCIIO didn't have the resources or staff" to provide for a lot of variation across states.²⁰³

C. INSTITUTIONAL CHARACTERISTICS WITHIN AND ACROSS
FEDERAL AGENCIES

A nearly universal theme in interviews with state officials was immense respect for and appreciation of CCIIO's willingness to work with states and be flexible. Multiple informants commented that working with CCIIO was the best experience they ever had interacting with the federal government.²⁰⁴ CCIIO staff would go out of their way to work with the states and were always available, including returning calls while they were technically on vacation.²⁰⁵ One state official compared their experience implementing exchanges to Medicare Advantage:

The experience between this and Medicare Advantage has just been night and day. Back in 2006, we were having phone calls with CMS at that point where both of us were threatening lawsuits on a daily basis. To actually have as much dialogue as we have had and as often as we have

²⁰³ Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld).

²⁰⁴ *E.g.*, Interview with senior official, state with state-run health insurance exchange (March 7, 2014) (interviewee identity and affiliation withheld) ("I've worked with several federal agencies And working with CCIIO was unlike working with any other federal agency – [demonstrating] flexibility and interest in making us successful and collaborating with us.") Interview with senior official, federally run health insurance exchange state (March 20, 2014) (interviewee identity and affiliation withheld) ("Of the federal regulators we dealt with throughout this process, CCIIO ultimately became our best partner."); Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld) ("There has been a genuine effort to have a supportive partnership, probably more so than I have ever seen in my bazillion years working with the states and the feds.").

²⁰⁵ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 11, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

had. . . . They would take input, and if they didn't take it they'd tell us why. For all of us to work together and not have it break down has been truly remarkable. And we're under so much more political pressure now than in 2006. That makes it very impressive.²⁰⁶

In particular, many informants highlighted the fact that HHS brought in many former state regulators to run CCIIO.²⁰⁷ And, as others have previously noted, former Secretary of HHS Kathleen Sebelius herself is a former state governor and insurance commissioner.²⁰⁸

Some officials noted that part of CCIIO's flexibility also came from the fact that it was a new entity, learning new things.²⁰⁹ One advised, "[I]f you want to get something done you create new state agency or a new federal agencies [sic] and make sure they get support from outlying agencies. If something is just a tweak to system, you can stick it into old agency."²¹⁰ Many state officials felt that CCIIO embodied a very different culture than older federal programs that are more entrenched.²¹¹ CCIIO staff members were relatively young, and respected the judgment of seasoned state regulators²¹² and brought an upstart, "entrepreneurial spirit"

²⁰⁶ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²⁰⁷ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state interest group (May 1, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interviewee identity and affiliation withheld).

²⁰⁸ *See, e.g.*, Metzger, *supra* note 7, at 613; Sandy Praeger, *A View from the Insurance Commissioner on Health Care Reform*, 20-SPG KAN. J.L. & PUB. POL'Y 186, 192 (2011); Seifter, *supra* note 11, at 475.

²⁰⁹ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²¹⁰ Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld).

²¹¹ *E.g.*, Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²¹² Interview with senior official, state with state-run health insurance exchange (Mar. 7, 2014) (interviewee identity and affiliation withheld).

to implementation.²¹³ Some state officials expressed frustration with the inexperience of some of the staff they were working with,²¹⁴ but states found that CCIIO staff were always been a willingness to “dig in” and try to get the job done.²¹⁵

Some, but not all, state officials found working with other federal entities, particularly IRS, to be more difficult than working with CCIIO: “CCIIO is very flexible They certainly bent over backwards to work with us. But IRS didn’t. They said here are the rules and we don’t care.”²¹⁶ As another official put it, “IRS doesn’t play well with other kids in the sandbox.”²¹⁷ A former federal official attributed it to IRS’s culture and the nature of their work: “IRS generally sees things in black and white. They very seldom regard an issue as open-ended in a statute If you are doing the tax stuff, you can’t have adaptability. You need consistency and bright lines Nobody asks, “what do we want to achieve?”²¹⁸

Reviews of federal Medicaid officials were mixed. State officials reported that while they were more flexible than IRS, they were also more bureaucratic, with a history and tradition that contributed to seeing states more as followers than partners.²¹⁹ One state official indicated that match funding under Medicaid contributed to this: the Center for Medicaid and CHIP Services (CMCS) “has much more leverage over state Medicaid officials than CCIIO does over state regulators. The conversation is completely different. Getting answers is difficult. The questions are much

²¹³ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²¹⁴ Interview with senior official, state with state-run health insurance exchange (May 2, 2014) (interviewee identity and affiliation withheld) (“What has bothered me immensely is that we have these very inexperienced people, pack of regulators on the federal side, looking at these rules and writing up regulations.”).

²¹⁵ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²¹⁶ Interview with senior official, state with state-run health insurance exchange (Mar. 19, 2014) (interviewee identity and affiliation withheld).

²¹⁷ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²¹⁸ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

²¹⁹ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

terser from federal officials.”²²⁰ In contrast, CCIIO “didn’t seem to be as guarded or use their leverage like other entities.”²²¹

D. FIRST-MOVER ADVANTAGE

In some instances states were able to secure accommodations when they were out ahead of the federal government and able to take a first-mover advantage. In these cases, the federal government appeared hesitant to disrupt functioning markets or to force states to change directions.

The clearest examples come from Massachusetts and Utah, which had moved ahead on establishing exchanges before passage of the ACA. Massachusetts’s health care reform initiative served as a model for the ACA, but the state faced barriers to full compliance due to differences in specific standards. For example, Massachusetts had distinct individual and employer coverage requirements and penalties, more generous subsidies for low-to-moderate income families, and more protective age and tobacco rating rules.²²² Massachusetts had also merged its individual and small group market. While the ACA explicitly did not preempt market mergers, Massachusetts found that implementation of the ACA’s rating reforms would threaten its ability to maintain a merged market.²²³ In response to Massachusetts’ concerns, CCIIO provided Massachusetts with a three-year transition period to phase out certain rating factors that are otherwise prohibited under the ACA.²²⁴ CCIIO cited its authority to section 1321(e) of the ACA, which allows the Secretary “to presume” that certain states

²²⁰ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²²¹ Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld).

²²² ROBERT W. SEIFERT & ANDREW P. COHEN, CTR. FOR HEALTH LAW & ECON., UNIV. OF MASS. MED. SCH., RE-FORMING REFORM: WHAT THE PATIENT PROTECTION AND AFFORDABLE CARE ACT MEANS FOR MASSACHUSETTS 7, 9, *available at* <http://bluecrossfoundation.org/sites/default/files/062110NHRReportFINAL.pdf>.

²²³ Letter from Joseph G. Murphy to author (Mar. 29, 2013) (on file with author) (Regarding patient protection and Affordable Care Act; Health insurance market rules; Rate review).

²²⁴ Letter from Gary Cohen, Deputy Adm’r & Dir., Ctr. for Consumer Infor. & Ins. Oversight, to Joseph Murphy, Mass. Comm’r of Ins. (Apr. 5, 2013), *available at* <http://www.mcguirewoods.com/news-resources/publications/mwc/CMS-MA-ACA-waiver.pdf>.

that operated an exchange before January 1, 2010 meet the ACA's approval standards for establishment of a state-based exchange.²²⁵ This arguable stretch of the statute, questioned in the media,²²⁶ demonstrates the great lengths the federal government was willing to go, in certain circumstances, to accommodate early moving states.

Utah had also already established a health insurance exchange for small businesses based on legislation that was enacted before passage of the ACA.²²⁷ Even though Utah refused to operate an ACA-compliant individual market exchange, the federal government ultimately decided to change its rules to allow Utah to continue operating its own small business exchange (Avenue H) while defaulting to a federally run individual market exchange, rather than attempt to compete with or preempt Avenue H by coming in with a federally run exchange serving both markets.²²⁸

As an additional example, a state official recounted that when the federal government first started talking about conducting plan management in states with federally facilitated exchanges, they were planning to build a new IT system.²²⁹ But most states are already on the System for Electronic Rate and Form Filing (SERFF) to facilitate the submission, review, and

²²⁵ Patient Protection and Affordable Care Act § 1321(e), 42 U.S.C. § 18041(e) (2012), (“PRESUMPTION FOR CERTAIN STATE—OPERATED EXCHANGES.—(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.”).

²²⁶ See, e.g., Josh Archambault, *ACA's Alice in Wonderland Twist: HHS Unilateral Delay of Regs for One State*, FORBES, (Apr. 17, 2013), <http://www.forbes.com/sites/theapothecary/2013/04/17/acas-alice-in-wonderland-twist-hhs-unilateral-delay-of-regs-for-one-state/2/>.

²²⁷ H.B. 133, 2008 Leg., Gen. Sess. (Utah 2008) (enacted) (created the health system reform task force and the Utah health exchange).

²²⁸ See *supra* Part IV.A.

²²⁹ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

approval of insurance product filings.²³⁰ State regulators were concerned about duplicative processes and the potential for increased burden on insurance companies, if the federal government mandated that they use a different system for the federally run exchange than they used to submit documents to the state department of insurance.²³¹ Multiple states came together and, over time, were able to convince federal officials to allow insurers to continue to submit product filings through SERFF rather than their alternative system if a state was conducting plan management on behalf of the federally run exchange.²³²

More generally, state officials reported that they felt that if they came to the federal government with a new idea that was not prohibited under the statute or existing rules, the federal government would listen. The federal government also seemed to proactively take cues from state action: “when the federal regulations [on navigators] came out, they were fairly similar to what we had and most states had A lot of times in meetings in person, they’d ask how we were doing things and would take notes.”²³³ A former federal official confirmed this assessment: regarding states, “if you answer [a question] one way and defend it as a lawful interpretation of the ACA, the federal government won’t go against you. I don’t know of any instance of states being more adventurous when they were later told to reverse themselves.”²³⁴ While some states took a lack of

²³⁰ NAT’L ASS’N OF INS. COMM’RS, STATE SERFF MANDATES (May 7, 2015), available at http://www.serff.com/documents/state_participation_mandates.pdf; see also *About SERFF*, SERFF, <http://www.serff.com/about.htm> (last visited May 22, 2015).

²³¹ Interview with senior official, federally run health insurance exchange state (Apr. 30, 2014) (interviewee identity and affiliation withheld).

²³² See, e.g., Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., 2015 Letter to Issuers in the Federally-facilitated Marketplaces (Mar. 14, 2014), available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

²³³ Interview with senior official, state with state-run health insurance exchange (Mar. 11, 2014) (interviewee identity and affiliation withheld).

²³⁴ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

answers as cause for inaction on their part,²³⁵ “other states saw the lack of timely federal guidance as an opportunity.”²³⁶

Looking forward to 2017, the opportunity to apply for waivers from the ACA’s exchange and market reform rules may create more opportunities for states to indirectly shape federal policy.²³⁷ It remains to be seen how popular these waivers become, and whether they are typically used for large or small changes. With a waiver option on the table however, states may have less incentive to change the rules governing exchanges writ large and instead opt out of any rules with which they disagree, as has been the case with Medicaid.²³⁸ Yet successful waivers can set examples that lead to broader reforms, just as the ACA was in many ways inspired by a Massachusetts Medicaid waiver.²³⁹

V. EVALUATING THE STATE ROLE IN FEDERAL DECISION-MAKING ON EXCHANGES IN LIGHT OF CHANGING DYNAMICS

As the preceding Part demonstrates, states actively engaged in the decision-making process and were able to exert influence over at least some outcomes. However, the dynamics that have shaped state influence over exchange establishment in the early years of implementation are likely to change significantly as we move forward. Below, this Article briefly discusses some of the most significant changes that are on the horizon. It also suggests that some of these changes may encourage states to push for more formal procedures for making their voices heard than have dominated state-federal interactions to date.

²³⁵ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld).

²³⁶ Interview with former senior federal official (Mar. 24, 2014) (interviewee identity and affiliation withheld).

²³⁷ See, e.g., Patient Protection and Affordable Care Act § 1332, 42 U.S.C. § 18052 (2012) (waiver for state innovation).

²³⁸ Ryan, *supra* note 10, at 63 (“Over time . . . the waiver program has become the standard way that Medicaid is administered, as most states now use the waiver provisions to individually tailor the terms of their own Medicaid programs.”).

²³⁹ See, e.g., Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996, 2005 (2014); Metzger, *supra* note 7, at 602; Ryan, *supra* note 10, at 63–64.

A. A REBALANCING OF NEGOTIATING POWER

As of 2015, no new federal exchange establishment grants will be approved²⁴⁰ and exchanges are required to be financially self-sustaining.²⁴¹ While the loss of federal dollars may reduce state incentives to operate their own exchanges or to take on additional functions on behalf of federally facilitated exchanges, it may also give states more power in negotiations with the federal government. As one state official observed, “Right now [in 2014,] it’s all about the grant money [The federal government is] paying for the system one hundred percent. When the grant money runs out, I don’t see that they’ll have the same leverage with states.”²⁴² Given that exchanges are the gateway for individuals to access premium tax credits and cost-sharing reductions, the federal government will still have a role to play in oversight,²⁴³ but it may be more limited than what states experience under conditional spending programs, like Medicaid.

State officials emphasized this distinction between exchanges and Medicaid, where ongoing federal matching funds can leave states at the mercy of the federal government.²⁴⁴ According to one: “With the exchange,

²⁴⁰ Patient Protection and Affordable Care Act § 1311(a), 42 U.S.C. § 18031(a)(4)(B) (2012) (“No grant shall be awarded under this subsection after January 1, 2015.”).

²⁴¹ *Id.* § 1311(d)(6), 42 U.S.C. § 18031(d)(5)(A) (“In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.”).

²⁴² Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²⁴³ For example, the ACA requires state exchanges to keep an accurate accounting of its activities, receipts, and expenditures and to report to the Secretary of HHS annually. CMS has said that it will use this information “to assist in determining if a state is maintaining a compliant operational Exchange,” as well as to inform potential changes to priorities and approaches for future years. Agency Information Collection Activities: Proposed Collection; Comment Request, 78 Fed. Reg. 68,851, 68,852 (Nov. 15, 2013), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-11-15/pdf/2013-27305.pdf>.

²⁴⁴ *E.g.*, Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

it won't be like that. Right now it's all about the grant money [The federal government is] paying for the system one hundred percent. When the grant money runs out, I don't see that they'll have the same leverage with states."²⁴⁵ To keep states at the table or to encourage more states to elect to transition to state-based exchanges in the future, the federal government may need to be more accommodating of state demands than they are used to being.

Despite this potential boost in leverage, however, states may need a protected voice at the table going forward to avoid the federal government unitarily deciding that it does not want or need to rely on states going forward.²⁴⁶ Professors Jessica Bulman-Pozen and Heather Gerken have argued that states “wield power against a federal government that depends on them to administer its programs” and that this leverage “only increases after the federal government has devolved regulatory power to the state.”²⁴⁷ In this case, given the large number of states that have defaulted to a federally run exchange, the federal government has only partially devolved power. Perhaps with experience the federal government will determine that it can effectively and efficiently operate a centralized exchange without relying significantly on states. Already, experts have calculated that state exchanges spent 2.3 times as much per enrollee than the federal government (with the most expensive model being partnership exchanges).²⁴⁸

Indeed, Professor Abbe Gluck has argued that cooperative federalism programs like health insurance exchanges can serve a “field-claiming” function²⁴⁹ and enable the expansion of federal power in a

²⁴⁵ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²⁴⁶ As Gluck has observed, “federal agencies have almost unrestrained power to make all of the critical allocation decisions. The Court’s most recent statement at the intersection of Chevron and federalism, the *City of Arlington* case . . . , extends the deference accorded federal agencies even further, to include questions of the agency’s jurisdiction, even when state law would be affected by that decision.” Gluck, *supra* note 239, at 2028 (describing *City of Arlington v. FCC*, 133 S. Ct. 1863 (2013)).

²⁴⁷ Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256, 1266 (2009).

²⁴⁸ Amy Lotven, *Analysis Finds State Exchanges Spent More Than Twice Per Enrollee Than FFE*, INSIDE WASH. PUBLISHERS, May 7, 2014 (subscription required) (copy on file with author).

²⁴⁹ Gluck, *supra* note 131, at 574.

“below-the-radar fashion.”²⁵⁰ Some state officials expressed concern that the federal government was making moves that could be interpreted to usurp or undermine state regulators’ authority, such as the aforementioned transition policy allowing the renewal of non-ACA-compliant health plans after January 1, 2014.²⁵¹ NAIC has also recently pushed back against the federal government’s proposal to increase scrutiny of health insurer provider networks. In a public letter to the acting director of CCIIO, NAIC requested that “[b]efore CCIIO considers any changes to the current federal requirements, [it] allow the NAIC time to thoughtfully analyze this issue, and that [it] continue to look to the NAIC for guidance and continue to recognize the importance of state flexibility.”²⁵²

As state officials shared, the informality of the proceedings sometimes limited their ability to protect their interests, as they received mixed messages from different contacts²⁵³ and were denied access to legal justifications of policy decisions.²⁵⁴ Some officials are also worried about the security of their current role given that no formal agreements, like MOUs, currently exist between states regulators and the federally

²⁵⁰ Gluck, *supra* note 7, at 1756.

²⁵¹ See *supra* note 180 and accompanying text. The federal government extended this policy for two years in subsequent guidance, allowing renewals of non-ACA-compliant policies up to October 1, 2016. Letter from Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016: Extended Transition to Affordable Care Act-Compliant Policies (March 5, 2014), available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

²⁵² Letter from Adam Hamm, Monica J. Lindeen, Michael F. Consedine & Sharon P. Clark to Dr. Mandy Cohen, *supra* note 138.

²⁵³ Interview with senior official, federally run health insurance exchange state (Mar. 21, 2014) (interviewee identity and affiliation withheld); see also, e.g., Interview with senior official, state with state-run health insurance exchange (Mar. 18, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (Mar. 20, 2014) (interviewee identity and affiliation withheld); Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld); Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

²⁵⁴ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

facilitated exchange.²⁵⁵ Additionally, while state officials reported that they were able to take advantage of their good relationships with federal officials when CCIIO was largely staffed by former state-regulators, there is no guarantee that such relationships will continue into the future. State officials expressed concern about the recent departures of many such allies and unease about whether their replacements would be as deferential.²⁵⁶ Looking forward, state officials may feel less secure in their ability to exert their influence through informal channels if their federal counterparts do not have backgrounds working at the state-level.

B. A CHANGING PACE TO DECISION-MAKING MAY OPEN THE DOOR FOR MORE FORMAL PROCEDURES

At least some of the reliance on informal mechanisms appears to have arisen from the fast-paced nature of early years of exchange establishment. As previously documented, many proposed rules were not released until late in the implementation process, when states were busy attempting to implement their own policies and operational systems. These later rules provided increasingly shorter windows to respond, and states were given little to no advance notice when they were coming. State officials also had little confidence that their comments would matter if submitted, which made it hard for some to justify spending time on responding.²⁵⁷

Arguably, neither the federal government nor the states had time to establish and participate in formal advisory groups or negotiated rulemaking during the first few years of exchange establishment. As one state official observed, there is a “really big difference between start up and ongoing programs. For states, the first few years were really busy and I

²⁵⁵ Interview with senior official, federally run health insurance exchange state (May 2, 2014) (interview identity and affiliation withheld).

²⁵⁶ See, e.g., Press Release, Nat’l Ass’n of Ins. Comm’rs, State Regulators Meet with President Obama on ACA (Apr. 17, 2014), available at http://www.naic.org/Releases/2014_docs/regulators_meet_with_obama_on_aca.htm (“State regulators expressed concern about the lack of insurance regulatory expertise with HHS Secretary Kathleen Sebelius’ departure and recommended that the appointment of a permanent director of the Center for Consumer Information and Insurance Oversight (CCIIO) be done quickly, and that the new director should rely on the expertise of state insurance regulators as decisions are made.”).

²⁵⁷ Interview with senior official, state with state-run health insurance exchange (Mar. 21, 2014) (interviewee identity and affiliation withheld).

think everyone was just doing as much as they could There just wasn't time to put together formal advisory groups."²⁵⁸ They also noted that the lack of a stable group of people working on exchanges at the state level in the early years also likely hampered any effort to create formal advisory groups.²⁵⁹

Going forward, however, the federal government should have a cadre of experienced state exchange officials available to inform its policies and more time to engage in formal deliberations with them. The federal government could establish standing advisory committees to oversee the long-term operation of the exchange program and use negotiated rulemaking when new rules or amendments to existing rules are required.

VI. CONCLUSION

States have played a critical role in the development of federal policy and operational rules governing exchanges. They have been able to provide input through formal and informal channels, and, at times, leverage third parties including state interest groups to amplify their voice. The federal government has not always accommodated state requests, but, for the most part, has been willing to listen to their opinions. While informal communication channels have been particularly important in early years, changing dynamics may lead states to push for a more formal seat at the table in the near future.

²⁵⁸ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

²⁵⁹ Interview with senior official, state with state-run health insurance exchange (Apr. 26, 2014) (interviewee identity and affiliation withheld).

Appendix A. Methodology

This Article is informed by a broad range of resources. It examines among other things, federal rulemaking pertaining to health insurance exchanges and state comments submitted in response to these rules and other solicitations published in the *Federal Register*. This process inherently involved arbitrary decisions over how broadly to define “exchange-related.” In some cases, I have chosen to include arguably tangential rules, such as rules primarily governing things such as Medicaid eligibility,²⁶⁰ premium tax credit eligibility,²⁶¹ and premium stabilization programs,²⁶² because they were released at the same approximate time as rules directly governing exchanges and states frequently responded to them collectively. In addition, some rules were issued as “omnibus” rules and while they may predominantly deal with issues not specific to exchanges, they address some provisions that tie back to exchanges.²⁶³ Appendix B

²⁶⁰ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Proposed Rule, 76 Fed. Reg. 51,148 (proposed Aug. 17, 2011) (to be codified at 42 C.F.R. pts. 431, 433, 435, 457); Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule, 77 Fed. Reg. 17,144 (proposed Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, 457).

²⁶¹ Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931 (proposed Aug. 17, 2011) (to be codified at 26 C.F.R. pt. 1); Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377 (proposed May 23, 2012) (to be codified at 26 C.F.R. pts. 1, 602); Health Insurance Premium Tax Credit, 78 Fed. Reg. 7,264 (proposed Feb. 1, 2013) (to be codified at 26 C.F.R. pt. 1); Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25,909 (proposed May 3, 2013) (to be codified at 26 C.F.R. pt. 1).

²⁶² Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 76 Fed. Reg. 41,930 (proposed July 15, 2011) (to be codified at 45 C.F.R. pt. 153); Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 77 Fed. Reg. 17,220 (proposed Mar. 23, 2012) (to be codified at 45 C.F.R. pt. 153).

²⁶³ See, e.g., Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4,594 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. pts. 430, 431, 433, 435, 440, 447, 457, 45 C.F.R. pt. 155); Medicaid and Children’s Health Insurance Programs:

includes information on the rules and other solicitations that I reviewed for this Article.

The process of finding state responses to comment solicitations posted in the *Federal Register* is also somewhat imprecise. Public comments are typically posted on Regulations.gov shortly after their submissions. While submission forms typically include a field where respondents can identify themselves (e.g., individual, academic, health care association, state government, etc.), comments are not sortable by these categories. In some cases, upwards of multiple thousands of responses were submitted to exchange-related solicitations. I have attempted to be thorough in my review of responses to identify comments from state officials or state interest groups, such as the NAIC. However, it is possible that I missed some due to my own error or technical errors with the website.

I also had to draw lines over what I chose to collect and report on. For this Article, I counted any comments submitted by state governors' offices or administrative agencies (such as departments of insurance or Medicaid agencies), state-based exchanges, and any legislative committees or task forces formed specifically to consider or monitor health care reform implementation. I did not include comments from individual state legislators, members of Congress, or local or municipal entities. Furthermore, the state response numbers I report below are based on whether any of the counted state entities responded to a solicitation. Frequently, multiple entities within a state would submit letters (or a single entity may submit multiple comment letters or documents). I do not individually count each of these instances. Appendix C documents these findings.

In addition, I conducted interviews with twenty state officials, two representatives of state interest groups, and two former federal officials to inform my findings and observations.²⁶⁴ State officials include representatives of both state-based exchanges and the different variations of federally facilitated exchanges. Because of the sensitive nature of some of

Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160 (proposed July 15, 2013) (to be codified at 42 C.F.R. pts. 431, 435, 436, 438, 440, 447, 457, 45 C.F.R. pts. 155, 156).

²⁶⁴ I also contacted a small number of current federal officials requesting interviews, but did not receive any responses.

their disclosures I have attempted to anonymize any quotes. Any references to specific states are based on publicly available information.

Appendix B. Federal Rulemaking & Solicitations, March 23, 2010 - May 30, 2014

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Planning & Establishment of State-Level Exchanges; RFC Regarding Exchange-Related Provisions in Title I of the PPACA	RFC	OCHIO	2010-Aug-03	Y	62	N
Application, Review, & Reporting Process for Waivers for State Innovation	PR	CMS; Treas	2011-Mar-14	Y	60	N
PPACA; Establishment of Exchanges and QHPs; Exchange Standards for Employers; PR	PR	HHS	2011-July-15	Y	108*	Y
PPACA; Standards Related to Reinsurance, Risk Corridors & Risk Adjustment	PR	HHS	2011-July-15	Y	108*	Y
Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers	PR	HHS	2011-Aug-17	Y	75	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010	PR	CMS	2011-Aug-17	Y	75	Y
Health Insurance Premium Tax Credit	NPRM	IRS	2011-Aug-17	Y	75	N
Application, Review, & Reporting Process for Waivers for State Innovation	FR	CMS; Treas	2012-Feb-27	N	N/A	N
Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010	FR; IFR	CMS	2012-Mar-23	Y	45	Y
PPACA; Standards Related to Reinsurance, Risk Corridors & Risk Adjustment	FR	HHS	2012-Mar-23	N	N/A	N
PPACA; Establishment of Exchanges and QHPs; Exchange Standards for Employers; FR & IFR	FR; IFR	HHS	2012-Mar-27	Y	45	Y
Health Insurance Premium Tax Credit	FR	IRS	2012-May-23	Y	90	N

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Data Collection to Support Standards Related to EHBs; Recognition of Entities for the Accreditation of QHPs	PR	HHS	2012-June-05	Y	30	Y
Data Collection to Support Standards Related to EHBs; Recognition of Entities for the Accreditation of QHPs	FR	HHS	2012-July-20	N	N/A	Y
Recognition of Entities for the Accreditation of QHPS	N	HHS	2012-Nov-23	N	N/A	N
PPACA, Standards Related to EHBs, Actuarial Value, & Accreditation	PR	HHS	2012-Nov-26	Y	30	Y
RFI Regarding Health Care Quality for Exchanges	RFI	CMS	2012-Nov-27	Y	30	N
HHS Notice of Benefit & Payment Parameters for 2014	PR	CMS	2012-Dec-07	Y	24	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Medicaid, CHIP, & Exchanges: EHBs in Alternative Benefit Plans, Eligibility Notices, Fair Hearing & for Medicaid and Exchange Eligibility Appeals & Other Provisions Related to Eligibility & Enrollment for Exchanges, Medicaid & CHIP, & Medicaid Premiums & Cost Sharing; PR	PR	CMS	2013-Jan-22	Y	22	Y
PPACA; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions	PR	CMS	2013-Feb-01	Y	45	Y
Health Insurance Premium Tax Credit	FR	IRS	2013-Feb-01	N	N/A	N
PPACA, Standards Related to EHBs, Actuarial Value, & Accreditation	FR	HHS	2013-Feb-25	N	N/A	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA; HHS Notice of Benefit & Payment Parameters for 2014 & Amendments to the HHS Notice of Benefit & Payment Parameters for 2014; FR; PPACA; Establishment of & QHPs; SHOP; PR	FR	CMS	2013-Mar-11	N	N/A	Y
PPACA, Amendments to the HHS Notice of Benefit & Payment Parameters for 2014	IFR	CMS	2013-Mar-11	Y	50	N
PPACA, Establishment of Exchanges & QHPs; SHOP	PR	CMS	2013-Mar-11	Y	21	Y
PPACA, Exchange Functions: Standards for Navigators & Non-Navigator Assistance Personnel	PR	CMS	2013-Apr-05	Y	31	Y
Minimum Value of Eligible Employer-Sponsored Plans & Other Rules Regarding the Health Insurance Premium Tax Credit	NPRM	IRS	2013-May-03	Y	60	N

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA, Establishment of Exchanges & QHPs; SHOP	FR	CMS	2013-June-04	N	N/A	Y
PPACA; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, & Market Standards; PR	PR	CMS	2013-June-19	Y	30	Y
PPACA; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; FR	FR	CMS	2013-July-01	N	N/A	Y
Information Reporting for Affordable Insurance Exchanges	NPRM	IRS	2013-July-02	Y	63	N
Medicaid & CHIP: EHBs in Alternative Benefit Plans, Eligibility Notices, Fair Hearing & Appeal Processes, & Premiums & Cost Sharing; Exchanges: Eligibility & Enrollment; FR	FR	CMS	2013-July-15	N	N/A	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA; Exchange Functions: Standards for Navigators & Non-Navigator Assistance Personnel; Consumer Assistance Tools & Programs of an Exchange & Certified Application Counselors; FR	FR	CMS	2013- July-17	N	N/A	Y
PPACA; Program Integrity: Exchange, SHOP, & Eligibility Appeals; FR	FR	CMS	2013- Aug-30	N	N/A	Y
Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of QHPs	N	CMS	2013- Sep-13	Y	32	N

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
PPACA; Program Integrity: Exchange, Premium Stabilization Programs, & Market Standards; Amendments to the HHS Notice of Benefit & Payment Parameters for 2014; FR	FR	CMS	2013-Oct-30	N	N/A	Y
PPACA; Exchanges & QHPs, Quality Rating System (QRS), Framework Measures & Methodology	NWC	CMS	2013-Nov-19	Y	63	N
PPACA; HHS Notice of Benefit & Payment Parameters for 2015; PR	PR	CMS	2013-Dec-02	Y	24	Y
PPACA; Maximizing January 1, 2014 Coverage Opportunities	IFR	CMS	2013-Dec-17	Y	6	Y

	Action	Issuing Agency	Issue Date	Solicits Comments	Days for Comments	FIS
Health Insurance Exchanges; Approval of an Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of QHPs	FN	CMS	2013-Dec-23	N	N/A	N
PPACA; HHS Notice of Benefit & Payment Parameters for 2015; FR	FR	CMS	2014-Mar-11	N	N/A	Y
PPACA; Third Party Payment of QHP Premiums	IFR	CMS	2014-Mar-19	Y	60	Y
PPACA; Exchange and Insurance Market Standards for 2015 & Beyond; PR	PR	CMS	2014-Mar-21	Y	31	Y
Information Reporting for Affordable Insurance Exchanges	FR	IRS	2014-May-07	N	N/A	N
PPACA; Exchange & Insurance Market Standards for 2015 & Beyond; FR	FR	CMS	2014-May-27	N	N/A	Y

CHIP=Children's Health Insurance Programs
CMS=Centers for Medicare & Medicaid Services
EHB=Essential Health Benefit
FIS=Federalism Impact Statement
FN=Final Notice
FR=Final Rule
HHS=Department of Health and Human Services
IFR=Interim Final Rule
IRS=Internal Revenue Services
N=Notice
NPRM=Notice of Proposed Rulemaking
NWC=Notice with Comment
OCIIO=Office of Consumer Information and Insurance Oversight
PR=Proposed Rule
PPACA= Patient Protection and Affordable Care Act
QHP=Qualified Health Plan
RFC=Request for Comments
RFI=Request for Information
SHOP=Small Business Health Options Program

* The original comment period for this proposed rule was seventy-five days. However, the federal government subsequently extended it to 108 days. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Extension of Comment Period, 76 Fed. Reg. 60,788–89 (Sept. 30, 2011) (codified at 45 C.F.R. pts. 153, 155, 156).

Appendix C. State Participation in Notice-and-Comment Rulemaking

	Request for Comments Regarding Exchange-Related Provisions ... (8/3/10)	Application, Review, and Reporting Requirements for Waivers... (3/14/11)	Establishment of Exchanges and Qualified Health Plans (7/15/11)	Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (7/15/11)	Exchange Functions in the Individual Market... (8/17/11)	Eligibility Changes Under the Affordable Care Act of 2010 (8/17/11)	Health Insurance Premium Tax Credit (8/17/11)	Eligibility Changes Under the Affordable Care Act of 2010 (IFR) (3/23/12)	Establishment of Exchanges and Qualified Health Plans... (IFR) (3/27/12)	Data Collection to Support Standards Related to Essential Health Benefits... (6/5/12)	Standards Related to Essential Health Benefits, Actuarial Value... (11/26/12)	Request for Information Regarding Health Care Quality for Exchanges (11/27/12)	HHS Notice of Benefit and Payment Parameters for 2014 (12/7/12)	Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices... (1/22/13)	Exchange Functions: Eligibility for Exemptions... (2/1/13)	Exchange Functions: Standards for Navigators... (4/5/13)	Minimum Value of Eligible Employer-Sponsored Plans and Other Rules... (5/3/13)	Program Integrity: Exchange, SHOP, Premium Stabilization Programs... (6/19/13)	Information Reporting for Affordable Insurance Exchanges (7/2/13)	Exchanges and Qualified Health Plans, Quality Rating System... (11/19/13)	HHS Notice of Benefit and Payment Parameters for 2014 (12/2/13)	Exchange and Insurance Market Standards for 2015 and Beyond (3/21/14)	Third Party Payment of QHP Premiums (3/19/14)
AL	X	-	-	-	X	X	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
AK	-	-	-	-	-	X	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	-	-
AZ	-	-	-	X	-	X	-	X	-	-	-	-	X	X	-	X	-	-	-	-	-	-	-
AR	X	-	X	-	-	X	-	-	-	-	X	-	-	X	-	-	-	-	-	X	-	-	-
CA	X	-	X	X	X	X	X	X	-	-	X	-	X	X	X	X	-	-	-	X	-	-	X
CO	X	-	X	-	X	X	X	-	-	-	X	X	-	X	-	X	-	-	X	-	-	-	X
CT	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	X	-	-
DE	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DC	-	-	X	X	X	X	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
FL	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
GA	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	X	X	-
HI	-	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-
ID	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	X
IL	X	-	X	X	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-
IN	-	X	X	X	X	X	X	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-
IA	-	-	X	X	X	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
KS	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	X	X	-
KY	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-
LA	X	-	X	-	X	X	-	X	X	-	X	-	X	X	-	X	-	-	X	-	X	-	-

	Request for Comments Regarding Exchange-Related Provisions ... (8/3/10)	Application, Review, and Reporting Requirements for Waivers... (3/14/11)	Establishment of Exchanges and Qualified Health Plans (7/15/11)	Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (7/15/11)	Exchange Functions in the individual Market... (8/17/11)	Eligibility Changes Under the Affordable Care Act of 2010 (8/17/11)	Health Insurance Premium Tax Credit (8/17/11)	Eligibility Changes Under the Affordable Care Act of 2010 (IFR) (3/23/12)	Establishment of Exchanges and Qualified Health Plans... (IFR) (3/27/12)	Data Collection to Support Standards Related to Essential Health Benefits... (6/5/12)	Standards Related to Essential Health Benefits, Actuarial Value... (11/26/12)	Request for Information Regarding Health Care Quality for Exchanges (11/27/12)	HHS Notice of Benefit and Payment Parameters for 2014 (12/7/12)	Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices... (1/22/13)	Exchange Functions: Eligibility for Exemptions... (2/1/13)	Exchange Functions: Standards for Navigators... (4/5/13)	Minimum Value of Eligible Employer-Sponsored Plans and Other Rules... (5/3/13)	Program Integrity: Exchange, SHOP, Premium Stabilization Programs... (6/19/13)	Information Reporting for Affordable Insurance Exchanges (7/2/13)	Exchanges and Qualified Health Plans, Quality Rating System... (11/19/13)	HHS Notice of Benefit and Payment Parameters for 2014 (12/2/13)	Exchange and Insurance Market Standards for 2015 and Beyond (3/21/14)	Third Party Payment of QHP Premiums (3/19/14)
ME	X	-	X	X	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
MD	X	-	X	-	X	X	X	-	-	X	-	-	X	X	-	-	-	X	-	-	-	X	-
MA	-	X	-	X	X	X	X	-	-	-	X	-	X	X	X	-	-	X	X	-	-	X	-
MI	-	-	X	X	X	X	X	-	-	-	X	-	-	X	-	-	-	-	-	-	X	X	-
MN	-	X	X	X	X	X	X	-	-	X	X	-	X	X	-	-	-	-	X	-	X	-	-
MS	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	-	-	-
MO	-	-	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
MT	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NE	-	-	X	-	X	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	X	-
NV	X	-	X	X	X	-	X	-	-	-	-	-	-	X	X	X	X	-	-	-	-	-	-
NH	-	-	X	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
NJ	-	-	X	-	-	X	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NM	X	-	X	-	-	X	-	X	-	-	X	-	-	X	X	-	-	-	-	-	-	X	-
NY	X	-	X	X	X	X	X	X	X	X	-	X	X	X	-	X	-	-	-	X	-	X	X
NC	-	-	-	-	-	-	X	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
ND	-	-	-	-	-	X	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-
OH	X	-	X	-	X	X	-	-	-	-	X	-	-	X	-	-	-	-	-	-	-	X	-
OK	-	-	X	X	X	X	X	-	-	-	X	-	X	X	-	X	-	-	-	-	X	X	-
OR	X	-	X	X	X	X	X	X	X	-	X	-	X	X	-	X	-	-	X	X	-	X	-
PA	-	X	-	-	-	X	-	-	-	-	-	-	-	X	-	-	-	-	-	-	-	-	-
RI	-	-	X	-	X	X	X	-	-	-	X	-	-	X	-	-	-	-	-	-	-	X	-
SC	-	-	X	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-

ERIE DENIED: HOW FEDERAL COURTS DECIDE INSURANCE COVERAGE CASES DIFFERENTLY AND WHAT TO DO ABOUT IT

JOHN L. WATKINS¹

Application of the Erie doctrine requires that federal courts exercising diversity jurisdiction apply substantive state law consistent with the state's highest court as a matter of federalism and to discourage forum shopping. This Article analyzes the reality, however, that federal courts decide important unsettled questions of state law differently than state courts, which undermines these two fundamental underpinnings of the Erie doctrine. Further, this Article demonstrates, through various examples, how these incorrect "Erie guesses" can have profound practical implications in the insurance context due to the standard use of form contracts for drafting insurance policies. As a result, litigants battle fiercely over the judicial forum, as federal courts are perceived, particularly by insurers, to decide procedural and substantive issues of state law differently than state courts.

Considering that the abolishment of diversity jurisdiction is highly improbable, this Article argues that federal courts should adopt clear, uniform standards that favor the liberal use of certification of unsettled questions of state law to the state's highest court. A constitutionally consistent approach to certification would promote the principles of federalism that underlie the Erie doctrine, and would render moot the less productive question of why federal courts decide the issues differently.

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I. INTRODUCTION

Federal courts exercising diversity jurisdiction decide cases differently than state courts despite their obligation under the *Erie* doctrine² to apply substantive law in the same manner as the state courts. Federal courts periodically make incorrect “*Erie* guesses” of unsettled questions of state law as later determined by the state’s highest court.³ In many instances, however, the state’s highest court will not have the opportunity to correct the error because the issue never reaches it.

Insurance coverage litigation provides a particularly important subject for studying this phenomenon for several reasons. First, federal courts are routinely called on to decide coverage questions, so there is a large body of case law to examine. Second, supreme courts from different states often reach diametrically different conclusions in deciding important coverage issues based on identical insurance policy language.⁴ The

² See generally *Erie R.R. Co. v. Tompkins*, 304 U.S. 64 (1938) (mandating that a federal court sitting in diversity jurisdiction must apply state substantive law).

³ The term “*Erie* guess” (referring to a federal court’s deciding of unsettled questions of state law) appears to have originated with the United States Court of Appeals for the Fifth Circuit, which stated in *Grey v. Hayes-Sammons Chemical Co.*, 310 F.2d 291, 295 (5th Cir. 1962), that *Erie* required it to “make an *Erie*, educated guess” as to Mississippi law. “*Erie* guess” is now used widely in the literature.

⁴ For example, state courts are about equally divided on whether a construction defect resulting from negligent construction constitutes an “occurrence” under a commercial general liability insurance policy. Compare *Am. Empire Surplus Lines Ins. Co. v. Hathaway Dev. Co.*, 707 S.E.2d 369, 372 (Ga. 2011) (defective construction may constitute an “occurrence”), with *Essex Ins. Co. v. Holder*, 261 S.W.3d 456, 460 (Ark. 2008) (defective construction not an “occurrence”). State courts are also divided about equally on whether the “sudden and accidental” pollution exclusion applies to bar coverage for the unintended release of pollutants over a long period of time. Compare *Claussen v. Aetna Cas. & Sur. Co.*, 380 S.E.2d 686, 688–89 (Ga. 1989) (finding “sudden” does not necessarily mean “abrupt” and is reasonably interpreted to mean “unexpected” and hence holding coverage not excluded for discharge over extended period of time), with *Dutton-Lainson Co. v. Cont’l Ins. Co.*, 716 N.W.2d 87, 97–100 (Neb. 2006) (deciding an event occurring over a period of time is not “sudden” and rejecting *Claussen*). The cases on this contentious issue are collected in *Dutton-Lainson*. Similarly, the courts are sharply split on whether the “absolute pollution exclusion”

potential for such divergence increases the possibility of an erroneous guess when a federal court decides an unsettled coverage question because of the likelihood of conflicting persuasive precedents from other jurisdictions. Third, the consequences of an incorrect *Erie* guess in coverage cases can have profound practical implications beyond the immediate case because insurance policies are typically written on common forms. A mistaken determination in one case may thus be repeated many times over in being applied as persuasive precedent to other claims. This is an important consideration.

This Article will demonstrate that federal courts have often guessed incorrectly in deciding important coverage issues. Moreover, the anecdotal view that insurers favor federal courts over state courts for both procedural and substantive reasons is supported by available survey and statistical evidence. The result is that federal courts often dispense—and are perceived to dispense—a different brand of justice than state courts.

The Article next examines how the practice of deciding unsettled coverage issues undermines the *Erie* doctrine. *Erie* has two fundamental underpinnings: First, the case firmly established that a state's highest court has the right to determine state law.⁵ Second, *Erie* was meant to discourage

precludes claims not involving environmental pollutants. *Compare* Reed v. Auto-Owners Ins. Co., 667 S.E.2d 90, 92 (Ga. 2008) (showing a claim arising from accidental release of carbon monoxide at rental house precluded by absolute pollution exclusion even though it did not involve environmental pollution), *with* Am. States Ins. Co. v. Koloms, 687 N.E.2d 72, 82 (Ill. 1997) (holding a claim arising from accidental release of carbon monoxide not precluded by absolute pollution exclusion, which must be read in the context of its purpose of limiting coverage for environmental contamination).

⁵ See *Erie*, 304 U.S. at 822 (“Except in matters governed by the Federal Constitution or by acts of Congress, the law to be applied in any case is the law of the state. And whether the law of the state shall be declared by its Legislature in a statute or by its highest court in a decision is not a matter of federal concern.”). *Erie* was decided on constitutional grounds, and this aspect of the decision, and others, have provoked a plethora of articles and debate. See, e.g., 17A JAMES WM. MOORE ET AL., MOORE’S FEDERAL PRACTICE § 124App.03 (Daniel R. Coquillette et al. eds., 3d ed. 2007) (citing numerous articles). With that said, *Erie*’s reliance on constitutional grounds is explicit and as prominent scholars have noted: “In the end . . . *Erie* must be accepted as a constitutional decision.” 19 CHARLES ALAN WRIGHT, ARTHUR R. MILLER & EDWARD H. COOPER, FEDERAL PRACTICE AND PROCEDURE § 4505 (2d ed. Supp. 2013). The main volume of Wright, Miller, and Cooper notes *Erie*’s explicit reliance on the Constitution and contains an extensive

forum shopping between the federal and state courts.⁶ When federal courts decide unsettled questions of state law, they intrude on the first principle. And when they decide—or even when they are perceived to decide—those questions differently than the state courts, they undermine the second.

Finally, the Article examines possible solutions. Almost all states now have statutes allowing federal appellate courts (and sometimes district courts) to certify unsettled questions of state law to a state’s highest court for decision. Although the United States Supreme Court has enthusiastically endorsed certification on a number of occasions, the use of the certification procedure by the lower federal courts is haphazard. The Supreme Court has never established standards for certification, and, left to their own devices, the federal appellate courts have espoused a crazy quilt of certification standards, ranging from liberally granting certification to using it sparingly. The solution is straight-forward: The federal courts should adopt uniform standards favoring the liberal use of certification of unsettled questions of state law to a state’s highest court.

II. FEDERAL COURTS MAKE INCORRECT *ERIE* GUESSES

Federal courts have made many incorrect *Erie* guesses, particularly in insurance coverage cases. This is not meant to be a blanket criticism of

collection of authorities. *See generally* Ernest A. Young, *A General Defense of Erie Railroad Co. v. Tompkins*, 10 J.L. ECON. & POL’Y 17 (2013) (containing a lengthy examination of *Erie*, its defenders and detractors). This Article will not wade into these controversies. The fundamental principle of *Erie*, that a state’s highest court has the final say on issues of state law, is so well-established that it cannot be seriously questioned. *See* *Salve Regina Coll. v. Russell*, 499 U.S. 225, 226 (1991) (“*Erie* mandates that a federal court sitting in diversity apply the substantive law of the forum State, absent a federal statutory or constitutional directive to the contrary.”).

⁶ *See* *Van Dusen v. Barrack*, 376 U.S. 612, 638 (1964) (quoting *Guar. Trust Co. of N.Y. v. York*, 326 U.S. 99, 109 (1945) (“The nub of the policy that underlies [*Erie*] is that for the same transaction the accident of a suit by a non-resident litigant in a federal court instead of in a state court a block away, should not lead to a substantially different result.”); *see also* *Hanna v. Plumer*, 380 U.S. 460, 468 (1965) (“[T]he twin aims of the *Erie* rule: [are the] discouragement of forum-shopping and avoidance of inequitable administration of the laws.”); *Salve Regina*, 499 U.S. at 234 (citing *Hanna*, 380 U.S. at 468) (explaining that the twin aims of *Erie* are avoiding the inequitable administration of justice and forum shopping).

the federal judiciary, nor is it meant to suggest that federal courts routinely make incorrect determinations of state law. Nevertheless, as some federal judges have candidly acknowledged, mistakes have been made. In the insurance context, the incorrect guess is particularly likely to be amplified due to the use of form contracts, making it more likely for the mistake to be repeated as precedent.

A. GENERALLY

A number of distinguished jurists have recognized that incorrect *Erie* guesses have plagued the federal judiciary for years in many different substantive areas of the law. In 1964, Judge Brown of the United States Court of Appeals for the Fifth Circuit observed that his court's record in predicting state law was terrible, particularly regarding Florida law:

Within the very recent past, both Texas and Alabama have overruled decisions of this Court, and the score in Florida cases is little short of staggering. In similar, but subsequent, cases, the Florida Courts have expressly repudiated our holdings in a number of cases. And now that we have this remarkable facility of certification, we have not yet "guessed right" on a single case.⁷

Writing twenty-eight years later, Judge Sloviter of the United States Court of Appeals for the Third Circuit observed that the predictions had not improved:

[T]he state courts have found fault with a not insignificant number of past "*Erie* guesses" made by the Third Circuit and our district courts. Despite our best efforts to predict the future thinking of the state supreme courts within our jurisdiction on the basis of all of the available data, we have guessed wrong on questions of the breadth of arbitration clauses in automobile insurance policies (we

⁷ *United Servs. Life Ins. Co. v. Delaney*, 328 F.2d 483, 486 (5th Cir. 1964) (Brown, J., concurring) (citations omitted); *see also* *Lehman Bros. v. Schein*, 416 U.S. 386, 390 n.6 (1974) (noting former Fifth Circuit's tendency to grant certification to state courts because of errors in predicting state law).

predicted they would not extend to disputes over the entitlement to coverage, but they do), the availability of loss of consortium damages for unmarried cohabitants (we predicted they would be available, but they are not), the “unreasonably dangerous” standard in products liability cases (we predicted the Restatement would not apply, but it does), and the applicability of the “discovery rule” to wrongful death and survival actions (we predicted it would toll the statute of limitations, but it does not). And this list is by no means exhaustive.

It is not that Third Circuit judges are particularly poor prognosticators. All of the circuits have similar problems in predicting state law accurately.⁸

As shown herein, there is no indication that the federal courts have gotten better in making predictions since Judge Sloviter’s article.

B. INSURANCE COVERAGE CASES

The federal courts have made incorrect *Erie* guesses in many insurance coverage cases. Even worse, these mistakes have often been on important recurring issues regarding the interpretation of common insurance policy provisions.

1. Environmental Response Costs as “Damages”

One of the more contentious insurance coverage issues of the 1980s and 1990s was whether environmental response costs such as cleanup costs and monitoring costs imposed under the federal Comprehensive Environmental Response Compensation Liability Act (CERCLA) were covered as “damages” under commercial general liability policies (“CGL”). In *Continental Insurance Co. v. Northeastern Pharmaceutical & Chemical Co.* (“NEPACCO”), the United States Court of Appeals for the Eighth Circuit made an *Erie* guess under Missouri law

⁸ Dolores K. Sloviter, *A Federal Judge Views Diversity Jurisdiction Through the Lens of Federalism*, 78 VA. L. REV. 1671, 1679–80 (1992) (footnotes omitted).

and held that response costs were not “damages.”⁹ The NEPACCO court reasoned that “damages” should be defined “in the insurance context” rather than “outside the insurance context,” and that in the “insurance context” they were not considered “damages.”¹⁰ Nine years later, in *Farmland Industries, Inc. v. Republic Insurance Co.*, the Supreme Court of Missouri held that response costs were “damages” under commercial general liability and other policies issued by the insurers and thus covered.¹¹ The *Farmland* court squarely rejected the Eighth Circuit’s guess:

The NEPACCO court misconstrues and circumvents Missouri law. The cases upon which the NEPACCO court relies for the proposition that “damages” distinguishes between claims at law and claims at equity are not persuasive. The cases do not determine the ordinary meaning of “damages” as required by Missouri law. Furthermore, no authority allows this Court to define words “in the insurance context.” To give words in an insurance contract a technical meaning simply by reading them “in the insurance context,” would render meaningless our law’s requirement that words be given their ordinary meaning unless a technical meaning is plainly intended.¹²

Similarly, the Maryland Court of Appeals held that environmental response costs were recoverable “as damages” under a CGL policy in *Bausch & Lomb Inc. v. Utica Mutual Insurance Co.*¹³ In *Bausch & Lomb*, the court specifically disavowed an earlier “*Erie* guess” to the contrary by the United States Court of Appeals for the Fourth Circuit in *Maryland Casualty Co. v. Armco, Inc.*¹⁴ The *Bausch & Lomb* court stated:

⁹ See *Cont’l Ins. Cos. v. Ne. Pharm. & Chem. Co.*, 842 F.2d 977, 987 (8th Cir. 1991) (en banc).

¹⁰ *Id.* at 985.

¹¹ *Farmland Indus., Inc. v. Republic Ins. Co.*, 941 S.W.2d 505, 512 (Mo. 1997).

¹² *Id.* at 510.

¹³ *Bausch & Lomb, Inc. v. Utica Mut. Ins. Co.*, 625 A.2d 1021, 1037 (Md. 1993).

¹⁴ See generally *Md. Cas. Co. v. Armco, Inc.*, 822 F.2d 1348 (4th Cir. 1987).

To the extent it suggests that the term “damages” imports a distinctively legal meaning in insurance matters, Armco misperceives the law of Maryland. As discussed earlier, we accord to words their usual and accepted signification. “Damages” in common usage means the reparation in money for a detriment or injury sustained. The reasonably prudent layperson does not cut nice distinctions between the remedies offered at law and in equity. Absent an express provision in the document itself, insurance policyholders surely do not anticipate that coverage will depend on the mode of relief, i.e. a cash payment rather than an injunction, sought by an injured party. Policyholders will, instead, reasonably infer that the insurer’s pledge to pay damages will apply generally to compensatory outlays of various kinds, including expenditures made to comply with administrative orders or formal injunctions.¹⁵

In its analysis, the court criticized the Fourth Circuit for overlooking case law establishing that insurance policies must be interpreted in accordance with the expectations of a reasonably prudent layperson.¹⁶

The *Bausch & Lomb* opinion noted the approach of many federal courts differed from the views of state courts on the recovery of environmental response costs as “damages” under CGL policies:

In confronting the legal issues present in the instant case, the majority of state appellate courts have concluded that the standard insuring language covers environmental response costs. They have construed the term “damages” to reach both monetary compensation to government agencies or aggrieved third parties and the expense of complying with environmental injunctions. The federal courts divide more or less evenly on the question.¹⁷

¹⁵ *Bausch & Lomb, Inc.*, 625 A.2d at 1032–33.

¹⁶ *Id.* at 1032 n.6. But despite this aspect of the court’s decision, it ultimately found in favor of the insurer, and found that the absence of third party property damage meant there was no coverage under the facts of the case. *Id.* at 1036.

¹⁷ *Id.* at 1030 (citations omitted).

This observation suggests there have been additional incorrect *Erie* guesses on this recurring issue.

2. Negligent Construction as an “Occurrence”

One of the most hotly contested issues in insurance coverage litigation in the past several years is whether negligently performed construction can constitute an “occurrence” under a CGL policy. Federal courts have made incorrect *Erie* guesses on this important issue. In Georgia, the United States District Court for the Northern District of Georgia and the United States Court of Appeals for the Eleventh Circuit issued a series of decisions holding that negligently performed construction could not constitute an occurrence. The first decision was *Owners Insurance Co. v. James*, which held that negligent installation of synthetic stucco could not be an occurrence because “the insurance policies at issue in this case provide coverage for injury resulting from accidental acts, but not for an injury accidentally caused by intentional acts.”¹⁸ This distinction—difficult even to comprehend—was embraced in other federal decisions.¹⁹ One federal judge expressed dismay regarding this approach, although he followed it, noting that the precedent “may create an awkward environment” for parties seeking to insure risks because “almost every conceivable accident involves some intentional action at some point in the chain of causation.”²⁰

When the issue reached the Supreme Court of Georgia, the court not only held that negligent construction could be an occurrence, but it also expressly rejected the reasoning of the federal cases: “[W]e reject out of

¹⁸ See *Owners Ins. Co. v. James*, 295 F. Supp. 2d 1354, 1364 (N.D. Ga. 2003).

¹⁹ *Owners Ins. Co. v. Chadd’s Lake Homeowners Ass’n, Inc.*, No. 1:03-cv-2050-WSD (N.D. Ga. Dec. 28, 2004) (“*Chadd’s Lake P*”); *Owners Ins. Co. v. Chadd’s Lake Homeowners Ass’n, Inc.*, No. 1:005-cv-00475-JOF, 2006 WL 1553888, at *4 (N.D. Ga. May 30, 2006) (“*Chadd’s Lake IP*”); *Travelers Indem. Co. of Conn. v. Douglasville Dev., LLC*, No. 1:07-cv-0410-JOW, 2008 WL 4372004, at *8–9 (N.D. Ga. Sept. 19, 2008); *Hathaway Dev. Co., Inc. v. Ill. Union Ins. Co.*, No. 07-00118-CV-MHS-1, 2008 WL 1773307, at *8–9 (11th Cir. Apr. 18, 2008).

²⁰ *Douglasville Dev., LLC*, 2008 WL 4372004, at *9 (Forrester, J.). It is somewhat ironic that the court stated that “every conceivable accident involves some intentional action” given that the basic express definition of “occurrence” in a CGL policy is an “accident.”

hand the assertion that the acts . . . could not be deemed an occurrence or accident under the CGL policy because they were performed intentionally. “[A] deliberate act, performed negligently, is an accident if the effect is not the intended or expected result”²¹

Similarly, in *Architex Association, Inc. v. Scottsdale Insurance Co.* the Supreme Court of Mississippi also held that negligent construction performed by a subcontractor can constitute an “occurrence” under a CGL policy.²² The court held that a contrary *Erie* guess by the Fifth Circuit in *ACS Construction Co., Inc. v. CGU*²³ was “inconsistent with Mississippi law.”²⁴

3. Application of the “Sudden and Accidental” Exception to the Pollution Exclusion in CGL policies

One of the most frequently and persistently litigated insurance coverage issues from the 1980s to today is the interpretation of the pollution exclusion in CGL policies with an exception for releases that are “sudden and accidental.” This version of the pollution exclusion, which was first utilized in 1973, excludes coverage for bodily injury or property damage “arising out of the discharge, dispersal, release or escape of smoke,

²¹ See *Am. Empire Surplus Lines v. Hathaway Dev. Co.*, 707 S.E.2d 369, 372 (Ga. 2011) (quoting *Lamar Homes v. Mid-Continent Cas. Co.*, 242 S.W.2d 1, 16 (Tex. 2007)). See J. Watkins, *American Empire Surplus Lines v. Hathaway Dev. Co.: An Important Occurrence in Georgia Insurance Law*, 17 GA. BAR J. 10 (2011), for a more thorough discussion of this issue.

²² *Architex Ass’n, Inc. v. Scottsdale Ins. Co.*, 27 So.3d 1148, 1162 (Miss. 2010).

²³ *ACS Constr. Co., Inc. of Miss. V. CGU*, 332 F.3d 885, 888-892 (5th Cir. 2003).

²⁴ *Architex Ass’n, Inc.*, 27 So.2d at 1162. Similarly, in *Lamar Homes, Inc. v. Mid-Continent Casualty Co.*, the Supreme Court of Texas decided that negligent construction could constitute an occurrence. *Lamar Homes* was decided on certified question from the United States Court of Appeals for the Fifth Circuit after the federal district court had made an incorrect *Erie* guess. *Lamar Homes, Inc. v. Mid-Continent Cas. Co.*, 335 F. Supp. 2d 754, 758–60 (W.D. Tex. 2004), *vacated*, 501 F.3d 435 (5th Cir. 2007). There was, however, Fifth Circuit authority consistent with the Texas Supreme Court’s holding in *Lamar Homes*. See *Federated Mut. Ins. Co. v. Grapevine Excavation Inc.*, 197 F.3d 720, 725 (5th Cir. 1999).

vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon the land, the atmosphere or any water course or body of water.” However, the policy also contains an exception to the exclusion that potentially restores coverage. Specifically, the exclusion “does not apply if such discharge, dispersal, release or escape is sudden and accidental.”²⁵

Considerable litigation has focused on the meaning of the “sudden and accidental” exception that restores coverage. Some courts have held that “sudden and accidental” means that the discharge must have been abrupt, and that “sudden” necessarily implies a temporal requirement. Hence, under this analysis, a discharge or release over a long period of time would be excluded. Other courts, in roughly equal numbers, have held that “sudden” is ambiguous and can reasonably be interpreted to mean “unexpected.” Under this interpretation, liabilities from unexpected long-term discharges or releases are not excluded. Which approach a court takes is significant, because it essentially means the difference between coverage and no coverage for expensive environmental liabilities.

Not surprisingly, federal courts have made incorrect *Erie* guesses on this issue. In *Mesa Oil, Inc. v. Insurance Co. of North America*, the United States Court of Appeals for the Tenth Circuit concluded that a “New Mexico court would likely honor the plain meaning of the word ‘sudden’ and conclude that the term encompasses a temporal component, and thus that pollution must occur quickly or abruptly before the exemption will apply.”²⁶ In *United Nuclear Corp. v. Allstate Insurance Co.*, the Supreme Court of New Mexico rejected the reasoning of *Mesa Oil*, specifically disagreeing with the Tenth Circuit’s observation that the “trend” was to find a temporal requirement in addition to its analysis of the policy language.²⁷ Thus, “*Mesa Oil*’s holding that ‘sudden’ clearly means ‘abrupt’ was premised on two assumptions we view to be erroneous”²⁸

²⁵ DANIEL P. HALE, CAMBRIDGE PROPERTY AND CASUALTY SPECIAL REPORT: HOW ABSOLUTE IS THE ABSOLUTE POLLUTION EXCLUSION? 2 (2008), available at <http://cambridgeunderwriters.com/wp-content/uploads/2013/05/How-Absolute-is-the-Absolute-Pollution-Exclusion.pdf>. This Article contains a good discussion of the history of the pollution exclusion, including form language prepared by the Insurance Services Office (“ISO”). The provision is also quoted in the cases discussed in this subsection.

²⁶ *Mesa Oil, Inc. v. Ins. Co. of N. Am.*, 123 F.3d 1333, 1340 (10th Cir. 1997).

²⁷ *United Nuclear Corp. v. Allstate Ins. Co.*, 285 P.3d 644 (N.M. 2012).

²⁸ *Id.* at 653.

In *Claussen v. Aetna Casualty & Surety Co.*, the United States District Court for the Southern District of Georgia emphatically rejected the argument that “sudden” was ambiguous: “Only in the minds of hypercreative lawyers could the word ‘sudden’ be stripped of its essential temporal attributes.”²⁹ While not all courts have agreed in this regard, recent decisions have recognized with increasing frequency that the pollution exclusion does mean just what it says.³⁰ When the case reached the Supreme Court of Georgia on certified question, however, the result was different, as was the analysis: “But, on reflection one realizes that, even in its popular usage, ‘sudden’ does not usually describe the duration of an event, but rather its unexpectedness: a sudden storm, a sudden turn in the road, sudden death. Even when used to describe the onset of an event, the word has an elastic temporal connotation that varies with expectations”³¹ Accordingly, the court concluded that environmental liabilities resulting from long term exposures were not excluded.

4. Application of the “Absolute” Pollution Exclusion to Non-Environmental Claims

Because many courts, particularly state courts, rejected the insurance industry’s interpretation of the “sudden and accidental” pollution exclusion, the industry adopted the “absolute” pollution exclusion in 1985. This pollution exclusion, in a typical form, excludes claims for bodily injury or property damage “arising out of actual or alleged or threatened discharge, dispersal, release or escape of pollutants” and defines “pollutants” to be “any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, alkalis, chemicals and waste.”³²

Particularly because the definition of “pollutants” is so broadly stated, insurers have, with some success, argued for the application of the exclusion to bar coverage for risks unrelated to traditional environmental

²⁹ *Claussen v. Aetna Cas. & Sur. Co.*, 676 F. Supp. 1571, 1580 (S.D. Ga. 1987), *rev’d*, 888 F.2d 747 (11th Cir. 1989) (per curiam).

³⁰ *Id.*

³¹ *Claussen v. Aetna Cas. & Sur. Co.*, 380 S.E.2d 686, 688 (Ga. 1989). *Claussen* illustrates the proper use of the certification procedure discussed at length later in this article.

³² HALE, *supra* note 25, at 10.

pollution, such as, for example, injuries or deaths in homes or other buildings resulting from the release of carbon monoxide from improperly maintained furnaces. Some courts, however, have read the exclusion narrowly and confined its application to claims involving environmental liabilities. Again, some federal courts have made incorrect *Erie* guesses on this important and contentious issue.

In *Essex Insurance Co. v. Tri-Town Corp.*, the United States District Court for the District of Massachusetts predicted that Massachusetts would find the absolute pollution exclusion unambiguous, and held that the exclusion barred coverage for underlying claims for personal injury resulting from the discharge of carbon monoxide from a malfunctioning Zamboni machine at a hockey game.³³ Three years later, in *Western Alliance Insurance Co. v. Gill*, the Supreme Judicial Court of Massachusetts reached the opposite conclusion and held that the absolute pollution exclusion in a policy did not bar coverage for claims for bodily injury sustained due to exposure to carbon monoxide while dining at a restaurant because a reasonable insured would not anticipate exclusion barred claims for non-environmental pollution.³⁴

This pattern repeated itself in Ohio. In *Longaberger Co. v. U.S. Fidelity & Guarantee Co.*, the United States District Court for the Southern District of Ohio, in the absence of Ohio Supreme Court authority, held that the absolute pollution exclusion would bar coverage for claims for bodily injury resulting from the discharge of carbon monoxide.³⁵ Three years later, in *Andersen v. Highland House Co.*, the Ohio Supreme Court reached the opposite conclusion, and held that the exclusion did not bar coverage for death and bodily injury claims caused by the release of carbon monoxide.³⁶

5. Other Recent Examples

There are other examples of federal courts making *Erie* guesses regarding insurance issues, many of broad potential importance, that were later disavowed by the state's highest court. For example, the Mississippi Supreme Court rejected the Fifth Circuit's interpretation and application of

³³ *Essex Ins. Co. v. Tri-Town Corp.*, 863 F. Supp. 38, 40–41 (D. Mass. 1994).

³⁴ *W. Alliance Ins. Co. v. Gill*, 686 N.E.2d 997, 1000–01 (Mass. 1997).

³⁵ *Longaberger Co. v. U.S. Fid. & Guar. Co.*, 31 F. Supp. 2d 595, 604 (S.D. Ohio 1998), *aff'd*, 201 F.3d 441 (6th Cir. 1999).

³⁶ *Anderson v. Highland House Co.*, 757 N.E.2d 329, 331 (Ohio 2001).

an “anticoncurrent condition clause” that, as applied by the Fifth Circuit, precluded coverage for wind damage as well as water damage in Hurricane Katrina cases.³⁷

In other recent cases, state supreme courts have rejected federal district court determinations in coverage cases upon certified question from the federal Court of Appeals. Thus, the Court of Appeals of New York held, contrary to the federal district court, that a contractual limitation period in a fire insurance policy requiring an insured to bring suit within two years from the date of “direct physical loss or damage” to recover replacement cost was unreasonable and unenforceable where the damaged property could not reasonably be replaced in that period.³⁸ The Supreme Court of Florida held, contrary to the federal district court, that a policy’s advertising injury coverage applied to violations of Telephone Consumer Protection Act.³⁹ There are other examples of this trend.⁴⁰ Although the incorrect guesses were thus corrected through the certification process—as this Article argues should be standard practice—the cases nevertheless illustrate that federal courts continue to make incorrect determinations of state law in coverage litigation.

³⁷ *Corban v. United Servs. Auto. Ass’n*, 20 So.2d 601, 616–18 (Miss. 2009).

³⁸ *Exec. Plaza, LLC v. Peerless Ins. Co.*, 5 N.E.3d 989, 992 (N.Y. 2014).

³⁹ *Penzer v. Transp. Ins. Co.*, 29 So.3d 1000, 1008 (Fla. 2010); *see* 47 U.S.C. § 227 (2000).

⁴⁰ *E.g.*, *Ewing Constr. Co. v. Amerisure Ins. Co.*, 420 S.W.3d 30, 38 (Tex. 2014) (holding, contrary to federal district court and initial panel determination of the Fifth Circuit, that general contractor who agrees to perform its construction work in a good and workmanlike manner, without more, does not “assume liability” for damages so as to trigger the contractual liability exclusion in CGL policy); *Fin. Indus. Corp. v. XL Specialty Ins. Co.*, 285 S.W.3d 877, 879 (Tex. 2009) (holding, contrary to federal district court, that insurer must show prejudice to deny payment on a claims made policy based on late notice given within the policy period); *Cornhusker Cas. Ins. Co. v. Kachman*, 198 P.3d 505, 509–10 (Wash. 2008) (en banc) (holding, contrary to federal district court, that notice of cancellation sent by certified mail that was never received did not satisfy state statutory requirements for cancellation).

III. PERCEIVED AND REAL BENEFITS OF FEDERAL COURTS TO INSURERS

The cases in the preceding section suggest that in many instances a federal venue favored the insurer. The substantive results support my own experience that insurers strongly, as a general rule, favor federal court.⁴¹ This section will demonstrate that the available survey and statistical evidence also supports this view.

When an insurance company is sued in state court, it has a strong tendency to invoke removal jurisdiction to move the case to federal court, if possible. The use of the removal process is significant. Approximately eleven to twelve percent of private litigant cases arrive in federal court by removal.⁴² Between 2007 and 2011, over 30,000 cases were removed annually from state court to federal court, with 34,190 cases removed in 2011.⁴³ But, the raw numbers may not tell the full story. Because of the \$75,000 jurisdictional threshold for removal,⁴⁴ it is likely that the most significant cases—at least from a monetary point of view—end up in federal court.

⁴¹ Some quarters of academia reject such experiential evidence. That said, the views of experienced practitioners should not be dismissed. In the words of baseball great Yogi Berra (“Berra”): “In theory, there is no difference between theory and practice. In practice, there is.” *Yogi Berra Quotes*, BRAINYQUOTE <http://www.brainyquote.com/quotes/quotes/y/yogiberra141506.html> (last visited Feb. 3, 2015). Berra also said: “You can observe a lot by just watching.” *Yogi Berra Quotes*, BRAINYQUOTE, <http://www.brainyquote.com/quotes/quotes/y/yogiberra125285.html> (last visited Feb. 11, 2015).

⁴² Neal Miller, *An Empirical Study of Forum Choices in Removal Cases Under Diversity and Federal Question Jurisdiction*, 41 AM. U. L. REV. 369, 388 (1992).

⁴³ DIR. OF THE ADMIN. OFF. OF U.S. COURTS, 2013 ANNUAL REPORT OF THE DIRECTOR: JUDICIAL BUSINESS OF THE UNITED STATES COURTS Table C-8 (2013) [hereinafter “Director’s Report”], available at <http://www.uscourts.gov/uscourts/Statistics/JudicialBusiness/2013/appendices/C08Sep13.pdf> (reporting the number of cases removed for 2012 and 2013 decreased slightly but remained above 32,000).

⁴⁴ See 28 U.S.C. § 1441 (2012) (providing that actions which could have been brought in the original jurisdiction of federal courts are generally removable); see also 28 U.S.C. § 1332(a) (2012) (matters between citizens of different states “where the matter in controversy exceeds the sum or value of \$75,000, exclusive of interest and costs” are within the original jurisdiction of the federal district courts).

A. PROCEDURAL PREFERENCE FOR FEDERAL COURT

A detailed attorney survey by Neal Miller regarding the use of removal jurisdiction revealed that defense counsel, including a large proportion representing insurance companies, “almost uniformly favored federal court judges (85.6%).”⁴⁵ Miller’s findings regarding defense counsel generally apply to insurers. An insurer may file a declaratory judgment action and thus act as the plaintiff. However, the surveys in the Miller study revealed that only 1.6% of plaintiff attorneys represented insurance companies, while 30.7% of defense attorney’s represented insurance companies.⁴⁶ Accordingly, the survey results attributed to defense counsel would overwhelmingly include the views of those representing insurers. Forty-seven-and-nine-tenths percent (47.9%) of defense attorneys reported that the availability of summary judgment rulings was an important factor in choosing a federal forum.⁴⁷ Further, when adjusted by experience in federal court, the percentage became extremely significant: “Among those defense attorneys who reported that over 50% of their practice occurred in federal court, two-thirds (66.6%) said that federal court summary judgment rules were a factor in forum selection, and 32.8% cited it as a ‘very strong’ reason for removal.”⁴⁸

Although the Miller study was published in 1992, there is reason to believe that defense counsel’s—and hence insurer counsel’s—preference for federal court has increased in the intervening twenty-three years. In 1993, the Supreme Court decided *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, which imposed new requirements limiting the introduction of expert testimony in federal court.⁴⁹ Further, the Supreme Court’s decisions in *Bell Atlantic Corp. v. Twombly*⁵⁰ and *Ashcroft v. Iqbal*⁵¹ established more stringent pleading requirements, thus permitting

⁴⁵ Miller, *supra* note 42, at 414.

⁴⁶ *Id.* at 400 ex. 2.

⁴⁷ *Id.* at 418.

⁴⁸ *Id.* at 419.

⁴⁹ *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 597 (1993); *see also* *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 158 (1999).

⁵⁰ *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007).

⁵¹ *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550 U.S. at 570).

the dismissal of cases filed in federal court before the discovery process.⁵² These developments all favor the defense and provide additional procedural tools that did not exist at the time of the Miller survey.

Federal court statistics from the Administrative Office of the United States Courts back up the perceptions that defense counsel favor federal court. Statistics further suggest that the use of summary adjudication in federal court is substantial and increasing. Statistics from 1997 through 2012 regarding civil insurance cases in federal court consistently indicate that approximately 73% to 79% of cases terminated by court action were terminated before pretrial.⁵³ Further, the percentage of cases actually decided by trial was both minuscule and declining. In 1997, 3.7% of insurance cases were decided by trial (jury and non-jury). The percentage resolved by trial stayed above 3% until 2002, when it dropped to 2.5%. The percentage stayed above 2% but below 3% until 2007, when it dropped to 1.6%.⁵⁴ Since 2007, the percentage of insurance cases decided by trial has stayed below 2%, ranging from 1.2% to 1.8%.⁵⁵

These percentage differences may seem insignificant, but they represent a substantial decline in the number of insurance cases proceeding to trial in the federal courts. The raw numbers for several years between 1997 and 2013 tell the story.

⁵² The complaint must include sufficient factual allegations “to raise a right to relief above the speculative level.” *Twombly*, 550 U.S. at 555. “To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to ‘state a claim to relief that is plausible on its face.’” *Iqbal*, 556 U.S. at 678 (quoting *Twombly*, 550 U.S. at 570).

⁵³ Director’s Report, *supra* note 43, at Table C–4.

⁵⁴ *Id.*

⁵⁵ *Id.*

Insurance Cases Resolved by Jury Trial in Federal Court⁵⁶

<u>Year</u>	<u>Non-Jury Trials</u>	<u>Jury Trials</u>	<u>Total Trials</u>
1997	83	161	244
2003	72	104	176
2007	47	97	144
2011	37	94	131
2012	34	95	129
2013	42	90	132

Therefore, there is simply no doubt that the federal courts are very likely to dispose of insurance cases before trial, and the chances of a case going to trial is exceedingly low. From 2011 to 2013, approximately 130 insurance cases per year went to trial in the entire federal court system, a very low number.

B. SUBSTANTIVE PREFERENCE FOR FEDERAL COURT

Insurance companies prefer federal court for substantive reasons as well. Fifty-three-and-one-half percent (53.5%) of defense counsel responding to the Miller survey “cited the likelihood of a more favorable federal court legal ruling.”⁵⁷ Although the substantive differences were more difficult to specify than the procedural advantages of federal court, defense counsel were clear in their perception: “The research findings indicate that some areas of state law are not consistently followed by federal court rulings.”⁵⁸ Survey responses indicated that federal courts may

⁵⁶ Director’s Report, *supra*, note 43, at Table C–4; DIR. OF THE ADMIN. OFF. OF U.S. COURTS, 2012 ANNUAL REPORT OF THE DIRECTOR: JUDICIAL BUSINESS OF THE UNITED STATES COURTS Table C–4 (2012); DIR. OF THE ADMIN. OFF. OF U.S. COURTS, 2011 ANNUAL REPORT OF THE DIRECTOR: JUDICIAL BUSINESS OF THE UNITED STATES COURTS Table C–4 (2011); DIR. OF THE ADMIN. OFF. OF U.S. COURTS, 2007 ANNUAL REPORT OF THE DIRECTOR: JUDICIAL BUSINESS OF THE UNITED STATES COURTS C–4 (2007); DIR. OF THE ADMIN. OFF. OF U.S. COURTS, 2003 ANNUAL REPORT OF THE DIRECTOR: JUDICIAL BUSINESS OF THE UNITED STATES COURTS Table C–4 (2003); DIR. OF THE ADMIN. OFF. OF U.S. COURTS, 1997 ANNUAL REPORT OF THE DIRECTOR: JUDICIAL BUSINESS OF THE UNITED STATES COURTS Table C–4 (1997).

⁵⁷ Miller, *supra* note 42, at 417.

⁵⁸ *Id.* at 437.

make their own predictions of state law and ignore precedent from intermediate state appellate courts.⁵⁹ The survey concluded that although no conclusions about the pervasiveness of the problem could be reached, “the large proportion of attorneys in the study who anticipated different rulings of law in state court points to the need for more definitive study.”⁶⁰

Thus, the reason why plaintiffs and defendants battle so fiercely over a state or federal forum is simple: despite *Erie*, federal courts are perceived, particularly by defense counsel, to decide procedural and substantive issues of state law differently than state courts. Statistics validate the perception that federal judges are very likely to dispose of cases without a trial. The risk of proceeding to trial for an insurer in federal court, which has been small for years, is now almost non-existent.

IV. CONSEQUENCES

The substantive misapplication of state law has serious consequences that directly undermine the fundamental principle of federalism underlying *Erie*, namely, the state courts’ ability to decide and shape state law. Moreover, perceived differences between the way federal and state courts decide state law encourage insurers and other parties to seek a federal forum, further undermining *Erie*’s policy against forum shopping.

A. DEPRIVATION OF SUBSTANTIVE RIGHTS

An incorrect *Erie* guess deprives a litigant of substantive rights. In the insurance context, the consequences are particularly obvious. An insured denied coverage based on an incorrect interpretation of state law loses, in a first party property case, the right to recover for a loss. In a liability case, the consequences may be even more severe, because the insured loses both the benefit of an insurer-provided defense as well as indemnity for any settlement or judgment. Further, insurance may provide the only means of recovery for the plaintiff.

Further, the loss is generally without any possible recourse. As observed by Judge Calabresi of the United States Court of Appeals for the Second Circuit: “In such a situation, the party who lost in federal court has

⁵⁹ *Id.* at 440.

⁶⁰ *Id.*

been unjustly denied her state-law rights, and often has been left with no means of effective redress.”⁶¹ In discussing a case in which a litigant was deprived of ownership of a valuable painting because of an incorrect *Erie* guess, Judge Calabresi noted that the plaintiff was deprived of her property “not because of any decision by the highest court of New York, but rather because of the will of the federal courts.”⁶²

The ramifications of an incorrect *Erie* guess, particularly in insurance coverage cases, often extend far beyond the lack of redress in a single case. Because the ruling becomes persuasive precedent, it is likely to be applied multiple times until the state’s highest court issues a contrary ruling. Accordingly, a single mistake may be repeated again and again. Because insurance policies are typically written on common policy forms, the potential for repeated errors in coverage litigation is acute.⁶³

B. ENCOURAGING FORUM SHOPPING

When a federal court decides an unsettled question of state law, it potentially undermines principles of federalism. This includes circumventing the right of a state’s highest court to determine questions of state law. In the context of discussing a hypothetical product liability case, Judge Calabresi observed:

If the federal court treats the plaintiff more favorably than the state tribunal would, then the plaintiff always files in federal court; similarly any departure in the manufacturer’s favor leads the defendant to remove any suit filed in state court. In either case, the state loses the ability to develop or restate the principles that it believes should govern the category of cases.⁶⁴

⁶¹ *McCarthy v. Olin Corp.*, 119 F.3d 148, 159 (2d Cir. 1997) (Calabresi, J., dissenting). Judge Calabresi’s dissent provides rare analysis and commentary from a member of the federal judiciary on this important subject.

⁶² *Id.* (Calabresi, J., dissenting).

⁶³ As noted previously, this is exactly what happened in the United States District Court for the Northern District of Georgia and the Eleventh Circuit regarding coverage for construction defects. *See supra* notes 19–21 and accompanying text.

⁶⁴ *McCarthy*, 119 F.3d at 158.

This is no small matter, particularly in light of the discussion above showing that federal courts routinely decide unsettled questions of state law, and often decide them incorrectly.

Further, contrary to *Erie's* intent, federal court decisions on unsettled questions of state law encourage forum shopping. As noted in the quotation from Judge Calabresi above, it really does not matter which party the decision favors, as one side or the other will be encouraged to forum shop in federal court.

For insurance coverage cases, experience and statistics show, as discussed above, that the insured will usually wish to proceed in state court and the insurer will normally wish to proceed in federal court. Further, as a general proposition and as demonstrated above, federal judges have always been likely, and are becoming even more likely, to rule on motions to dismiss or for summary judgment, resulting in a minuscule chance for an insurance coverage case to proceed to trial.

Accordingly, when there is an insurance coverage dispute, and there is diversity jurisdiction, the insurer may well race to file first in federal court. If the insured files first in state court, the insurer will often still have the option to remove the case to federal court. To be sure, there may be jurisdictions in which the opposite situation prevails, and the insured would prefer to proceed in federal court and the insurer in state court. In such instances, the insured can use the same procedural techniques to maneuver the case to federal court.⁶⁵ But recognizing this possibility merely highlights the fundamental point: In all cases in which diversity exists and there is an unsettled question of state law, one party is likely to try to maneuver the case to federal court to achieve a different substantive result.

V. POSSIBLE REMEDIES

A. ELIMINATING DIVERSITY JURISDICTION

One obvious solution would simply be to eliminate diversity jurisdiction. Diversity jurisdiction is controversial, and there have long been calls to eliminate it. In the past several decades, serious legislative

⁶⁵ 28 U.S.C. § 1441 (2012).

efforts were made to abolish diversity jurisdiction.⁶⁶ Most notably, in 1990, a specially appointed federal study committee recommended repealing diversity jurisdiction in all but a limited number of situations on the basis that no type of jurisdiction had a “weaker claim” on federal judicial resources, and because eliminating diversity jurisdiction would reduce the caseload of the federal courts.⁶⁷ Predictably, the committee’s recommendation met with substantial resistance, including among the bar.⁶⁸

Efforts to limit or curtail diversity jurisdiction have failed, and, as Professor Underwood put it, “Congress chose a different path.”⁶⁹ Most recently, Congress expanded the scope of federal jurisdiction through the adoption of the Class Action Fairness Act of 2005 (“CAFA”),⁷⁰ which expands federal court jurisdiction to cover certain class action lawsuits in the absence of complete diversity.⁷¹

Regardless of the recent change in political fortunes, the elimination of diversity jurisdiction would seem, under almost any circumstance, to be highly improbable. Any such effort would be strongly opposed by insurers, big business, and the defense bar. In short, little basis

⁶⁶ The House of Representatives voted twice to abolish diversity jurisdiction in the late 1970s, even though it never reached the Senate. James M. Underwood, *The Late, Great Diversity Jurisdiction*, 57 CASE W. RES. L. REV. 179, 199 (2007) [hereinafter “Underwood”]. Underwood’s article provides a comprehensive and entertaining recitation of the ebb and flow of support or diversity jurisdiction. See also L. Lynn Hogue, *Law in a Parallel Universe: Erie’s Betrayal, Diversity Jurisdiction, Georgia Conflicts of Laws Questions in Contracts Cases in the Eleventh Circuit, and Certification Reform*, 11 GA. ST. U. L. REV. 531, 533–35 (1995).

⁶⁷ H.R. REP. NO. 5381, at 63 (1990).

⁶⁸ See *Report of the N.Y. Cnty. Lawyers’ Ass’n Comm. on the Fed. Courts on the Recommendation of the Fed. Courts Study Comm. to Abolish Diversity Jurisdiction Adopted by the Bd. of Dirs. of the N.Y. Cnty. Lawyers’ Ass’n*, 158 F.R.D. 185 (1995) [hereinafter “New York Committee Report”]. The New York Committee Report contains a measured but very detailed criticism of the Committee Report, including a survey of federal judges that casts doubt upon the Committee Report’s underlying assumptions.

⁶⁹ Underwood, *supra* note 66, at 201.

⁷⁰ 28 U.S.C. §§ 1332(d), 1711–1714 (2012).

⁷¹ 28 U.S.C. § 1332(d).

exists for challenging Professor Baker's observation that "no one should expect it to be abolished in an existing lifetime plus twenty-one years."⁷²

Further, the expansion of federal court jurisdiction suggests that the federal courts will necessarily be facing an even greater number of state law questions. Thus, the question remains how to achieve the goals and requirements of *Erie*. Fortunately, a ready solution exists, although not in the way it is currently utilized.

B. USE OF AVAILABLE CERTIFICATION PROCEDURES

When a federal court in a diversity case faces an uncertain question of state law, it currently has three possible choices. First, the court can predict how the state's highest court would rule, often leading to unsatisfactory results as discussed above. Second, the court can abstain from deciding the question under the *Pullman* abstention doctrine, which is seldom applicable.⁷³ Third, if available, the court can certify the question to the state's highest court under statutory certification procedures. Almost all states now have certification statutes, so the opportunity to certify exists in most cases.⁷⁴

⁷² THOMAS E. BAKER, *RATIONING JUSTICE ON APPEAL: THE PROBLEMS OF THE U.S. COURTS OF APPEALS* 190 (1994).

⁷³ See generally *R.R. Comm'n of Tex. v. Pullman Co.*, 312 U.S. 496 (1941). The *Pullman* abstention doctrine generally provides that, "if [there are] unsettled questions of state law in a case that may make it unnecessary to decide a federal constitutional question, the federal court should abstain until the state court has resolved the state questions." 17A CHARLES ALAN WRIGHT, ARTHUR R. MILLER & EDWARD H. COOPER, *FEDERAL PRACTICE AND PROCEDURE* § 295 (3d ed. 2007).

⁷⁴ Rebecca A. Cochran, *Federal Court Certification of Questions of State Law to Federal Courts: A Theoretical and Empirical Study*, 29 J. LEGIS. 157, 159 n.13 (2003) (compiling statutes); see also JONA GOLDSCHMIDT, *CERTIFICATION OF QUESTIONS OF STATE LAW* 1, 15–17 (American Judicature Society ed., 1995) (listing 43 states as of 1995). Cochran lists Arkansas, North Carolina, and New Jersey as not having certification procedures. However, New Jersey adopted a statute permitting certification effective in 2000, N.J. STAT. ANN. § 2:12A-1 (West 1999), and Arkansas adopted certification in 2002, see *Ark. Sup. Ct. R. 6-8*; *Longview Prod. Co. v. Dubberly*, 352 Ark. 207, 208 (2003) ("Rule 6–8 was adopted in 2002 pursuant to Section 2(D)(3) of Amendment 80 to the Arkansas Constitution: 'The Supreme Court shall have original jurisdiction to answer questions of state law certified by a court of the United States which may be exercised pursuant to Supreme Court rule'"). It appears that North Carolina is the only state that has not adopted a certification

Florida was the first state to adopt a certification statute in 1945. Over fifty years ago in *Clay v. Sun Insurance Office Ltd.*, Justice Frankfurter lauded the “rare foresight” of the Florida legislature by providing a mechanism for “authoritatively determining unresolved state law involved in federal litigation by a statute which permits a federal court to certify such a doubtful question of state law to the Supreme Court of Florida for its decision.”⁷⁵

Since *Clay*, the Supreme Court has enthusiastically embraced the use of the certification procedure in a number of cases.⁷⁶ The Court has stressed: “Through certification of novel or unsettled questions of state law for authoritative answers by a state’s highest court, a federal court may save ‘time, energy, and resources and hel[p] build a cooperative judicial federalism.’”⁷⁷ The Court has observed that a “question of state law usually can be resolved definitively . . . if a certification procedure is available and is successfully utilized.”⁷⁸

provision. Eric Eisenberg, *A Divine Comity: Certification (at Last) in North Carolina*, 58 DUKE L.J. 69, 71 (2008) (“North Carolina remains the only state never to have enacted such a procedure, putting it behind the District of Columbia, Puerto Rico, the Northern Mariana Islands, and Guam.”) (footnotes omitted); see Shakira Robinson, *Right, But for the Wrong Reasons: How A Certified Question to the Supreme Court of North Carolina Could Have Alleviated Conflicting Views and Brought Clarity to North Carolina State Law*, 34 N.C. CENT. L. REV. 230, 230 (2012) (“Unconstitutional or dogmatic, North Carolina is the only state that has never enacted a procedure by which a federal court could certify a question of state law to its state Supreme Court”). As noted by Eisenberg, although Missouri has adopted a statute permitting certification, the Missouri Supreme Court has refused to accept certified questions on the ground they are not within its jurisdiction under the Missouri Constitution. See *Grantham v. Missouri Dep’t of Corr.*, No. 72576, 1990 WL 602159, at *1 (Mo. July 13, 1990).

⁷⁵ *Clay v. Sun Ins. Office Ltd.*, 363 U.S. 207, 212 (1960).

⁷⁶ *E.g.*, *Virginia v. Am. Booksellers Ass’n, Inc.*, 484 U.S. 383, 398 (1988) (certifying questions to Supreme Court of Virginia); *Lehman Bros. v. Schein*, 416 U.S. 386, 395 (1974) (remanding for consideration of certification to Supreme Court of Florida).

⁷⁷ *Arizonans for Official English v. Ariz.*, 520 U.S. 43, 77 (1997) (quoting *Lehman Bros.*, 416 U.S. at 391).

⁷⁸ *Salve Regina Coll. v. Russell*, 499 U.S. 225, 237 n.4 (1991).

C. THE PROBLEM: LACK OF UNIFORM APPLICATION OF CERTIFICATION

Although the Supreme Court has endorsed the use of certification procedures when available, it has never established definitive standards for certification. Rather, the Court has stated that the decision to certify is one of discretion, and “not obligatory.”⁷⁹ However, the Court has not provided guidance to the federal courts on the factors to be considered in exercising their discretion. As one District Court judge observed: “The Supreme Court has never indicated the necessary conditions before a court can resort to certification.”⁸⁰

In the absence of definitive guidance from the Supreme Court, there remains considerable conflict among the Circuits in the approach to be taken in certifying questions for review. Some courts take a hospitable view, noting the Supreme Court’s enthusiastic support for certification.⁸¹ For example among this group, the courts certify simply when “[t]here is no controlling precedent to be found in the decisions.”⁸² The Eighth Circuit certified “because of the unsettled nature of Nebraska law on this issue and because a determination of this issue could be dispositive of this case.”⁸³

Conversely, other courts take a very restrictive view. The Second Circuit resorts to certification “sparingly” on the theory that its job is to predict how the Court of Appeals of New York would rule.⁸⁴ Another court adopted a restrictive six-part test.⁸⁵ Some courts seem irritated with the very suggestion of certification, particularly after they have decided an unsettled question of state law.⁸⁶ Other courts appear to have charted a

⁷⁹ *Lehman Bros.*, 416 U.S. at 390–391 (certification “not obligatory” and matter of discretion, but helps build a “cooperative judicial federalism”).

⁸⁰ *Fiat Motors of N. Am. Inc. v. Mayor of Wilmington*, 619 F. Supp. 29, 33 (D.C. Del. 1985).

⁸¹ *E.g.*, *Puckett v. Rufenacht, Bromagen & Hertz, Inc.*, 903 F.2d 1014 (5th Cir. 1990).

⁸² *Holmes v. Amerex Rent-A-Car*, 113 F.3d 1285, 1287 (D.C. Cir. 1997).

⁸³ *Hatfield v. Bishop Clarkson Mem’l Hosp.*, 701 F.2d 1266, 1267 (8th Cir. 1983).

⁸⁴ *E.g.*, *Runner v. N.Y. Stock Exch., Inc.*, 568 F.3d 383, 388 (2d Cir. 2009).

⁸⁵ *Zimmer v. Travelers Ins. Co.*, 454 F. Supp. 2d 839, 861 (S.D. Iowa 2006).

⁸⁶ One court has remarked:

middle ground: “While we apply judgment and restraint before certifying, however, we will nonetheless employ the device in circumstances where the question before us (1) may be determinative of the case at hand and (2) is sufficiently novel that we feel uncomfortable attempting to decide it without further guidance.”⁸⁷

Notably, some courts have been inconsistent in considering certification in their own rulings. For example, the Eleventh Circuit has stated both that (1) a question should be certified if there is “any doubt” as to state law on an issue⁸⁸ and (2) that it will “exercise discretion and restraint in deciding to certify questions to state courts.”⁸⁹ The Eleventh Circuit recently recited the “any doubt” test, but also inconsistently stated that certification decisions must be made with “restraint.”⁹⁰ Even more recently, the Eleventh Circuit appeared to abandon the “any doubt” test, noting that certification should be used with “restraint,” but declared that “truly debatable” issues of state law should be certified.⁹¹ It is thus impossible to ascertain any clear standard for certification in this court.

Certification is not to be routinely invoked whenever a federal court is presented with an unsettled question of state law. Late requests for certification are rarely granted by this court and are generally disapproved, particularly when the district court has already ruled. Filing a motion to certify after an adverse ruling, as was done in this case, is not favored.

Potter v. Synerlink Corp., No.08-CV-674-GKF-TLW, 2012 WL 2886015, at *1 (N.D. Okla. July 13, 2012) (citations and internal quotation marks omitted). The approach advocated by *Potter* may be questioned, as it essentially asks advocates to assume the federal court will make a mistake and to request certification before ruling. An advocate may, with some understanding, be reluctant to make such a suggestion for strategic reasons. In any event, a refusal to grant a legitimate request for certification based solely on timing seems to undermine the basic reason for the process: a correct determination of state law by the court authorized to have the final and definitive word.

⁸⁷ *Pino v. United States*, 507 F.3d 1233, 1236 (10th Cir. 2007).

⁸⁸ *Colonial Props., Inc. v. Vogue Cleaners, Inc.*, 77 F.3d 384, 387 (11th Cir. 1996).

⁸⁹ *Escareno v. Noltina Crucible & Refractory Corp.*, 139 F.3d 1456, 1461 (11th Cir. 1998).

⁹⁰ *Royal Capital Dev., LLC v. Md. Cas. Co.*, 659 F.3d 1050, 1054–1055 (11th Cir. 2011).

⁹¹ *Ruderman ex rel. Schwartz v. Wash. Nat. Ins. Corp.*, 671 F.3d 1208, 1212 (11th Cir. 2012).

D. THE NEED FOR CLEAR STANDARDS FOR CERTIFICATION

Use of the certification process clearly fosters the policies underlying *Erie*, and promotes, as the Supreme Court has said, a “cooperative judicial federalism.”⁹² As currently practiced, however, certification procedures often serve only to add a further level of uncertainty in deciding unsettled questions of state law. Although some use of certification is better than none, the reality is that the availability of certification is dependent upon the court in which the case is pending, and, in many cases, seems to turn on nothing more than how the judicial winds are blowing on a particular day.

The result is that, while some litigants receive the constitutional benefits of certification, others do not. Equally important, a state’s highest court is often deprived of its constitutional prerogative to determine the law of the state. Fortunately, the status quo need not continue. The best solution would be a definitive ruling from the Supreme Court, establishing liberal and consistent standards for certification. Even in the absence of Supreme Court guidance, however, lower federal courts can and should adopt consistent principles designed to foster the use of available certification procedures consistent with the constitutional mandate of *Erie*.

E. TOWARD A CONSTITUTIONALLY CONSISTENT APPROACH TO CERTIFICATION

A constitutionally consistent approach toward certification should be far more uniform than is currently practiced, but will not be completely uniform. The guiding principle of federalism is that certification must be consistent with the requirements of the state certification statute. Obviously, if a state has mandated certain requirements, they must be followed, and state certification procedures, although generally consistent in their broad outline, vary somewhat. Some procedures permit only the United States Supreme Court and the United States Courts of Appeal to certify. Others permit United States District Courts to certify as well. Some statutes establish additional requirements.⁹³ Whatever state statutory requirements exist, the first principle is that they should be satisfied before a question is certified. That said, states that do not currently permit District

⁹² *Salve Regina Coll. v. Russell*, 499 U.S. 225, 239-240 (1991).

⁹³ *GOLDSCHMIDT*, *supra* note 74, at 15–17.

Courts to certify should strongly consider amending their statutes. Certification by a District Court permits the parties to obtain a definitive determination of unsettled law early in the litigation, thus promoting efficiency.

Second, subject to state requirements, there should be a liberal presumption in favor of certifying unsettled questions of state law. This approach is consistent with the Supreme Court's oft-stated enthusiasm for certification, not to mention *Erie*'s core principle of federalism. It is also hardly radical. As noted above, some federal courts have followed this approach. Further, this approach is also consistent with the states' own endorsement of the certification mechanism as demonstrated by the nearly unanimous adoption of the process. In the insurance context, certification has been used—although haphazardly and pursuant to different standards—to resolve many unsettled state insurance questions.⁹⁴

Third, the certifying court should consider whether a particular area of law, or a particular question, has led other courts to reach differing conclusions. As discussed above, the insurance coverage cases provide a particular example of such an area. If so, this factor will further support certification.

Fourth, the certifying court should make a clear determination that the controlling legal question has not been decided by the state's highest court, and it should clearly articulate the controlling question of state law. In most instances, this can and will be done without difficulty. In other cases, however, the case may turn not on a disputed or undecided substantive legal principle but upon the admissibility of evidence or other non-substantive issues. In such instances, certification might not be appropriate.

Fifth, the certifying court may wish to consider whether the legal principle has potential significance beyond the current case. In most instances, it is likely that there will be future ramifications. This is particularly true in the area of insurance coverage, because policies are written on standardized forms, virtually assuring that the same question will arise in multiple cases. Nevertheless, there may be cases that are so unique that certification would lend little to the development of state law, and, in such circumstances, certification may be declined. Even then,

⁹⁴ See *supra* notes 41–43 and accompanying text.

however, consideration of the substantive rights of the litigants may favor certification.⁹⁵

This approach will foster the principles of federalism that underlie *Erie*. It should decrease incentives for forum shopping between state and federal courts in the same jurisdiction. It will help prevent litigants from being deprived of substantive rights under state law through incorrect *Erie* guesses. Perhaps most importantly, it will ensure that the court entitled to make the final determination of state law gets a fair chance to make it.

It may be questioned whether these principles should apply only to insurance coverage litigation or generally. My view is that they should apply generally, because the policies underlying *Erie* apply generally. That said, the principles are particularly applicable to insurance coverage litigation, and if consistently applied, almost all unsettled insurance coverage issues would qualify for certification.

VI. A POSTSCRIPT: “WHY” REALLY DOES NOT MATTER

An early draft of this Article attempted to explain why federal courts often seem to decide insurance coverage cases differently than state courts; specifically, whether there is some identifiable difference in procedural approach or substantive doctrine that explained the divergence. At the end of the day, it was simply not possible to determine any definitive reasons why federal courts often decide insurance coverage cases differently from state courts, even though the evidence strongly suggests that they do.

One thing, however, is clear: different states often reach diametrically differing conclusions regarding the meaning and application of insurance policy forms.⁹⁶ Accordingly, when a federal court faces an unsettled question of state insurance law, there may well be conflicting precedent from other jurisdictions based on fundamentally different approaches. Thus, when a federal court chooses one line of precedent in the face of substantial precedent to the contrary, it increases the probability

⁹⁵ Of course, there may be other unique factors militating in favor of or against certification, and the law should always allow for considerations applicable to the case under consideration. With that said, the consideration of unique factors should not undermine the general presumption in favor of certification.

⁹⁶ See *supra* note 4 and accompanying text.

of an incorrect *Erie* guess, because the state's highest court might well choose the reasoning in the other cases.

The fact that a federal court may choose to follow one line of conflicting precedent over another on an unsettled question is not, in the abstract, "wrong," if the federal court were left to its own devices. The problem, however, is that *Erie* does not leave federal courts to their own devices, but rather directs them to follow state law, even if they believe another approach would be preferable. The state's highest court has the last word, or at any rate, is supposed to have it.

Accordingly, rather than focusing on how they would decide the question, the federal courts should instead focus on using certification procedures to allow the state's highest court to exercise its constitutional prerogative to make the decision. Such an approach fosters the "cooperative judicial federalism"⁹⁷ on which *Erie* is based, and renders moot the question of why federal courts would decide the issue differently.

VII. CONCLUSION

Although *Erie* has been the law of the land for over seventy years, its constitutional underpinnings are often forgotten. The fundamental principle underlying *Erie* is that the highest court of a state must have the final say in interpreting and determining state law. In spite of this principle, federal courts routinely make guesses on state law insurance questions, and frequently come up with the wrong answers. Incorrect *Erie* guesses not only affect the substantive rights of litigants, they undermine the constitutionally mandated prerogative of state courts to determine state law.

Certification statutes provide a readily available remedy in virtually every state. Although certification has been widely praised by the United States Supreme Court, its use in practice varies greatly, with some courts liberally granting certification, and others only in exceptional circumstances. As a result, the best available mechanism for implementing *Erie*'s principles has been unevenly applied. The approach advocated in this Article will bring greater uniformity and greater availability to certification procedures, and will also help eliminate forum shopping, with the ultimate result being that the principles of federalism underlying *Erie* are properly applied.

⁹⁷ *Lehman Bros. v. Schein*, 416 U.S. 386, 390–391 (1974).

AMERICA'S GROWING PROBLEM: HOW THE PATIENT PROTECTION AND AFFORDABLE CARE ACT FAILED TO GO FAR ENOUGH IN ADDRESSING THE OBESITY EPIDEMIC

ASHLEY A. NOEL*

For the last several decades, the United States has been facing an uphill battle against obesity. In addition to constituting a public health crisis, the increasing prevalence of obesity poses serious economic consequences for the United States as health care costs continue to soar. In an attempt to combat this growing problem, Congress included numerous provisions in the Patient Protection and Affordable Care Act aimed at reducing the high rates of obesity in the United States.

This Note argues that the Affordable Care Act could have more effectively addressed the obesity crisis by providing a meaningful financial incentive encouraging the adoption of healthier lifestyles to obese Americans. This Note suggests two ways in which the Affordable Care Act could have incorporated such an incentive: (1) an amendment to section 213 of the Internal Revenue Code and (2) mandatory insurance coverage of weight loss- and health-related expenses.

I. INTRODUCTION

In merely a quarter of a century, skyrocketing rates of obesity have transformed this once uncommon disease into a public health crisis threatening the American population as greatly as the prevalence of smoking once did.¹ While obesity surely poses a significant health risk, rising rates of the disease also correlate to increasing economic consequences: medical expenses associated with obesity constitute one of the driving forces behind soaring health care costs in the United States, accounting for one-quarter of all health expenses,² with some

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¹ Alan S. Go et al., *Heart Disease and Stroke Statistics—2013 Update: A Report from the American Heart Association*, 127 CIRCULATION e6, e59–60, e62 (2012), available at <http://circ.ahajournals.org/content/127/1/e6.full.pdf>.

² Y. Tony Yang & Len M. Nichols, *Obesity and Health System Reform: Private vs. Public Responsibility*, 39 J.L. MED. & ETHICS 380, 380 (2011).

commentators even going as far as to suggest that rising incidences of obesity are affecting the nation's economic competitiveness on a global scale.³ In addition to the obvious health concerns raised by obesity, the government needs to address the rising health care costs associated with the disease, which affect not only obese individuals, but also the American public as a whole, by providing an effective means of encouraging the adoption of healthier lifestyles.

Legislation aimed at counteracting drastically increasing rates of obesity in the United States has been on the Congressional calendar since the early 1990s.⁴ Since the introduction of the first obesity-related bill, the need for a government response to this expanding problem has increased significantly. As a result, the United States has seen a number of efforts to address this problem at all levels of government, from the proposed sugary drink ban in New York City⁵ to First Lady Michelle Obama's "Let's Move!" campaign, which targets childhood obesity.⁶ In 2010, Congress enacted the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA"),⁷ the primary purpose of which was to provide affordable health insurance coverage for all Americans.⁸ Additionally, in an attempt to tackle the growing obesity problem plaguing the United States, Congress included numerous provisions in the Affordable Care Act that seek to decrease the prevalence of obesity in the United States while

³ *Id.* (arguing that "the less fit and less productive U.S. work-force has gradually eroded the nation's industrial competitiveness").

⁴ Daniel M. Reach, Article, *Fitness Tax Credits: Costs, Benefits, and Viability*, 7 NW. J. L. & SOC. POL'Y 352, 358 (2012).

⁵ See Michael M. Grynbaum, *New York Plans to Ban Sale of Big Sizes of Sugary Drinks*, N.Y. TIMES, May 30, 2012, http://www.nytimes.com/2012/05/31/nyregion/bloomberg-plans-a-ban-on-large-sugared-drinks.html?_r=0.

⁶ See generally Press Release, White House: Office of the First Lady, First Lady Michelle Obama Launches Let's Move: America's Move to Raise a Healthier Generation of Kids (Feb. 9, 2010), available at <http://www.whitehouse.gov/the-press-office/first-lady-michelle-obama-launches-lets-move-americas-move-raise-a-healthier-genera>.

⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, 30, and 42 U.S.C.), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

⁸ See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2580 (2012) ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care.").

simultaneously encouraging healthier lifestyles for all Americans. Despite these efforts, however, the Affordable Care Act failed to go far enough.

One of the greatest barriers preventing perhaps a majority of obese Americans from attempting to lose weight is the high cost of health club memberships and weight loss programs.⁹ Accordingly, the Affordable Care Act could have more effectively targeted the growing prevalence of obesity by providing a financial incentive to encourage the adoption of overall healthier lifestyles in order to diminish health care costs not only for obese individuals, but also for the American public as a whole.

This Note suggests two ways in which the Affordable Care Act could have provided a financial incentive aimed at spurring weight loss and the adoption of healthier lifestyles, each of which would also serve the Act's underlying purpose of decreasing health care costs. First, Congress could have amended the Internal Revenue Code in order to provide a tax deduction for obese Americans who incur significant medical expenses in an effort to lose weight and remedy their obesity. Rather than provide a meaningful financial incentive through the tax code, however, the Affordable Care Act actually moves a pre-existing financial incentive aimed at encouraging healthier behaviors for obese individuals, section 213 of the Internal Revenue Code, even further out of reach for most Americans.¹⁰ Second, Congress could have mandated insurance coverage of expenses incurred by obese individuals in an attempt to lose weight and adopt a healthier lifestyle, but did not. As a result, the Affordable Care Act failed to adequately address the expanding American obesity epidemic.

Part II of this Note begins with an overview of the U.S. obesity epidemic. Next, Part III explores the various provisions in the Affordable Care Act relating to obesity. Part IV then discusses why the Affordable Care Act should have incorporated a financial incentive encouraging the adoption of healthier lifestyles for obese individuals. Part V proposes two ways in which the Affordable Care Act could have provided such a financial incentive. Finally, Part VI concludes by arguing that the Affordable Care Act failed to go far enough in addressing the obesity epidemic due to the lack of a financial incentive directed at reducing the prevalence of obesity in the United States.

⁹ Arterburn et al., *Insurance Coverage and Incentives for Weight Loss Among Adults with Metabolic Syndrome*, 16 *OBSITY* 70, 70 (2008).

¹⁰ See Patient Protection and Affordable Care Act § 9013, I.R.C. § 213 (Supp. 2013–2014).

II. THE OBESITY CRISIS CURRENTLY FACING THE UNITED STATES

A. DEFINING OBESITY AND WEIGHING THE STATISTICS

The National Center for Health Statistics (“NCHS”), a part of the Centers for Disease Control and Prevention (“CDC”), classifies any adult with a body mass index (“BMI”) greater than or equal to thirty as obese, while adults with a BMI between twenty-five and 29.9 fall under the category of overweight.¹¹ Among children, the NCHS defines obesity as “a BMI equal to or greater than the age- and sex-specific ninety-fifth percentile of the 2000 CDC growth charts,”¹² while children with a BMI equal to or greater than the eighty-fifth percentile are classified as overweight.¹³

Many factors contribute to an individual becoming obese. In addition to the more obvious causes, such as a lack of energy balance (i.e., consuming more energy than one’s body expends) and an inactive lifestyle, the National Health, Lung, and Blood Institute lists the environment in the United States, including large portion sizes, demanding work schedules, and food deserts, hormone disorders, consumption of certain medications, emotional factors, quitting smoking, age, and inadequate sleep as causes of obesity.¹⁴ Moreover, evidence suggests that genetics play a key role in determining whether an individual will develop obesity, with the genetic contribution to obesity being greater than that for other conditions with a strong hereditary link, such as breast cancer and schizophrenia.¹⁵

¹¹ Body mass index is calculated by dividing weight in kilograms by height in meters squared. CYNTHIA L. OGDEN ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 82, PREVALENCE OF OBESITY IN THE UNITED STATES, 2009–2010, 6 (2012); U.S. DEP’T OF HEALTH & HUMAN SERVS., NAT’L INST. OF DIABETES & DIGESTIVE & KIDNEY DISEASES, OVERWEIGHT AND OBESITY STATISTICS, 1 (2012), available at <http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf> [hereinafter OVERWEIGHT AND OBESITY STATISTICS].

¹² OGDEN ET AL., *supra* note 11.

¹³ OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11.

¹⁴ *What Causes Overweight and Obesity?*, NAT’L HEART, LUNG & BLOOD INST. (July 13, 2012), <http://www.nhlbi.nih.gov/health/health-topics/topics/obe/causes>.

¹⁵ Jeffrey M. Friedman, *Modern Science Versus the Stigma of Obesity*, 10 NATURE MED. 563, 563 (2004).

Throughout the 1960s and 1970s, the prevalence of obesity in the United States remained relatively stable;¹⁶ however, this changed rapidly beginning in the early 1980s. Between 1980 and 2008, the percentage of American adults classified as obese more than doubled, rising from 13.4% to 34.3%.¹⁷ During this same period, the prevalence of childhood obesity more than tripled, rising from 5% in 1980 to 17% in 2008.¹⁸ When compared to rates from 1973 and 1974, the increase was exponentially higher, despite the relatively small difference in time, with the percentage of obese children being five times higher in 2008–2009 than in 1973–1974.¹⁹

The dramatic spike in the prevalence of obesity among all sectors of the American population culminated in a total of 78 million American adults falling under the classification of obese between 2009 and 2010, which translates to about 35% of the American population.²⁰ Furthermore, an additional 33% of the population was overweight between 2007 and 2010.²¹ As a whole, this amounts to 73% of American men and 64% of American women being classified as overweight or obese during this recent period.²²

The statistics are equally as daunting for children. Between 2009 and 2010, 17% of children in the United States were classified as obese, amounting to about 12.5 million children.²³ What is perhaps even more unnerving is that overweight and particularly obese children have a 70% chance of becoming obese upon adulthood, a risk that rises to 80% if one of the child's parents is overweight or obese.²⁴

¹⁶ U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE SURGEON GEN., THE SURGEON GENERAL'S VISION FOR A HEALTHY AND FIT NATION 2010, 2 (2010), available at <http://www.surgeongeneral.gov/initiatives/healthy-fit-nation/obesityvision2010.pdf> [hereinafter THE SURGEON GENERAL'S VISION FOR A HEALTHY AND FIT NATION 2010].

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Alan S. Go et al., *supra* note 1, at e60.

²⁰ OGDEN ET AL., *supra* note 11, at 2.

²¹ Go et al., *supra* note 1.

²² *Id.*

²³ OGDEN ET AL., *supra* note 11, at 2–3.

²⁴ JENNIFER BISHOP ET AL., ASPE RESEARCH BRIEF: CHILDHOOD OBESITY (Aug. 2005), available at http://aspe.hhs.gov/health/reports/child_obesity/index.cfm.

While the rising rates of obesity appear to be slowing in more recent years,²⁵ researchers predict that more than 50% of the American population will be obese by 2030.²⁶ The increasing prevalence of obesity in the United States can likely be attributed to overall greater calorie consumption. Although the average level of physical activity among the population has remained consistent since the 1980s, calorie consumption has increased drastically.²⁷

It is a common misconception that obesity is a disease that disproportionately affects the poor.²⁸ The majority of obese Americans, however, are actually not low-income.²⁹ Rather, the correlation between obesity and poverty varies according to gender, race, age, and education level.³⁰ Thus, for example, while higher rates of obesity among non-Hispanic white women correspond to lower-income levels, higher rates of obesity among non-Hispanic African-American men and Mexican-American men actually correspond to higher-income levels.³¹ Moreover, any correlation between obesity and income level appears to be decreasing over time³² as obesity rates increase across all income levels.³³

²⁵ OGDEN ET AL., *supra* note 11, at 1.

²⁶ Go et al., *supra* note 1, at e61.

²⁷ David M. Cutler et al., *Why Have Americans Become More Obese?*, 17 J. ECON. PERSPECTIVES 93, 93 (2003) (arguing that the difference in calorie intake can be explained by mass food preparation).

²⁸ *Relationship Between Poverty and Overweight or Obesity*, FOOD & RES. ACTION CTR., <http://frac.org/initiatives/hunger-and-obesity/are-low-income-people-at-greater-risk-for-overweight-or-obesity/> (last visited May 27, 2015).

²⁹ CYNTHIA OGDEN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 50, OBESITY AND SOCIOECONOMIC STATUS IN ADULTS: UNITED STATES, 2005–2008, at 2 (2010); CYNTHIA OGDEN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 51, OBESITY AND SOCIOECONOMIC STATUS IN CHILDREN AND ADOLESCENTS: UNITED STATES, 2005–2008, at 2 (2010).

³⁰ Ogden et al., OBESITY AND SOCIOECONOMIC STATUS IN ADULTS, *supra* note 29, at 6.

³¹ *Id.* For a more detailed discussion of the intersection between obesity, income level, gender, race, age, and educational level, see *id.* and OGDEN ET AL., OBESITY AND SOCIOECONOMIC STATUS IN CHILDREN AND ADOLESCENTS, *supra* note 29.

³² *Relationship Between Poverty and Overweight or Obesity*, *supra* note 28.

³³ OGDEN ET AL., OBESITY AND SOCIOECONOMIC STATUS IN ADULTS, *supra* note 29, at 6; OGDEN ET AL., OBESITY AND SOCIOECONOMIC STATUS IN CHILDREN AND ADOLESCENTS, *supra* note 29, at 4.

B. RELATION TO OTHER HEALTH PROBLEMS

While obesity constitutes a chronic disease in itself,³⁴ individuals suffering from obesity also face countless associated health risks. Obese adults, as well as some overweight individuals, have a much higher risk of developing other serious medical conditions, such as type 2 diabetes, heart disease, osteoarthritis, liver disease, and certain types of cancer, including breast, colon, endometrial, and kidney cancers, while other associated health risks include high blood pressure and a greater likelihood of suffering from a stroke.³⁵ Additionally, recent studies suggest that obesity may also correlate to the development of Alzheimer Disease and vascular dementia in some individuals.³⁶

Obesity-associated health risks for children are similar to those for adults. Overweight and obese children face an increased probability of developing significant health problems, including certain cardiovascular diseases, such as hypertension, hyperlipidemia and diabetes mellitus, asthma, sleep apnea, and musculoskeletal disorders.³⁷ Similar to overweight and obese adults, obese children are also at an increased risk of developing some cancers and suffering from a stroke.³⁸ Moreover, as previously mentioned, overweight and obese children are significantly more likely to become obese adults, which puts them at risk for further health risks later in life.³⁹ In addition to associated health risks, overweight and obese children are also at a risk of developing certain unhealthy behaviors early on in their lives. These include underachieving school performance, tobacco and alcohol use, and poor dietary habits.⁴⁰

Perhaps the most alarming obesity-related health risk is that of premature death. Obesity represents one of the foremost causes of premature death in the United States, responsible for one in ten deaths in 2005 according to a study by the Harvard School of Public Health.⁴¹ To put

³⁴ See Rev. Rul. 2002-19, 2002-1 C.B. 778.

³⁵ OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11, at 2.

³⁶ Go et al., *supra* note 1, at e61.

³⁷ *Id.*

³⁸ *Id.*

³⁹ BISHOP ET AL., *supra* note 24.

⁴⁰ Go et al., *supra* note 1, at e61.

⁴¹ Goodarz Danaei et al., *The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk*

this into perspective, the CDC's Behavioral Risk Factor Surveillance System estimates that the number of quality life years lost due to obesity is equal to or greater than those lost due to smoking. Furthermore, the prevalence of obesity and its effect on both lifespan and quality of life may be beginning to counteract any benefits seen in the United States in terms of life expectancy due to the cessation of smoking.⁴²

C. THE COSTS OF OBESITY

While the prevalence of obesity poses a significant public health problem for the United States, the disease also represents a substantial fiscal burden on the country. An obese individual spends roughly 42% more on health care each year than an average individual of a healthy weight, amounting to \$1,429 per year.⁴³ This number reflects 46% higher inpatient costs, 27% additional outpatient visits, and 80% more spent on prescription drugs than the average healthy individual.⁴⁴ On a national level, obesity-related expenses accounted for nearly 10% of all medical spending in 2008, which translates to \$147 billion in that year alone. If obesity rates continue to rise in alignment with current trends, this number could reach \$957 billion in 2030, or about 16–18% of all medical spending.⁴⁵

Heightened health insurance costs tied to obesity account for a noteworthy portion of rising medical spending, in both the private and public sectors. In the private sector, health insurance companies risk-pool both obese and non-obese insureds in formulating insurance rates, which results in higher prices for all insureds, as obesity-related costs are shifted to non-obese insureds,⁴⁶ as well as taxpayers through subsidies for employer-sponsored health insurance.⁴⁷ While private insureds incur the

Factors, PLOS MED., Apr. 28, 2009, available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000058>.

⁴² Go et al., *supra* note 1, at e62.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Merav W. Efrat & Rafael Efrat, *Tax Policy and the Obesity Epidemic*, 25 J.L. & HEALTH 233, 245 (2012).

⁴⁷ See Julia James, *Premium Tax Credits*, HEALTH AFFAIRS, Aug. 1, 2013, at 1–2, available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicy_brief_97.pdf.

majority of obesity-related expenditures,⁴⁸ the public sector also bears a substantial portion of obesity related costs, with Medicare financing 23% of obesity costs and Medicaid financing 19%.⁴⁹ The additional costs incurred by these publicly funded programs are subsequently passed on to American taxpayers.⁵⁰

In addition to its direct relation to health care expenditures, obesity also imposes non-medical costs, particularly on employers. Absenteeism, or a habitual pattern of missing work, and lower productivity attributed to obesity impose a cost of well over \$4 billion annually, or about \$506 per obese employee per year.⁵¹ According to a 2011 Gallup poll, overweight and obese employees also suffering from other health conditions missed roughly 450 million more days of work than healthy employees, which resulted in \$153 billion in absenteeism costs in that year alone.⁵² Other costs attributable to obesity include morbidity costs, or income lost from lower productivity, and mortality costs, or the value of future income lost due to diminished lifespan.⁵³

Thus, obesity is not merely a public health crisis. Rather, the prevalence of obesity in the United States poses significant economic consequences, with many of the associated costs being passed on to others, whether it is fellow insureds, taxpayers, or employers.⁵⁴

⁴⁸ Eric A. Finkelstein et al., *Annual Spending Attributable to Obesity: Payer-And-Service-Specific Estimates*, 28 HEALTH AFFAIRS w822, w829 (2009).

⁴⁹ Justice G. Trogdon et al., *State- and Payer-Specific Estimates of Annual Medical Expenditures Attributable to Obesity*, 20 OBESITY 214, 214 (2012).

⁵⁰ Efrat & Efrat, *supra* note 46, at 245–46.

⁵¹ Denise Cohen, Note, *Childhood Obesity: Balancing the Nation's Interest with a Parent's Constitutional Right to Privacy*, 10 CARDOZO PUB. L. POL'Y & ETHICS J. 357, 368 (2012).

⁵² Dan Witters & Sangeeta Agrawal, *Unhealthy U.S. Workers' Absenteeism Costs \$153 Billion*, GALLUP (Oct. 17, 2011), <http://www.gallup.com/poll/150026/unhealthy-workers-absenteeism-costs-153-billion.aspx>.

⁵³ Reach, *supra* note 4, at 354.

⁵⁴ *But see generally* Colin Hector, *Nudging Towards Nutrition? Soft Paternalism and Obesity-Related Reform*, 67 FOOD & DRUG L.J. 103, 104–08 (2012) (discussing disagreement over labeling obesity as an “epidemic” and the costs of obesity).

III. WEIGHT LOSS- AND OBESITY-RELATED PROVISIONS IN THE AFFORDABLE CARE ACT

President Barack Obama signed his seminal health care reform act, the Patient Protection and Affordable Care Act, on March 23, 2010, ushering in a new age in American health care.⁵⁵ Having first survived a Supreme Court challenge,⁵⁶ many of the provisions of the Act are just beginning to take effect, most notably the individual mandate, which requires all individuals, with certain exclusions, to maintain minimum health insurance coverage beginning in January 2014.⁵⁷ While much of the media coverage of the controversial act has surrounded the individual mandate and the rollout of online health insurance exchanges, the Affordable Care Act also contains numerous provisions aimed at addressing the prevalence of obesity in the United States and promoting the adoption of healthier lifestyles. In regard to the obesity epidemic, the relevant provisions of the Affordable Care Act fall into three generalized categories: (1) wellness programs, (2) community grants, and (3) outreach campaigns.

A. WELLNESS PROGRAMS

Wellness programs comprise a recurring theme throughout the Affordable Care Act. In the context of employer-provided wellness programs,⁵⁸ the ACA defines a wellness program as “a program offered by an employer that is designed to promote health or prevent disease . . .”⁵⁹ It further provides that,

⁵⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, 30, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

⁵⁶ *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

⁵⁷ Patient Protection and Affordable Care Act § 1501(b), I.R.C. § 5000A(a) (2012).

⁵⁸ The provisions discussed above relating to employer-provided wellness programs constitute a portion of the Affordable Care Act amending Title III and Part A of Title XXVII of the Public Health Service Act. *See* 42 U.S.C §§ 241 to 280m, 300gg to 300gg-9 (2012).

⁵⁹ Patient Protection and Affordable Care Act § 1201(4), 42 U.S.C. § 300gg-4(j)(1)(A) (2012).

A program complies with [the definition of a wellness program] if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.⁶⁰

The term “wellness program” covers an extensive variety of activities, ranging from employer-funded gym memberships, to diagnostic testing programs, to programs aimed at tobacco addiction, to health education seminars.⁶¹

In order to encourage employees to participate in wellness programs, the ACA also provides for a range of insurance-based incentives aimed at stirring participation. Perhaps the most prominent incentive offered for participating in a wellness program is a significant discount on health insurance premiums. The ACA currently authorizes employers to discount coverage up to 30% for enrollment in a wellness program;⁶² however, the Secretaries of Health and Human Services, Labor, and the Treasury are empowered to raise this to 50% if deemed appropriate.⁶³ In addition to discounted health care coverage, other qualified incentives include the elimination of co-payments or deductibles.⁶⁴

As the rewards and incentives for work-based wellness programs constitute a significant economic cost on employers, particularly small businesses, the ACA also created a five-year grant program to provide small businesses, those with less than one hundred full-time employees, with the funds necessary to institute a comprehensive wellness program.⁶⁵ Under this section, the Secretary of Health and Human Services was allocated \$200,000,000 for the five-year period between 2011 and 2015 for disbursement in the form of grants to small businesses. Once approved for a grant, a business must institute a wellness program that embraces four requirements: (1) “[h]ealth awareness initiatives,” which are defined to include “health education, preventative screening, and health risk

⁶⁰ *Id.* § 1201(4), 42 U.S.C. § 300gg-4(j)(3)(B).

⁶¹ *Id.* § 1201(4), 42 U.S.C. § 300gg-4(j)(2).

⁶² *Id.* § 1201(4), 42 U.S.C. § 300gg-4(j)(3)(A).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.* § 10408, 42 U.S.C. § 280l note.

assessments,” (2) “[e]fforts to maximize employee engagement,” which is meant to stir employee participation in the program, (3) “[i]nitiatives to change unhealthy behaviors and lifestyle choices,” which includes “counseling, seminars, online programs, and self-help materials,” and (4) “[s]upportive environment efforts,” which encompasses “workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health.”⁶⁶

Lastly, as a way of providing governmental assistance for employer-provided wellness programs, the Affordable Care Act also directs the Director of the Centers for Disease Control and Prevention to aid employers of all sizes in running their wellness programs.⁶⁷ This includes providing technical assistance, as well as helping employers evaluate the success of their programs and offering means of improvement.⁶⁸

Although wellness programs are not limited to the promotion of healthy eating, physical activity, and weight loss, these objectives constitute an essential goal of employer-provided programs.⁶⁹ The importance of combatting America’s overweight and obesity problem is evidenced both through the language utilized in the sections of the ACA addressing employer-provided wellness programs, such as the explicit mention of healthy eating and physical activity under the provision authorizing grants to small businesses, as well as the theme of obesity running throughout the ACA as a whole. Further, in practice, many of the employers instituting wellness programs tie the financial rewards of participation in the program to an employee’s success, such as the achievement of losing a certain amount of weight or a decreased BMI.⁷⁰

In addition to employer-provided wellness programs, the Affordable Care Act also authorizes the development of a five-year pilot wellness program for Medicare beneficiaries.⁷¹ More specifically, the ACA

⁶⁶ *Id.* § 10408, 42 U.S.C. § 280l note.

⁶⁷ *Id.* § 4303, 42 U.S.C. § 280l(1).

⁶⁸ *Id.* § 4303, 42 U.S.C. §§ 280l(1)–(2).

⁶⁹ According to the Harvard School of Public Health, obesity and smoking constitute the two primary targets of employee wellness programs. Larry Hand, *Employer Health Incentives: Employee Wellness Programs Prod Workers to Adopt Healthy Lifestyles*, HARV. SCH. OF PUB. HEALTH MAG., Winter 2009, available at <http://www.hsph.harvard.edu/news/magazine/winter09healthincentives/>.

⁷⁰ See Matt Lamkin, *Health Care Reform, Wellness Programs and the Erosion of Informed Consent*, 101 KY. L.J. 435, 441 (2012–2013).

⁷¹ Patient Protection and Affordable Care Act § 4202, 42 U.S.C. § 300u-14(a)(1).

directs the Secretary of Health and Human Services to award grants to state and local health departments and Indian tribes for the institution of community-based prevention and wellness programs for individuals between the ages of fifty-five and sixty-four.⁷² The ACA divides these programs into several different segments: public health interventions, community preventative screenings, and clinical referral and treatment for chronic diseases.⁷³ Notably, each of these categories specifically mentions subjects relating to weight loss and obesity. For example, under intervention activities, efforts to improve nutrition and increase physical activity are the first types of activities listed.⁷⁴ Moreover, under community prevention screening, each of the diseases for which health screening is recommended, cardiovascular disease, cancer, stroke, and diabetes, is an obesity-related disease. These illnesses are also the key ailments listed under treatment for chronic diseases.⁷⁵ In sum, perhaps even more so than employer-provided wellness programs, the pilot program for Medicare wellness programs illustrates how the ACA seeks to conquer obesity.

B. COMMUNITY GRANTS

Community grants represent another manner in which the Affordable Care Act targets obesity. First, section 4201 of the ACA instructs the Secretary of Health and Human Services to award grants to governments at both state and local levels, as well as community-based organizations, “for the implementation, evaluation, and dissemination of evidence-based community preventative health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.”⁷⁶ The Community Transformation Grant program constitutes a part of the broader Prevention and Public Health Fund, also established by the ACA,⁷⁷ which represents “the first

⁷² *Id.*

⁷³ *Id.* § 4202, 42 U.S.C. § 300u-14(a)(3).

⁷⁴ *Id.* § 4202, 42 U.S.C. § 300u-14(a)(3)(B)(ii).

⁷⁵ *Id.* § 4202, 42 U.S.C. § 300u-14(a)(3)(C)(i), (D)(i).

⁷⁶ *Id.* § 4201, 42 U.S.C. § 300u-13(a).

⁷⁷ *Id.* § 4002, 42 U.S.C. § 330u-11.

dedicated federal funding source for prevention and public health programs.”⁷⁸

The language of section 4201, such as the mentioning of chronic diseases and secondary conditions, impliedly targets obesity. The focus on obesity is further evidenced by the activities that a grantee may use the awarded funds to implement; such activities include creating healthier school environments through the addition of healthier meals and promoting physical activity, developing programs for individuals of all ages to allow better access to proper nutrition and physical activity, and highlighting healthy menu options at restaurants.⁷⁹ Moreover, those receiving grants are expressly prohibited from using the funds to implement activities that could lead to higher incidences of obesity or inactivity, such as video games.⁸⁰ The ACA also instructs the entities receiving grants to assess the success of the programs by measuring changes in weight, proper nutrition, and physical activity.⁸¹

C. OUTREACH CAMPAIGNS

Lastly, the Affordable Care Act orders the institution of education and outreach campaigns aimed at diminishing the prevalence of obesity in the United States. One such campaign requires the Secretary of Health and Human Services to implement “a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span,” allocating \$500 million for the campaign.⁸² The outreach is to take the form of both a media campaign, as well as a new website providing information on nutrition, regular exercise, and obesity reduction, in addition to several other objectives.⁸³ When listing the requirements of the campaign, the ACA places healthy living first and foremost, stating that the campaign must “be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5

⁷⁸ Christine Fry et al., *Healthy Reform, Healthy Cities: Using Law and Policy to Reduce Obesity Rates in Underserved Communities*, 40 *FORDHAM URB. L.J.* 1265, 1285 (2013).

⁷⁹ Patient Protection and Affordable Care Act § 4201, 42 U.S.C. § 330u-13(c)(2)(B).

⁸⁰ *Id.* § 4201(e), 42 U.S.C. § 330u-13(e).

⁸¹ *Id.* § 4201(c)(4), 42 U.S.C. § 330u-13(c)(4)(A)–(B).

⁸² *Id.* § 4004, 42 U.S.C. § 300u-12(a), (h).

⁸³ *Id.* § 4004, 42 U.S.C. § 300u-12(c), (d).

leading disease killers”⁸⁴ The position of nutrition, exercise, and obesity reduction among the first four goals illustrates the importance placed on targeting America’s obesity problem in the ACA.

In addition to this national educational campaign, the Affordable Care Act also authorizes the creation of state-sponsored campaigns specifically targeted at preventative and obesity-related services.⁸⁵ In consultation with the Secretary of Health and Human Services, states are directed to implement public awareness campaigns in order to educate Medicaid enrollees on preventative and obesity-related services, such as obesity screening and counseling for both children and adults, with a specified goal of reducing obesity among this population, which is more susceptible to developing obesity as a whole.⁸⁶ Similarly, the ACA also allocates \$25 million for funding the Childhood Obesity Demonstration Project, which seeks to address childhood obesity among low-income children.⁸⁷

In sum, the Affordable Care Act includes many provisions aimed at counteracting increasing rates of obesity in the United States. While several of these provisions, namely employer-sponsored wellness programs, are tied to a financial incentive, the ACA failed to provide a meaningful financial incentive that is available to all Americans, rather than a financial incentive limited to those participating in employer-sponsored wellness programs.

⁸⁴ *Id.* § 4004, 42 U.S.C. § 300u-12(c)(2)(A).

⁸⁵ *Id.* § 4004, 42 U.S.C. § 300u-12(i)(1)–(2).

⁸⁶ *Id.*; see Go et al., *supra* note 1, at e59.

⁸⁷ Patient Protection and Affordable Care Act § 4306, 42 U.S.C. § 1320b-9a(e); see *Childhood Obesity Demonstration Project*, CTR. FOR DISEASE CONTROL & PREVENTION (Apr. 27, 2012), <http://www.cdc.gov/obesity/childhood/researchproject.html>. The Medicare Access and Chip Reauthorization Act of 2015 amended section 4306 of the ACA to allocate an additional \$10 million to the Childhood Obesity Demonstration Project for 2016–2017. Medicare Access and Chip Reauthorization Act of 2015, Pub. L. No. 114-10, § 304, 129 Stat. 87, 158 (to be codified at 42 U.S.C. § 1320b-9a(e)(8)).

IV. THE CASE FOR A FINANCIAL INCENTIVE

The high cost of gym and health club memberships,⁸⁸ nutritional counseling, and weight loss programs⁸⁹ presents a significant barrier for obese Americans seeking to lose weight and adopt a more active lifestyle.⁹⁰ In order to overcome this financial impediment, the Affordable Care Act could have more effectively addressed the prevalence of obesity in the United States through the inclusion of a financial incentive aimed at spurring weight loss and the adoption of healthier lifestyles among obese individuals.

As a threshold matter, some critics argue that the federal government should not engage itself in the obesity debate, as “obesity should be understood in terms of personal responsibility, and . . . is a consequence of individual choice.”⁹¹ The government, however, has long been involved in protecting the health of its citizens,⁹² a power that stems from the traditional police powers of the states and the taxing and commerce powers of the federal government.⁹³ For example, the government played an active role in the fight against tobacco in recent decades, a public health crisis to which obesity often draws comparisons.⁹⁴ Furthermore, more than three-quarters of the U.S. population believe that the government should have at least some role in attempting to control the

⁸⁸ The average monthly cost of a gym membership is \$55. Geoff Williams, *The Heavy Price of Losing Weight*, U.S. NEWS (Jan. 2, 2013, 10:10 AM), <http://money.usnews.com/money/personal-finance/articles/2013/01/02/the-heavy-price-of-losing-weight>.

⁸⁹ For example, Weight Watchers costs between \$18.95 per month for online-only access and \$42.95 per month for in-person meetings, while Nutrisystem costs between \$270 and \$300 per month. *Id.*

⁹⁰ See Arterburn et al., *supra* note 9.

⁹¹ Hector, *supra* note 54, at 103 (discussing the two narratives surrounding the obesity debate); see also David Adam Friedman, *Public Health Regulation and the Limits of Paternalism*, 46 CONN. L. REV. 1687, 1727 (2014) (“The first question to pose is whether an individual’s decisions over time to consume certain foods and remain sedentary comprise a harm that should be corrected.”).

⁹² Reach, *supra* note 4, at 357.

⁹³ See Fry et al., *supra* note 78, at 1278–1280 (discussing the power of the government to regulate public health).

⁹⁴ See Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. DAVIS L. REV. 121, 132–135 (2013).

obesity epidemic.⁹⁵ Lastly, from an economic standpoint, the obesity crisis has had a significant impact on increasing health care spending, rising insurance costs, and perhaps even the American economy as a whole,⁹⁶ which provides even more reason for government involvement.

Studies have continually proven that financial incentives present a viable method of encouraging people to adopt certain behaviors.⁹⁷ The use of financial incentives in the weight loss context has proven particularly successful. In a 2007 study conducted by RTI International, a non-profit research organization, and the University of North Carolina at Chapel Hill, researchers found that participants who were monetarily compensated for achieving certain weight loss benchmarks lost more weight than those who received no compensation and those who received slightly less compensation for their weight loss.⁹⁸ A more recent study by the Mayo Clinic, the results of which were revealed at an American College of Cardiology conference in March 2013, yielded similar results: employees who were paid monthly for achieving weight loss goals and had to pay a penalty for not losing weight lost more than those who were not provided with any sort of incentive.⁹⁹ A third study performed by the University of Washington's Exploratory Center for Obesity Research and the Group Health Center for Health Studies demonstrated that a health insurer-provided financial incentive tied to weight loss substantially increased interest in participation in a weight management program.¹⁰⁰

As these studies illustrate, individuals respond to financial enticements aimed at spurring weight loss. A government-sponsored incentive has the greatest potential to meaningfully affect the obesity epidemic, as it would reach the greatest number of people. In other words, a government-provided incentive would be beneficial to all segments of the American public suffering from obesity, particularly to those who do not

⁹⁵ *Id.*

⁹⁶ *See supra* Part II.C.

⁹⁷ Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 302–03 (2012).

⁹⁸ Nanci Hellmich, *Financial Incentives Can Encourage Weight Loss, Research Finds*, USA TODAY, Sept. 11, 2007, http://usatoday30.usatoday.com/news/health/2007-09-10-weightloss-incentives_N.htm.

⁹⁹ Nicole Ostrow, *Cash Incentives Help People Lose Weight, Researchers Find*, BLOOMBERG (March 7, 2013, 11:00 AM), <http://www.bloomberg.com/news/2013-03-07/cash-incentives-help-people-lose-weight-researchers-find.html>.

¹⁰⁰ Arterburn et al., *supra* note 9, at 70, 74.

have the opportunity to engage in employer-sponsored programs. As will be discussed below, providing an incentive designed to spur weight loss and health improvement through the Internal Revenue Code or through mandatory insurance coverage constitutes a viable option for attempting to counteract the obesity problem in the United States.

Moreover, combatting obesity through the implementation of weight loss incentives will likely diminish obesity-related costs, which not only affect obese individuals, but also employers, fellow insureds, and the public as a whole. Obese individuals incur significantly higher health care costs than their healthier counterparts,¹⁰¹ as a result, obese individuals who take advantage of financial incentives to motivate their own weight loss would likely decrease their own individual health care costs as their weight decreases.¹⁰² Furthermore, decreasing costs associated with obesity will also lessen the burden that is currently transferred to the employers and the co-workers of obese individuals in the form of diminished employee performance, absenteeism, and increased insurance costs.¹⁰³ Lastly, obesity poses a significant problem for the American economy, as obesity-associated costs presently constitute roughly 10% of all medical spending, a number that could potentially double in two decades.¹⁰⁴ Were the implementation of a financial incentive targeted at encouraging weight loss and the adoption of healthier lifestyles to accomplish the goal of diminishing obesity-related costs, the resulting decrease in medical spending would benefit the American economy as a whole.

V. TWO WAYS IN WHICH THE AFFORDABLE CARE ACT COULD HAVE INCORPORATED A FINANCIAL INCENTIVE

In including the aforementioned provisions in the Affordable Care Act, Congress recognized the significance of the consequences obesity poses for the United States in terms of the effect on public health, as well as economically. The Affordable Care Act failed to go one step further, however, and draw on other provisions in the act in order to provide a meaningful financial incentive to obese individuals to counteract the increasing prevalence of obesity in the United States. This could have been

¹⁰¹ Reach, *supra* note 4, at 354–55.

¹⁰² See *id.* at 355 (stating that “an obese person incurs 42% more in medical costs than someone of normal weight”).

¹⁰³ See Yang & Nichols, *supra* note 2, at 380, 383.

¹⁰⁴ Go et al., *supra* note 1, at e62.

accomplished in one of two ways. First, Congress could have amended the Internal Revenue Code to provide a blanket deduction for obesity-related medical expenses. Second, Congress could have mandated insurance coverage of obesity-related expenses.

A. AMENDMENT TO SECTION 213 OF THE INTERNAL REVENUE CODE

Section 213 of the Internal Revenue Code, the medical expenses deduction, allows a taxpayer to deduct certain medical expenses that exceed a threshold amount.¹⁰⁵ For qualified individuals, section 213 allows for the deduction of obesity-related expenses.¹⁰⁶ The Affordable Care Act, however, increased the minimum threshold for claiming this deduction,¹⁰⁷ thus rendering it useless for most taxpayers. In alignment with the numerous obesity-related provisions in the act, the Affordable Care Act could have eliminated this threshold requirement for qualified individuals undertaking significant obesity-related expenses in order to provide an incentive aimed at combatting the obesity crisis.

This section will proceed as follows: (1) a brief survey of tax-based alternatives for addressing the obesity epidemic, (2) a history and overview of the medical expenses deduction, (3) an analysis of the intersection of the Affordable Care Act and the medical expenses deduction, and (4) a proposal for how the Affordable Care Act could have provided a financial incentive by amending section 213.

1. Survey of Tax-Based Alternatives

As a preeminent health concern for the United States, proposals for how to combat the ever-increasing obesity problem, many of which are tax-based, are abundant. These include sin taxes, fitness tax credits, and tax credits for all weight loss-related expenses.

A “sin” tax, sometimes referred to as a “fat tax,” imposes a type of excise tax on unhealthy foods in order to deter the consumer from purchasing such foods.¹⁰⁸ Similar to cigarette taxes, a food sin tax increases the cost of foods deemed unhealthy, such as soda and other foods high in

¹⁰⁵ See I.R.C. § 213 (Supp. 2013–2014).

¹⁰⁶ See *infra* Part V.A.2.ii–iii.

¹⁰⁷ Patient Protection and Affordable Care Act § 9013, I.R.C. § 213.

¹⁰⁸ See Reach, *supra* note 4, at 360.

sugar.¹⁰⁹ Sin taxes have received great attention in recent years, with thirty-four states having already placed a sales tax on soda.¹¹⁰ Sin taxes are subject to harsh criticism by consumers due to the governmental intrusion on personal autonomy and the disparate impact on low-income consumers, as well as by manufacturers.¹¹¹ Furthermore, there is little evidence that these taxes have any substantial of impact on weight loss or curbing obesity.¹¹²

A system of fitness tax credits represents a second tax-based alternative to address the obesity crisis. This proposal advocates for the adoption of a new tax credit, the Americans in Shape Tax Credit, modeled after a program already in place in Canada, which would provide a tax credit of up to \$1,000 for fitness expenses and would be coupled with government-provided awareness about healthier lifestyles.¹¹³ One of the significant advantages of a fitness tax credit is the benefit to low-income taxpayers, who may not otherwise be able to afford fitness expenses.¹¹⁴ However, the fitness tax credit plan fails to go far enough, both by ignoring other weight loss expenses, namely the cost of enrolling in a weight loss program, which can be significantly more expensive than a health club membership.

Similar to the fitness tax credit, another recently proposed alternative for combatting the obesity epidemic recommends a Public Health Tax Credit. Under this proposal, obese and overweight taxpayers would be reimbursed via a tax credit for all weight loss-related expenses.¹¹⁵ Of the three discussed alternatives, the Public Health Tax Credit, which in a way implicitly builds on the Americans in Shape Tax Credit, represents the most advantageous proposal as it provides the most direct benefit to taxpayers of all income levels and does not directly penalize consumers for their dietary choices.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *See id.*

¹¹² *Id.* For a critique of sin taxes, see Katherine Pratt, *A Constructive Critique of Public Health Arguments for Antiobesity Soda Taxes and Food Taxes*, 87 TUL. L. REV. 73 (2012).

¹¹³ Reach, *supra* note 4, at 364-65.

¹¹⁴ *See id.*

¹¹⁵ Lauren Ridley, Comment, *Our Taxes Get a Diet: The Code Attacks the Overweight & Obesity Epidemic*, 85 TEMP. L. REV. 951, 996-97 (2013).

2. The Medical Expenses Deduction

The 77th United States Congress enacted what is commonly referred to as the medical expenses deduction as part of the Revenue Act of 1942.¹¹⁶ In over seventy years and fifteen revisions, the actual overall language of section 213, formerly section 23, of the Internal Revenue Code (“the Code”), has changed little. The minor textual amendments to this section, particularly the recent enactment of the Affordable Care Act, however, have dramatically altered the substantive impact of the deduction by altering both the floor for claiming the deduction, as well as the cap on the maximum deductible amount.

a. History of the medical expenses deduction

The Roosevelt administration introduced the medical expenses deduction in the midst of the Second World War as part of legislation the President referred to as “the greatest tax bill in American history.”¹¹⁷ At the time of the enactment of the deduction, expenses for medical care, defined as expenses incurred for the “diagnosis, cure, mitigation, treatment, or prevention of disease,”¹¹⁸ not otherwise compensated for by insurance were deductible so long as they exceeded 5% of net income.¹¹⁹ The deduction was subject to a cap of \$2,500 for those filing a joint return and heads of households and \$1,250 for single taxpayers.¹²⁰ According to Representative John Carl Hinshaw, a Republican from California, the underlying purpose of this tax deduction was to provide financial assistance for those incurring “unusual outlays for medical purposes,” not common medical expenses.¹²¹ Given that the deduction was enacted in the midst of World War II, it is

¹¹⁶ Revenue Act of 1942 § 127, I.R.C. § 23 (1942).

¹¹⁷ Kelly Phillips Erb, *Deduct This: The History of the Medical Expenses Deduction*, FORBES (June 20, 2011, 8:25 AM), <http://www.forbes.com/sites/kellyphillipserb/2011/06/20/deduct-this-the-history-of-the-medical-expenses-deduction/>.

¹¹⁸ Revenue Act of 1942 § 127, I.R.C. § 23.

¹¹⁹ *Id.*; Letter from George J. Blaine, Deputy Assoc. Chief Counsel of Income Tax & Accounting of the I.R.S. 1 (December 29, 2006), *available at* <http://www.irs.gov/pub/irs-wd/06-0088.pdf> [hereinafter Blaine].

¹²⁰ Revenue Act of 1942 § 127, I.R.C. § 23.

¹²¹ Blaine, *supra* note 119 (quoting statement of Congressman Hinshaw, 88 CONG. REC. 8569 (1942)).

likely that Congress intended for it to primarily benefit wounded soldiers returning from overseas.¹²²

The first noteworthy revision to the medical expenses deduction occurred when the 83rd Congress enacted the Internal Revenue Code of 1954. The 1954 version of the Code lowered the minimum threshold for claiming the medical expenses deduction, now section 213, to 3% of adjusted gross income.¹²³ Additionally, the 1954 revision more than doubled the cap for the amount of deductible medical expenses, which rose to \$5,000 for single taxpayers and \$10,000 for those filing a joint tax return.¹²⁴ The cap on the deduction, however, was eliminated shortly thereafter in the 1960s.¹²⁵ The 1954 version of the medical expenses deduction prevails as perhaps the most favorable for taxpayers, as the 3% threshold remains the lowest percentage of adjusted gross income for claiming the deduction and the cap on the total amount of expenses capable of being deducted was reasonably high, especially when considering the \$5,000–10,000 cap in light of inflation.

During Ronald Reagan's tenure as president, the medical expenses deduction received several amendments as part of the President's multiple tax reforms. The Tax Equity and Fiscal Responsibility Act of 1982 reinstated the 5% minimum for claiming the deduction,¹²⁶ while the noteworthy Tax Reform Act of 1986 again increased the threshold to 7.5%.¹²⁷ The 7.5% floor remained in place until the enactment of the Affordable Care Act in 2010.¹²⁸ According to Senate reports detailing the legislative history behind the 1986 reforms, Congress intended only those medical expenses constituting a considerable amount of a taxpayer's income, which would perhaps diminish the taxpayer's ability to pay his taxes, to qualify for the deduction.¹²⁹ Additionally, Congress also sought to

¹²² Erb, *supra* note 117.

¹²³ Internal Revenue Code of 1954 § 213, I.R.C. § 213 (1954). Although the Revenue Act of 1942 set the floor for claiming the deduction at 5% of net income, this was changed to 5% of adjusted gross income in 1944. See Ridley, *supra* note 115, at 955.

¹²⁴ Internal Revenue Code of 1954 § 213, I.R.C. § 213.

¹²⁵ Erb, *supra* note 117.

¹²⁶ Tax Equity and Fiscal Responsibility Act of 1982 § 202, I.R.C. § 213 (1982).

¹²⁷ Tax Reform Act of 1986 § 133, I.R.C. § 213 (1988).

¹²⁸ For a more detailed history of the medical expenses deduction, see Erb, *supra* note 117, and Ridley, *supra* note 115.

¹²⁹ Blaine, *supra* note 119 (citing S. REP. NO. 99-313, at 59 (1986)).

decrease the percentage of Americans claiming the medical expense deduction, allegedly to remove the burden of record keeping off of the taxpayers, but more likely for the principal reason of decreasing the need for the Internal Revenue Service to analyze smaller claims.¹³⁰

b. Evolution of Interpretation

In regard to weight loss expenses, the Internal Revenue Service's ("IRS") interpretation as to what qualifies for the deduction represents the most significant aspect of the history of the medical expenses deduction. The IRS first considered the deduction of weight loss-related expenses in 1955 with Revenue Ruling 55-261, concluding that "fees paid to a health institute where the taxpayer takes exercise, rubdowns, etc., are held to be a personal expense, deduction for which is prohibited by section 24(a)(1) [now section 262] of the Code."¹³¹ The agency further held, however, that certain expenses could qualify for the deduction if the treatment was prescribed by a physician as necessary for the "alleviation of a physical or mental defect or illness."¹³² Given the relatively low rates of obesity at the time of this decision,¹³³ the IRS's reluctance to allow a deduction for weight loss-related expenses is not surprising. Moreover, Revenue Ruling 55-261 was a narrow decision in that it was limited to the consideration of exercise-related expenses, rather than weight loss-related expenses as a whole. This can likely be attributed to the fact that the extensive weight loss programs presently offered were, for the most part, non-existent in the 1950s.

The IRS did not discuss the issue of the deductibility of weight loss expenses again until nearly twenty-five years later in 1979. The agency held that "[t]he cost of an individual's participation in a weight reduction program that is not for the purpose of curing any specific ailment or disease, but for the purpose of improving the individual's appearance, health, and sense of well being, is not deductible as a medical expense."¹³⁴

¹³⁰ Blaine, *supra* note 119.

¹³¹ Rev. Rul. 55-261, 1955-1 C.B. 307.

¹³² *Id.*

¹³³ In the 1950s, 9.7% of American adults were obese. Beverly Bird, *How Much Have Obesity Rates Risen Since 1950?*, LIVESTRONG (Aug. 16, 2013), <http://www.livestrong.com/article/384722-how-much-have-obesity-rates-risen-since-1950/>.

¹³⁴ Rev. Rul. 79-151, 1979-1 C.B. 116.

Thus, any expenses incurred for reasons other than for the treatment of a disease were held to be personal and therefore not deductible under section 262 of the Code.

In addressing weight loss expenses generally, Revenue Ruling 79-151 broadened the scope of the prior revenue ruling, which only pertained to exercise expenses, while also maintaining the distinction that any expenses undertaken for the purpose of weight loss, whether via exercise or another program, were only deductible if for the treatment of a disease, which did not include obesity. The stipulation that expenses had to be undertaken for the treatment of a disease in order to claim the deduction relates back to section 213's definition of medical care, which limits the availability of the deduction to expenses incurred in connection with a specific disease.¹³⁵

The IRS issued its most recent decision regarding weight loss expenses in 2002. In Revenue Ruling 2002-19, the agency made a marked change in its interpretation of section 213, holding that,

[u]ncompensated amounts paid by individuals for participation in a weight-loss program as treatment for a specific disease or diseases (including obesity) diagnosed by a physician are expenses for medical care that are deductible under § 213, subject to the limitations of that section. The cost of purchasing diet food items is not deductible under § 213.¹³⁶

In its decision, the IRS specifically addressed the World Health Organization's recognition of obesity as a disease in 1997, as well as the classification of obesity as a chronic disease by the National Heart, Lung, and Blood Institute in 1998;¹³⁷ these classifications were thus impliedly a principal motivating factor in the decision. Moreover, the 2002 ruling clarified that obesity would not have been considered a disease for the purposes of the deduction in prior years, including in the IRS's decisions in its earlier rulings.

¹³⁵ I.R.C. § 213(d)(1)(A) (2012).

¹³⁶ Rev. Rul. 2002-19, 2002-1 C.B. 778.

¹³⁷ *Id.*

*c. The Medical Expense Deduction in Practice
Prior to the Affordable Care Act*

Prior to the implementation of the Affordable Care Act, the applicable section of which went into effect in 2013 (the revision of section 213), a taxpayer could deduct eligible medical and dental expenses incurred by the taxpayer, his spouse, and any dependents so long as he satisfied several conditions: (1) the expenses directly or proximately related to the “diagnosis, cure mitigation, treatment, or prevention of disease” or “the purpose of affecting some structure or function of the body,”¹³⁸ (2) the primary purpose of each expense incurred was primarily for the treatment or prevention of a physical or mental illness, (3) the expenses were incurred within the applicable taxable year, (4) insurance had not reimbursed the taxpayer for the expenses, (5) the total expenses claimed equaled or exceeded 7.5% of the taxpayer’s adjusted gross income, and (6) the taxpayer itemized his deductions.¹³⁹

In general, expenses for weight loss programs qualify for the deduction so long as the taxpayer has been diagnosed with a disease for which weight loss is recommended as a treatment.¹⁴⁰ This includes obesity, as well as obesity-associated diseases, such as heart disease or type 2 diabetes; an individual does not have to be diagnosed with obesity itself as well as an obesity-related disease in order to deduct expenses for a weight loss program.¹⁴¹ Obese individuals, as well as those with other physician-diagnosed diseases for which weight loss is prescribed as treatment, may also deduct the cost of any physician-prescribed medications used for weight loss.¹⁴² It does not appear that a taxpayer may claim the deduction if he is classified as overweight, but not obese, even though a weight loss program for an individual in this situation could seemingly qualify as “prevention of disease” as defined by section 213.¹⁴³

¹³⁸ *Havey v. Comm’r*, 12 T. C. 409, 413 (1949).

¹³⁹ I.R.C. § 213; *see also* I.R.S. PUB. 502: MEDICAL AND DENTAL EXPENSES 2–3 (2012).

¹⁴⁰ I.R.S. PUB. 502, *supra* note 139, at 15.

¹⁴¹ *Weight Loss Programs May Be Tax Deductible*, DUKE DIET & FITNESS CTR. (June 28, 2011), http://www.dukehealth.org/services/diet_and_fitness/about/news/weight_loss_programs_may_be_tax_deductible.

¹⁴² I.R.C. § 213(b) (2012).

¹⁴³ *Id.*

There are numerous limitations, however, on which categories of expenses associated with weight loss are deductible. Regardless of whether weight loss is recommended for an individual, the cost of a gym or health club membership is not deductible, nor is the cost of special dietary food, as this substitutes for the food that the individual would still consume otherwise.¹⁴⁴ The extent to which the cost of special dietary food exceeds the price of a normal diet, however, may qualify for the deduction.¹⁴⁵

In regard to obesity, the main taxpayers who benefit from the medical expenses deduction are those who undergo bariatric surgery, the all-encompassing term for weight loss surgical procedures.¹⁴⁶ This markedly limits the availability of the deduction, as bariatric surgery is generally only available for severely or morbidly obese individuals, or individuals with a BMI of forty or higher, which translates to just over 6% of American adults as of 2009–2010, not all of whom can afford the expensive procedure.¹⁴⁷ There are also further limitations on qualifying for the surgery, such as age restrictions and evidence of prior attempts of adopting a healthier lifestyle.¹⁴⁸ Once an individual even qualifies for bariatric surgery, the price can range from as low as \$12,000 to upwards of \$35,000, with only select insurers offering coverage for the procedure.¹⁴⁹ Thus, although the price of weight loss surgery would undoubtedly qualify most taxpayers for the deduction under section 213 if not covered by insurance, due to the low number of taxpayers even eligible for the surgery, the availability of the deduction is extremely limited in this context.

Despite the high expense of enrolling in a weight loss program, few taxpayers take advantage of the medical expenses deduction.¹⁵⁰ This can perhaps be attributed to the high floor for claiming the deduction, as well as taxpayer unawareness about the availability of the deduction.

¹⁴⁴ I.R.S. PUB. 502, *supra* note 139, at 15–17.

¹⁴⁵ *Id.* at 15; *see* Ridley, *supra* note 115, at 963, 996–97.

¹⁴⁶ Connie Farrow, *IRS Allows Tax Deduction for Doctor-Approved Weight-Loss*, USA TODAY, Mar. 1, 2004, http://usatoday30.usatoday.com/money/perfi/taxes/2004-03-01-weightloss_x.htm.

¹⁴⁷ *Information on Bariatric Surgery*, U.S. NEWS: HEALTH (Jan. 28, 2010), <http://health.usnews.com/health-conditions/heart-health/information-on-bariatric-surgery#2>; OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11, at 1–2.

¹⁴⁸ *Information on Bariatric Surgery*, *supra* note 147, at 1–2.

¹⁴⁹ *Id.*

¹⁵⁰ Erb, *supra* note 117.

Notwithstanding the cause of the underuse of the deduction, it appears that Congress' intent with the 1986 reforms has been realized.¹⁵¹

d. Amendment to Section 213 under the Affordable Care Act

The Affordable Care Act constitutes the latest amendment to the medical expenses deduction, again increasing the floor for claiming the deduction.¹⁵² The section now reads, "There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent . . . to the extent that such expenses exceed 10 percent of adjusted gross income."¹⁵³ The Act thus raises the minimum threshold for utilizing the deduction by 2.5% beginning in 2013; taxpayers over sixty-five, however, are exempt from the increase through 2016.¹⁵⁴ The increase, or rather the revenue gained from increasing the minimum for claiming the deduction, was implemented in part to help subsidize the ACA,¹⁵⁵ which also explains why the increase was included in a piece of health reform legislation, rather than a revenue act.

e. The Affordable Care Act, the Medical Expenses Deduction, and Tax Policy

The Affordable Care Act and tax policy are forever intertwined since the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, in which Chief Justice John Roberts proclaimed the penalty imposed on those individuals who fail to purchase health insurance to be a tax.¹⁵⁶ In regard to tax benefits for weight loss expenses, this decision raises an interesting question: if the federal government can tax an

¹⁵¹ See Blaine, *supra* note 119, at 1 ("The Congress wanted to reduce the number of tax returns claiming deductions for medical expenses . . .").

¹⁵² Patient Protection and Affordable Care Act § 9013, I.R.C. § 213 (Supp. 2013–2014).

¹⁵³ I.R.C. § 213(a).

¹⁵⁴ *Id.* § 213(f).

¹⁵⁵ Kelly Phillips Erb, *Tax Breaks for Medical Expenses Under ObamaCare*, FORBES (Nov. 26, 2012, 11:54 AM), <http://www.forbes.com/sites/kellyphillipserb/2012/11/26/tax-breaks-for-medical-expenses-under-obamacare/>.

¹⁵⁶ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2600 (2012).

individual for failing to purchase health insurance, why should the government not provide taxpayers with a tax break for engaging in behavior that will presumably decrease their health care costs? The motivation behind the Affordable Care Act, at least in part, was to improve access to health care and lower health insurance costs.¹⁵⁷ By choosing to expend a portion of their income on weight loss expenses, some taxpayers contribute to lower health insurance costs in another way, as reducing rates of obesity will likely lead to lower insurance costs in the aggregate.¹⁵⁸ Thus, it is puzzling that the Affordable Care Act renders a tax benefit for these individuals more unattainable by amending section 213 when such individuals are actually contributing to the achievement of one of the underlying purposes of the ACA.

3. Proposed Amendment to Section 213

By increasing the threshold for claiming the medical expenses deduction to 10% of adjusted gross income, the Affordable Care Act further limited the number of taxpayers eligible for claiming the deduction, rendering it largely unavailable for the average taxpayer. In amending the medical expenses deduction in this manner, Congress effectively eliminated a pre-existing benefit for obese taxpayers. In order to have provided an incentive for undertaking weight loss and health improvement expenses for obese individuals, and in alignment with the provisions in the ACA aimed at counteracting the increasing prevalence of obesity in the United States, Congress could have amended section 213 to eliminate the threshold for claiming the deduction, as well as to expand the categories of eligible expenses.

First, Congress could have eliminated the floor for the claiming the medical expenses deduction in order to incentivize taxpayers to undertake obesity-related expenses.¹⁵⁹ Such an amendment would render the

¹⁵⁷ See Alicia Ouellete, *Health Reform and the Supreme Court: The ACA Survives the Battle of the Broccoli and Fortifies Itself Against Future Fatal Attack*, 76 ALB. L. REV. 87, 90–91 (2012–2013).

¹⁵⁸ See Lamkin, *supra* note 70, at 449.

¹⁵⁹ The legislative history of the Affordable Care Act reveals that at least one Congressional leader, Representative Paul Broun of Georgia, advocated for eliminating the floor for claiming the medical expenses deduction, although his proposal was not limited to obesity-related expenses. This proposal was defeated in the Committee on Rules. H.R. REP. NO. 111-148 pt. 6, at 14 (2010).

deduction available for all obese taxpayers, as well as all individuals with physician-diagnosed diseases for which weight loss is recommended as treatment.

Second, the category of weight loss-associated expenses that qualifies for the deduction could have been expanded. Currently, only certain expenses are eligible for the deduction, namely formal weight loss programs.¹⁶⁰ This does not include the most obvious tool for spurring weight loss: a gym or health club membership.¹⁶¹ Similar to eliminating the threshold for claiming the deduction, expanding the category of deductible expenses would increase access to the deduction, especially for low-income taxpayers who may not be able to otherwise afford a weight loss program.

Additionally, expanding the deduction to cover the cost of certain foods would further benefit taxpayers.¹⁶² Currently, the cost of diet food is generally not deductible; only to the extent that it exceeds the cost of a normal diet does it potentially qualify.¹⁶³ By preventing the increased cost of a nutritious diet from being eligible for deduction, the IRS ignores the fact that healthy foods generally constitute a much higher expense than the unhealthy alternatives that typically contribute to obesity.¹⁶⁴ In order to encourage healthier consumption, the ACA could have provided that, in addition to the increased cost of special dietary foods, the amount that a healthy diet generally exceeds the cost of an unhealthy one qualifies for the deduction. This would, of course, require substantiation by the taxpayer of the expenses incurred for healthier foods in comparison with the cost of his or her formerly unhealthy diet.

In order for these amendments to have a meaningful effect, it is important to note that any proposed amendment to section 213 would necessarily have to be accompanied by increased awareness about the availability of the deduction, as the deduction is not widely utilized, which

¹⁶⁰ I.R.S. PUB. 502, *supra* note 139.

¹⁶¹ *Id.*

¹⁶² For an argument in support of the deductibility of diet foods, see Ryan A. Bailey, *Obesity and the Internal Revenue Code: Deducting Costs of Diet Food Items Incorporated in Physician-Prescribed Weight-Loss Programs*, 13 DEPAUL J. HEALTH CARE L. 377, 386 (2011).

¹⁶³ Rev. Rul. 2002-19, 2002-1 C.B. 778.

¹⁶⁴ *See* Reach, *supra* note 4, at 360.

can perhaps be attributed to a lack of awareness, as well as the high threshold for claiming the deduction.¹⁶⁵

There are several reasons for which amending section 213 in the proposed manner represents the most viable in which Congress could have provided a tax-based incentive for encouraging healthier behavior in the Affordable Care Act. First, altering the deduction presents the most feasible means of addressing obesity through the tax code, particularly in light of the fact that the Affordable Care Act actually amended section 213. Furthermore, rather than introducing a new benefit, such a refundable tax credits for fitness- or weight loss-related expenses, a revision of section 213 would amend a deduction already in place.

Additionally, amending section 213 to eliminate the threshold for claiming the deduction and to expand eligible expenses has the potential to decrease administrative costs associated with the medical expenses deduction, as it would reduce the amount of time spent by the IRS determining which expenses qualify for the deduction.¹⁶⁶ In contrast, a tax credit could potentially increase administrative costs due to the added burden of issuing the credit to each qualified taxpayer.

Finally, an expanded deduction poses less potential for abuse than a refundable tax credit. According to Senator Orrin Hatch, a member of the Senate Finance Committee, refundable tax credits are highly susceptible to abuse and fraud, with the risk of fraud rising with the desirability of the credit; for example, the Earned Income Tax Credit is far too often a target for abuse, as it provides an appealing benefit, especially for lower-income taxpayers who may not be subject to federal taxes at all.¹⁶⁷ A recent report by the Associated Press revealed that, over the past decade, the IRS issued over \$110 billion in improper refundable tax credits.¹⁶⁸ Although any tax credit received for the reimbursement of fitness or weight loss program expenses would likely be significantly less than most current available tax credits, such as the Earned Income Tax Credit, a potential credit for these

¹⁶⁵ See Erb, *supra* note 117 (noting that roughly 6% of taxpayers claimed the medical expenses deduction in 2001).

¹⁶⁶ See Associated Press, *IRS Paid More than \$110 Billion in Improper Tax Credits*, FOX NEWS (Oct. 22, 2013), <http://www.foxnews.com/politics/2013/10/22/irs-paid-more-than-110-billion-in-improper-tax-credits/>.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*; see also *IRS Goes after Tax Credit Fraud and Identity Theft*, CLIFTON LARSON ALLEN (Nov. 21, 2012), <http://www.claconnect.com/Tax-Watch/IRS-Goes-After-Tax-Credit-Fraud-Identity-Theft.aspx> (highlighting examples of recent tax credit abuse).

expenses would still pose potential for abuse due to the tangible benefit received, i.e., a cash reimbursement for expenses paid during the taxable year. In contrast, an expanded deduction seemingly would not be as susceptible to abuse, as the deduction would lower taxable income rather than provide the taxpayer with a cash refund.

The historical roots of what is now section 213 of the Internal Revenue Code lie in Congressional desire to ease the burden of taxpayers who incur exceptional health costs. This section, however, has lost most of its impact and functionality over the last several decades, as the deduction has become unattainable for the vast majority of Americans due to the high threshold for claiming the deduction, as well as judicially imposed limits on which expenses are eligible for the deduction. For this reason, eliminating the threshold for claiming the deduction and expanding the categories of expenses which qualify for the deduction under the Affordable Care Act, in conjunction with increased taxpayer awareness, could have placed this financial benefit back in the hands of more taxpayers, while also encouraging them to take charge of their health.

B. MANDATORY INSURANCE COVERAGE

Increased access to affordable health care for all Americans represents perhaps the principal and most notable purpose underlying the Affordable Care Act. Requiring all Americans to purchase health insurance by January 2014, and imposing a federal tax on those who do not, the ACA seeks an ideal of a fully insured population, with a particular emphasis on providing insurance for those who could not previously afford it. While increased access to affordable health care is a feat within itself, this expansion in the percentage of insured Americans also presented a valuable opportunity to address the obesity epidemic. While the Affordable Care Act does mandate insurance coverage of preventative services, the act could have mandated coverage of all obesity-related expenditures in order to provide an incentive aimed at counteracting obesity.

1. Survey of Insurance-Based Alternatives

In addition to the numerous tax-based proposals for how to combat the obesity crisis, a number of proposals focus on mandating insurance coverage of certain obesity-related expenses.

One insurance-centered alternative advocates for increased insurance coverage of bariatric surgery.¹⁶⁹ Prior to providing coverage for bariatric surgery, many insurers require that an individual satisfy several conditions. Generally, not only must a primary care physician recommend that an individual undergo bariatric surgery, an individual must provide documented proof from his or her primary care physician that the individual has failed to lose weight under a medically supervised dietary program.¹⁷⁰ Moreover, some insurance companies require that bariatric surgery be medically necessary before providing coverage.¹⁷¹ Noting that the Affordable Care Act failed to require insurance coverage of bariatric surgery, this proposal argues that the federal government should mandate coverage of bariatric surgery for individuals with a BMI of thirty or greater in accordance with FDA recommendations in order to increase overall health and diminish health care costs.¹⁷²

A second proposal suggests that public and private health insurance providers should provide coverage for gym or health club memberships, as well as nutrition counseling, in order to encourage physical activity and the adoption of healthier lifestyles.¹⁷³ This proposal, however, does not go as far as to suggest that the government require health insurers to provide such coverage.

Each of these proposals targets a specific type of obesity-related expense. In order to reach the largest number of individuals and have the most meaningful impact, the Affordable Care Act could have mandated insurance coverage for all obesity-related expenses, including bariatric surgery and the cost of a gym or health club membership.

2. Mandatory Insurance Coverage of All Obesity-Related Expenses

Section 1001 of the Affordable Care Act, an amendment to the Public Health Service Act, obligates health insurers to provide coverage for

¹⁶⁹ Jessica A. Nardulli, Commentary, *The Road to Health is a Battle Hard Fought: Support for Requiring Coverage of Bariatric Surgery for an Expanded Group of Qualified Individuals*, 33 J. LEGAL MED. 399, 414–15 (2012).

¹⁷⁰ *Id.* at 410.

¹⁷¹ *Id.*

¹⁷² *Id.* at 414–15.

¹⁷³ Deena Patel, Note, *Are We Too Darned Fat? Trying to Prevent and Treat Obesity with Health Care Reform*, 8 QUINNIPIAC HEALTH L.J. 141, 152–54 (2004).

preventative services recommended by the United States Preventative Services Task Force without imposing cost-sharing on their insureds;¹⁷⁴ this includes BMI screening and other obesity-related services.¹⁷⁵ While this requirement is certainly a step in the right direction, the ACA falls short of increasing insureds' access to weight loss programs and services by failing to require insurers to provide coverage for weight loss- and health-related expenses incurred by obese individuals.

Congress missed a vital opportunity to institute an insurance-based solution for conquering the obesity crisis with the Affordable Care Act for several reasons. First and foremost, the mandatory coverage provision of the ACA, which went into effect on January 1, 2014,¹⁷⁶ will, in theory, drastically increase the number of Americans with health insurance, with a large number of new insureds being low-income individuals who could not previously afford insurance. As such, requiring health insurers to provide full coverage¹⁷⁷ for weight loss- and health-related expenses incurred by obese individuals could potentially have a considerable impact on the obesity epidemic, as it would increase the number of obese individuals with access to the means to lose weight and adopt healthier lifestyles.

Moreover, mandatory insurance coverage for obesity-related expenses also constitutes a financial incentive, which, as previously discussed, is proven to positively affect human behavior.¹⁷⁸ Studies have demonstrated that insurance incentives in particular can help to encourage weight loss. For example, the University of Washington's Exploratory Center for Obesity Research, in conjunction with the Group Health Center for Health Studies, published a study focusing on overweight and obese adults suffering from metabolic syndrome¹⁷⁹ in 2008, which revealed that a

¹⁷⁴ Patient Protection and Affordable Care Act § 1001(5), 42 U.S.C. § 300gg-13(a)(5) (2012).

¹⁷⁵ Wiley, *supra* note 94, at 152.

¹⁷⁶ Patient Protection and Affordable Care Act § 1501(b), I.R.C. § 5000A(a) (2012).

¹⁷⁷ Many health insurers provide coverage for gym or health club memberships. For example, UnitedHealthcare, through its Fitness Reimbursement Program, offers a \$20 reimbursement for every month an insured goes to the gym or health club at least twelve times. *Fitness Reimbursement Program*, UNITEDHEALTHCARE, <http://uhctogether.com/uhcwellness/16181.html> (last visited May 27, 2015).

¹⁷⁸ See *supra* Part IV.

¹⁷⁹ "Metabolic syndrome" is defined as "a constellation of weight-related risk factors (elevated blood pressure, elevated waist circumference, and elevated levels

hypothetical proposal increasing insurance coverage for weight management programs from 10% to 100% dramatically increased interest in participation in such a program.¹⁸⁰ The researchers further postulated that, while providing full insurance coverage to obese individuals for enrollment in a weight loss program would temporarily increase health care costs, such coverage could lead to decreased medical spending in the long run due to a reduction in obesity-related costs.¹⁸¹ Thus, this study¹⁸² strongly supports the proposition that mandatory insurance coverage of weight loss expenses has the potential to become an effective tool in the battle against obesity.

Furthermore, mandating insurers to provide coverage of obesity-related expenses also solves one problem raised by solely amending section 213 to provide a financial incentive for inspiring weight loss: some individuals, including a substantial of Americans affected by obesity, are not subject to federal income taxes. Insurance coverage of these expenses would insure that all Americans are provided with a financial incentive encouraging weight loss, rather than just taxpayers. Moreover, the language of section 213 prevents a double benefit from occurring in this context, meaning that taxpayers can only deduct expenses not covered by insurance.¹⁸³

In sum, while Congress now requires insurers to cover, with no co-pay, preventative services aimed at diminishing the prevalence of obesity in the United States, it stops short of mandating coverage for expenses incurred by obese Americans who seek to lose weight and shed the label of obese. While mandatory coverage of weight loss-driven expenses would certainly be costly for insurance providers at the outset, if this tactic accomplished the desired result, decreasing the percentage of Americans suffering from obesity, health care costs would likely decrease as obesity

of lipoprotein cholesterol levels; and reduced high-density lipoprotein cholesterol levels) affecting 24% of US adults.” Arterburn et al., *supra* note 9, at 71.

¹⁸⁰ *Id.* at 70.

¹⁸¹ *Id.*

¹⁸² The study also found that a majority of adults, specifically 76% of women and 57% of men, supported the institution of a health insurer-provided financial incentive program through which insurers would pay participants for achieving certain weight loss goals, with 41% of study participants stating that they believed that such a program would motivate them to lose weight. *Id.* at 73.

¹⁸³ I.R.C. § 213(a) (Supp. 2013–2014).

rates decline.¹⁸⁴ As a result, mandated coverage of these expenses could potentially benefit insurers in the long run.

VI. CONCLUSION

In recent decades, obesity has gone from affecting less than 15% of the population in the 1960s to a major health crisis credited with causing 112,000 premature deaths in 2000.¹⁸⁵ Not only does obesity pose a major public health concern, but the prevalence of this chronic disease in the United States has caused skyrocketing medical spending and increased health insurance costs, which affect both obese individuals and the rest of the population alike.¹⁸⁶ Although Congress made strides towards combatting this public health crisis with the Patient Protection and Affordable Care Act, the act could have more effectively targeted the escalating prevalence of obesity by providing a financial incentive to encourage weight loss and the adoption of overall healthier lifestyles.

Drawing on other provisions included in the act, the Affordable Care Act could have provided a financial incentive in one of two ways. First, rather than increasing the floor for claiming the medical expenses deduction, the Affordable Care Act could have amended section 213 of the Internal Revenue Code to eliminate the threshold for claiming a deduction for obesity-related expenses, as well as expand the categories of expenses eligible for the deduction. Second, Congress could have mandated health insurance coverage of weight loss- and health-related expenses incurred by obese individuals. Although in no way an exhaustive list of ways in which the Affordable Care Act could have provided a financial incentive, the implementation of such an incentive would have provided a meaningful means of addressing the obesity epidemic, which continues to pose dire consequences on public health, as well as the American economy.

¹⁸⁴ See *supra* notes 101–04 and accompanying text.

¹⁸⁵ OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11, at 4; Go et al., *supra* note 1, at e61.

¹⁸⁶ See *supra* Part II.C.

EVEN I CAN'T COVER ME: EXAMINING THE NCAA'S EFFECTIVE PROHIBITION ON "LOSS OF VALUE" INSURANCE FOR ITS STUDENT-ATHLETES

MICHAEL D. RANDALL*

This Note analyzes the NCAA's effective prohibition on student-athletes exploring outside insurance to cover the loss of value of their athletic talents. Currently, the vast majority of collegiate athletes are only permitted to obtain insurance for career-ending injuries. Existing NCAA Bylaws serve to effectively prevent these individuals from protecting themselves against value or earnings potential-reducing injuries. This situation is of particular concern because of the importance and prevalence of intercollegiate athletics as a (sometimes mandatory) step toward a career in professional sports. This Note examines the NCAA's current insurance structure and the rationales for this system, which includes an effective prohibition against obtaining loss of value insurance to guard against losses in earnings. It then explores why this bar should be lifted and how current student-athletes could mount a challenge, as well as possible remedies and the implications of a successful challenge. Finally, it discusses how the NCAA and its member institutions could go about implementing a loss of value insurance program, should they choose or be required to do so, and what concerns would arise.

I. INTRODUCTION

The debate over the exploitation of college athletes has carried on for decades. Athletes, administrators, school presidents, parents, and countless other invested parties have wrestled over whether athletes are adequately compensated for their financial contributions to their schools. Supporters of compensating athletes contend that these young men and women put their bodies (and future livelihoods) at risk to earn millions of dollars for their institutions. Opponents contend that these athletes are

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already compensated with a “free ride” in the form of an athletic scholarship and the opportunity to showcase their talents on a national stage.

While there may soon be a legal conclusion to this debate,¹ athletes are further harmed when they are denied the opportunity to protect themselves against future losses. Though the National Collegiate Athletic Association (hereinafter “NCAA”) currently provides medical and disability insurance to all of its athletes, coaches, managers, trainers, and cheerleaders,² it does not provide loss-of-value-insurance.³ Though there is an extra coverage policy available to a select portion of athletes,⁴ it too only covers permanent total disability. Thereby, the vast majority of individuals do not have access to benefits that would protect them should they suffer an injury that only impairs their athletic ability.

Many of the arguments that apply in the student-athlete compensation debate are also pertinent to a discussion of loss of value benefits. Since many American professional sports leagues require athletes to wait anywhere from one⁵ to three years⁶ after completing their high

¹ See generally *O’Bannon v. Nat’l Collegiate Athletic Ass’n*, 7 F. Supp. 3d 955 (N.D. Cal. Aug. 8, 2014), *appeals filed*, No. 14-16601 (9th Cir. Aug. 21, 2014), No. 14-17068 (Oct. 21, 2014).

² See *Student-Athlete Insurance Programs*, NCAA, <http://www.ncaa.org/about/resources/insurance/student-athlete-insurance-programs> (last visited May 20, 2015) [hereinafter “NCAA Insurance Programs”].

³ Zach Schonbrun, *Injury Raises Questions About Insurance for College Stars*, N.Y. TIMES, Feb. 14, 2013, http://www.nytimes.com/2013/02/15/sports/ncaa-basketball/injury-to-nerlens-noel-raises-questions-about-disability-insurance-for-athletes.html?_r=0.

⁴ See NCAA Insurance Programs, *supra* note 2.

⁵ Per a rule instituted in 2005, in order for an individual to be eligible for the National Basketball Association (hereinafter “NBA”) draft, he must be at least 19 years old “during the calendar year in which the Draft is held” and, if the player is not an international player, “at least one (1) NBA Season has elapsed since the player’s graduation from high school.” NBA COLLECTIVE BARGAINING AGREEMENT art. X, § 1(b)(i) (2011), available at <http://nbpa.com/cba/>; see also *O’Bannon*, 7 F. Supp. 3d at 967–68 (discussing how basketball recruits are effectively forced to play for NCAA programs because they cannot enter the NBA out of high school).

⁶ There are similar rules concerning athletes’ eligibility for the National Football League (herein after “NFL”) and Major League Baseball (hereinafter “MLB”) drafts which, in certain circumstances, require athletes to wait at least three years after completing their high school degree in order to become draft-

school degree before they are eligible to turn pro, these individuals, depending on their sport, are automatically deprived of potential earning capacity. The lack of comparable alternative options to college athletics effectively forces these individuals to play collegiate sports if they have any hopes of pursuing a professional career.⁷ Should an athlete choose to forego playing his sport after high school until he is draft-eligible, he would presumably see his draft position reduced due to a perceived loss in ability, potential, talent, and missed opportunities for growth and development in the eyes of the professional teams he is hoping to join.⁸ This process has

eligible. The rule instituted by the NFL mandates that athletes wait at least three years after high school before they may enter the draft. NFL COLLECTIVE BARGAINING AGREEMENT art. 6, § 2(b) (2011), *available at* http://images.nflplayers.com/mediaResources/files/PDFs/General/2011_Final_CB_A_Searchable_Bookmarked.pdf. The MLB rule provides athletes with a choice: they may either declare themselves eligible for the draft immediately out of high school, or, if they decide to attend college, they must then complete, in order to become draft-eligible, either their junior year if attending a four-year college or at least one year if attending junior college. *First-Year Player Draft*, MLB.COM <http://www.mlb.com/mlb/draftday/rules.jsp> (last visited May 20, 2015); *see also* *O'Bannon*, 7 F. Supp. 3d at 967–68 (discussing how football recruits are effectively forced to play for NCAA programs because they cannot enter the NFL out of high school).

⁷ Basketball and football recruits who are skilled enough to play NCAA Division I athletics “do not typically pursue other options for continuing their education and athletic careers beyond high school”, such as other college or professional leagues, because “[n]one of these other divisions, associations, or professional leagues . . . provide the same combinations of goods or services offered by FBS football and Division I basketball schools.” *O'Bannon*, 7 F. Supp. 3d at 967; *see also* Scott Kacsmar, *Where Does NFL Talent Come From?*, BLEACHER REPORT (May 16, 2013), <http://bleacherreport.com/articles/1641528-where-does-nfl-talent-come-from> (explaining that only two of the 1,947 players who played at least one game in the NFL in 2012 did not play in college); Jay Schalin, *SCHALIN: Time for Universities to Punt Football*, WASH. TIMES, Sept. 1, 2011, <http://www.washingtontimes.com/news/2011/sep/1/time-for-universities-to-punt-football/> (discussing the success of MLB subsidizing its own minor league system and the academic success of college baseball players versus their football counterparts).

⁸ For example, each of the 254 players taken in the 2013 NFL Draft and each of the 256 players taken in the 2014 NFL Draft played football collegiately. *2013 NFL Draft Pick List and Results*, ESPN, http://espn.go.com/nfl/draft/rounds/_/year/2013 (last visited May 20, 2015); *2014 NFL Draft Pick List and Results*, ESPN, http://espn.go.com/nfl/draft/rounds/_/year/2014 (last visited May 14, 2015).

created a reality in which collegiate athletic teams effectively function as “feeder” programs for professional leagues.⁹ Essentially, regardless of whether an athlete is ready to turn pro out of high school, he is forced to wait, and if he wants to have a chance to realize the professional dream at the end of that waiting period, he must play somewhere in the interim. His best (and effectively only) option is to seek a spot on a collegiate team where he will be barred from earning any direct income as a result of athletic performance while remaining exposed to the same injury risks that would be present if he were playing for a professional team.

However, this Note does not address the issues relating to student-athlete compensation as a whole. Rather, it specifically focuses on whether or not these athletes should be provided, or at least entitled to obtain, loss of value insurance for their future earnings. The college athlete, stuck between wanting to ensure his health and well-being in hopes of a professional career and wanting to do everything possible to bolster his chances of making it, is left unable to fully protect his livelihood. He remains protected should disaster strike in college, but only if his career is completely ended.¹⁰ If he were projected as a first-round draft pick, thereby enabling him to earn perhaps tens of millions of dollars,¹¹ and then suffered a debilitating injury during his collegiate career which did not render him completely unable to play but still deprived him of some skill, ability, and athleticism, he would stand only to earn a fraction of what he previously could and without a means of financial redress.¹²

⁹ 2013 NFL Draft Pick List and Results, *supra* note 8; 2014 NFL Draft Pick List and Results, *supra* note 8.

¹⁰ See NCAA Insurance Programs, *supra* note 2.

¹¹ For example, the first overall pick of the 2013 NFL Draft signed for \$22.19 million, while the last pick of the first round signed for \$6.767 million. 2013 NFL Draft First-Round Picks' Signing Status, NFL (July 30, 2013), <http://www.nfl.com/draft/story/0ap1000000168476/article/2013-nfl-draft-firstround-picks-signing-status>. The 2013–2014 NBA Rookie Contract Scale, which is used to determine the range of potential dollar amounts draft picks can sign for, capped the value of a three-year contract for the number one overall pick at roughly \$16.69 million (120% of the maximum value) while limiting the amount for a contract of the same length for the last pick of the first round to \$2.21 million (80% of the minimum value). 2013 First Round Draft Picks Cap Holds, SHAMSPORTS, <http://data.shamsports.com/content/pages/data/salaries/draftpickcapholds.jsp> (last visited May 20, 2015).

¹² Several student-athletes, originally projected as first overall or otherwise high draft picks, have seen their draft stock (and their earnings) fall substantially

This Note addresses where student-athletes *are not* protected by looking at why athletes who lose everything can protect themselves while those who lose *nearly* everything cannot. First, the Note starts with a general discussion of sports loss of value insurance. Second, the Note then provides an overview of the current NCAA Catastrophic Injury Insurance Program, as well as an explanation of the specialized Exceptional Student-Athlete Disability Insurance program available to select college athletes. Third, the discussion includes a brief explanation of what the NCAA deems to be “impermissible benefits” and examines the specific NCAA Bylaws that work in conjunction to effectively bar student-athletes from purchasing loss of value insurance. Fourth, the Note lays the groundwork as to how student-athletes could successfully challenge for the right to obtain loss of value insurance free from restriction and the legal and policy arguments that could be made in their favor. Fifth, possible remedies and suggestions for how the NCAA and its member institutions could effectively implement a loss of value program, should they choose or be forced to do so, are explained. Sixth, the Note examines the likely impact that the creation of a loss of value insurance program (or a private equivalent) could have for NCAA athletes, its member institutions, and the insurance industry. Finally, the Note addresses the possible concerns arising from the implementation of such a program.

after suffering an injury in college. Former Kentucky center Nerlens Noel, projected as the number one pick in the 2013 NBA Draft, suffered a torn ACL during his 2012–13 freshman season and ended up being drafted at number six overall, a slide that cost him nearly \$5,622,100 of guaranteed money in his first two seasons alone. Neal J. Leitereg, *How Much Money Did Nerlens Noel's Draft-Night Slide Cost Him?*, EXAMINER.COM (June 29, 2013), <http://www.examiner.com/article/how-much-money-did-nerlens-noel-s-draft-night-slide-cost-him>. Former South Carolina football player Marcus Lattimore, projected by most analysts to be a late first-round pick and the first running back taken in the 2013 NFL Draft, tore his left ACL in 2011 and then his right ACL the following season and fell to the fourth round, securing a \$2.4 million contract, only \$300,584 of which was guaranteed, rather than the contract in the \$7.5 million range typically given to late first-round picks. Darryl Slater, *Marcus Lattimore Will Get to Play with Another Comeback Running Back, Frank Gore, in San Francisco*, POST & COURIER, Apr. 28, 2013, <http://www.postandcourier.com/article/20130428/PC20/130429278/1037/marcus-lattimore-will-get-to-play-with-another-comeback-running-back-frank-gore-in-san-francisco&source=RSS>.

II. BACKGROUND

A. ATHLETIC LOSS OF VALUE INSURANCE

While there are different types of sports loss of value policies,¹³ student-athletes typically pursue a specific type of coverage commonly referred to as a “loss of draft position” provision.¹⁴ For purposes of this Note, “loss of value” shall only refer generally to loss of draft position coverage, as this form of protection is the only one relevant to collegiate athletes. This coverage is aimed at protecting athletes who are drafted lower than they likely would have been had they not suffered some sort of injury or illness that affected their athletic ability.¹⁵ To obtain loss of value coverage, it must be combined with a disability policy.¹⁶ Despite the appeal of such protection, the prevalence of these policies has decreased in recent years, due in large part to the current economic situation in the United States.¹⁷

In order for the student-athlete to collect on the loss of value policy, the suffered injury “must be serious and lasting.”¹⁸ In order for an injury to be considered serious, it must “negatively affect the player’s skills in a manner that causes substantial and material deterioration in his or her

¹³ Glenn M. Wong & Chris Deubert, *The Legal & Business Aspects of Career-Ending Disability Insurance Policies in Professional and College Sports*, 17 VILL. SPORTS & ENT. L.J. 473, 495–96 (2010). There are two other common types of sports loss of value policies available only to professional athletes, mostly due to the fact that they turn on contractual earnings and free agency, two concepts which are unique to professional sports leagues. The first type of professional loss of value coverage protects a player who is nearing free agency by setting a “threshold amount of value lost based on the player’s most recent contract offer.” *Id.* The policy requires that the player miss a certain amount of games and that the next contract offer subsequent to the injury or illness is less than the threshold amount. *Id.* The second type of coverage involves agreeing to a maximum benefit amount, whereby if the player ends up receiving less than that amount because of injury or illness, the insurer pays the difference. *Id.* The premiums for these policies can be substantial, and are often in the \$100,000 range. *Id.*

¹⁴ *Id.* at 496–97.

¹⁵ *Id.* at 496.

¹⁶ Darren Rovell, *Matt Barkley Had No Insurance*, ESPN (Apr. 30, 2013), http://espn.go.com/nfl/story/_id/9228764/matt-barkley-returned-usc-trojans-insurance-sources.

¹⁷ Wong & Deubert, *supra* note 13, at 496.

¹⁸ *Id.* at 496–97.

ability to perform.”¹⁹ If the student-athlete aims to collect as a result of a sickness, the illness “must negatively affect his or her skills permanently.”²⁰ In other words, the injury suffered must be the cause for the player’s drop in the draft.

The loss of value provision usually kicks in when the insured enters the draft and loses a predetermined amount of value (often 40%) from his predetermined draft value.²¹ The insurer initially determines compensation based on the student-athlete’s anticipated draft position, generally capping the maximum liability limit at 50% of the expected compensation²² or a flat number, typically \$5 million, regardless of the amount of actual financial harm suffered. If the insured is shown to have lost \$5 million or more as a result of his fall in the draft, he is able to collect the full amount.²³ These contracts typically contain a clause that protects the insurer should the insured athlete end up earning more than the anticipated compensation amount during a specified number of years over the course of his professional career.²⁴ If it turns out that the student-athlete, through income and the loss of draft position policy, ends up earning more than the amount he was originally covered for, he is required to return the difference to the insurer.²⁵ It appears that other specific terms of the policy, such as whether the coverage period includes one or two collegiate seasons, are negotiated with each athlete individually.

The process to obtain loss of value coverage for a college athlete projected as a top pick is as follows: the athlete, widely projected to be a

¹⁹ *Id.* at 497.

²⁰ *Id.* There is no threshold requirement that a player must miss a certain amount of games as a professional in order to be indemnified. *Id.* at 496.

²¹ Rovell, *supra* note 16.

²² Wong & Deubert, *supra* note 13, at 497. For example, if the player was expected to be drafted in the top three picks of the upcoming draft and the expected guaranteed income from such a draft spot was \$20 million, the limit on the policy would be \$10 million. Should the player only receive a \$5 million contract due to the injury or illness, the policy would pay the full \$10 million, leaving the player with a total of \$15 million.

²³ Rovell, *supra* note 16.

²⁴ Wong & Deubert, *supra* note 13, at 497.

²⁵ *Id.* Continuing from the example in note 22, *supra*, if the specified term was five years, and the player ended up earning \$12 million in income, this amount, combined with the \$10 million insurance payout, would leave the player with \$22 million in total earnings, or \$2 million more than the original expected amount. Therefore, the player would be required to refund \$2 million to the insurer.

high pick in the draft of his sport's professional league, approaches an independent insurer seeking coverage. The insurer then assesses the athlete's draft stock and assigns him a projected spot.²⁶ Based on the typical guaranteed earnings from the projected draft spot, the insurer then creates a policy that includes both total disability coverage, as required, and a loss of value provision.²⁷ The amount of coverage is limited to a percentage or a maximum (typically \$5 million) and subject to the requirement that the insured loses a percentage of value in the draft.²⁸

For example, a star quarterback who is a consensus top draft pick in the upcoming National Football League Draft would likely be able to secure a total disability policy with a loss of value provision for the significant premium of \$52,000.²⁹ The payout would be either a percentage of lost earnings or a capped total (e.g., \$5 million) depending on the wishes of the insured and the insurer.³⁰ In this hypothetical, based on the projections of his draft position, the quarterback is evaluated to be likely taken fourth overall, which typically nets an estimated \$20 million in guaranteed earnings.³¹ If the quarterback then suffered an injury during that collegiate football season and subsequently fell in the draft, he could collect on the difference between his projected \$20 million and whatever his actual guaranteed earnings are, up to the percentage limit³² or the \$5 million maximum included in the policy.³³

One notable example of an athlete who purchased loss of draft position insurance is former University of Southern California quarterback Matt Leinart. Leinart passed on the 2005 National Football League Draft after his junior year and returned to school, at which point he purchased a

²⁶ Rovell, *supra* note 16.

²⁷ *Id.*

²⁸ *Id.*

²⁹ Chris Larcheveque, Senior Vice President of Sports and Entertainment at Hanleigh Insurance, estimated this premium, as well as the other amounts contained in this example, based on former University of Southern California quarterback Matt Barkley. The estimates are hypothetical, as Barkley did not obtain insurance of any kind for his senior season. *Id.*

³⁰ *Id.*

³¹ *Id.*

³² Wong & Deubert, *supra* note 13, at 497.

³³ Rovell, *supra* note 16.

loss of value policy for himself, presumably with private funds.³⁴ The coverage only kicked in if Leinart, who was slated to go in the top five picks had he come out as a junior, fell past the fifteenth pick in the 2006 draft.³⁵ Leinart fell, but not far enough to trigger the policy, and was taken tenth overall.³⁶

B. CURRENT AVAILABILITY OF ATHLETIC LOSS OF VALUE INSURANCE

Athletic loss of value protection, particularly with loss of draft value coverage, is not widely available.³⁷ Very few insurance companies offer policies to cover an athlete's draft status, and those that do often do so for substantial premiums.³⁸ There is not much available information about the amount of underwriters offering these types of policies or who these underwriters are.³⁹

The limited availability is due to the high risk to the insurers and the lack of profitability.⁴⁰ This results in a limited market because coverage is only aimed at a very select subset of athletes for whom the protection would be viable given the high premiums.⁴¹ The NCAA prohibition presumably has a substantial impact on this, as its requirement that outside financing not be used to secure the coverage⁴² substantially reduces the

³⁴ Darren Rovell, *Source: Marquise Lee insured for \$10M*, ESPN (Aug. 30, 2013), http://espn.go.com/los-angeles/college-football/story/_/id/9614189/usc-trojans-marquise-lee-picks-10m-insurance-policy-source-says.

³⁵ *Id.*

³⁶ *Id.*

³⁷ Shaun H. Crosner, *Elite Student-Athletes Should Take Stock of Their Disability Insurance Needs as They Head into the Summer*, POLICYHOLDER INFORMER (June 27, 2013), <http://www.policyholderinformer.com/2013/06/27/elite-student-athletes-should-take-stock-of-their-disability-insurance-needs-as-they-head-into-the-summer/>.

³⁸ *Id.*; Warren K. Zola, *Does Lack of Real Insurance Drive Players to NFL?*, SPORTS LAW BLOG (Jan. 20, 2011), <http://sports-law.blogspot.com/2011/01/does-lack-of-real-insurance-drive.html>.

³⁹ One known underwriter for these policies is Hanleigh Insurance. Rovell, *supra* note 16.

⁴⁰ Crosner, *supra* note 37.

⁴¹ Zola, *supra* note 38.

⁴² *Id.*

pool of eligible purchasers.⁴³ The result is a vicious cycle where the limited customer base and high risk of the coverage creates high premiums, and these high premiums serve to limit the potential purchasers of such insurance.

C. THE BASIC NCAA STUDENT-ATHLETE DISABILITY INSURANCE POLICY

The NCAA requires each of its member institutions and their respective athletes to maintain medical insurance as a prerequisite for athletic participation and offers its own coverage known as the Group Basic Accident Medical Program (hereinafter “G.B.A.M.P.”).⁴⁴ Students can always be covered through their own family insurance plans, but in the event they are not, institutions must cover their athletes up to the \$90,000 deductible on the Catastrophic Injury Insurance program,⁴⁵ which can be \$75,000 or \$90,000, depending on the source of the basic accident coverage.⁴⁶ The NCAA offers coverage to satisfy the requirement through its G.B.A.M.P., which the schools then offer to their athletes.⁴⁷ Additional coverage is also provided during NCAA championships, insuring student-athletes for up to \$90,000 in medical expenses, which effectively doubles the coverage provided by either the school or the student’s family insurance.⁴⁸ After this level, the Catastrophic Injury Insurance coverage kicks in.⁴⁹

⁴³ The majority of insurers generally do not offer policies for which there is not a large market, as it would likely be cost-prohibitive. The NCAA’s restriction effectively reduces the possible eligible pool for loss of value coverage (college athletes) to zero.

⁴⁴ See *Student-Athlete Insurance Certification Legislation: Overview*, NCAA, <http://www.ncaa.org/about/resources/insurance/student-athlete-insurance-certification-legislation> (last visited May 20, 2015).

⁴⁵ NCAA Insurance Programs, *supra* note 2; *NCAA Catastrophic Injury Insurance Program Frequently Asked Questions*, NCAA, <http://www.ncaa.org/sites/default/files/Cat%2BFAQs%2B8.12.pdf> (last visited Jan. 14, 2015) [hereinafter “Catastrophic Injury Insurance FAQ”].

⁴⁶ *Id.*

⁴⁷ NCAA Insurance Programs, *supra* note 2.

⁴⁸ *Insurance Coverage for Student-Athletes*, NCAA, <http://www.ncaa.org/about/resources/insurance/insurance-coverage-student-athletes> (last visited May 20, 2015).

⁴⁹ *Id.*

The NCAA provides a form of disability insurance to all its athletes, referred to as the Catastrophic Injury Insurance program.⁵⁰ The current program, underwritten by Mutual of Omaha Insurance Company,⁵¹ “covers the student-athlete who is catastrophically injured while participating in a covered intercollegiate athletic activity.”⁵² It contains two different deductible limits: the first is \$75,000 and pertains to schools that participate in the G.B.A.M.P.; the second is \$90,000 and concerns all other eligible institutions.⁵³ The policy automatically covers every active member institution, and the NCAA pays all premiums,⁵⁴ which typically amount to a total of \$10 million annually.⁵⁵

D. THE NCAA’S EXCEPTIONAL STUDENT-ATHLETE DISABILITY INSURANCE PROGRAM

1. Exceptional Student-Athlete Disability Insurance: An Overview

In addition to its Catastrophic Injury Insurance program, the NCAA offers extra insurance coverage to a select subset of college athletes. The permanent total disability policy, known as the “Exceptional Student-Athlete Disability Insurance” program (hereinafter “E.S.D.I.”), was instituted in 1990 but originally only covered football and men’s basketball.⁵⁶ The program was then expanded, first in 1991 to include baseball,⁵⁷ again in 1993 to include men’s ice hockey,⁵⁸ and then a third time in 1998 to include women’s basketball.⁵⁹ The NCAA created the program in an effort to help protect its student-athletes from both injury concerns and attempts by agents to lure the student-athletes away from

⁵⁰ NCAA Insurance Programs, *supra* note 2.

⁵¹ Catastrophic Injury Insurance FAQ, *supra* note 45.

⁵² NCAA Insurance Programs, *supra* note 2.

⁵³ Catastrophic Injury Insurance FAQ, *supra* note 45.

⁵⁴ *Id.*

⁵⁵ Wong & Deubert, *supra* note 13, at 508 (discussing the NCAA’s contribution to its E.S.D.I. policy).

⁵⁶ NCAA Insurance Programs, *supra* note 2.

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

school and into the professional leagues.⁶⁰

In order to be eligible for coverage, the athlete first must have “remaining eligibility” at an NCAA institution in “intercollegiate football, men’s or women’s basketball, baseball, or men’s ice hockey”⁶¹ The athlete then must demonstrate that he or she has “professional potential to be selected in the first three rounds of the upcoming National Football League or National Hockey League draft or the first round of the upcoming draft of the National Basketball Association, Major League Baseball, or Women’s National Basketball Association. . . .”⁶² The policy does not explicitly list what criteria is used to determine whether a student-athlete demonstrates “professional potential,”⁶³ but the NCAA often uses professional scouting services to assist in their evaluations, which can be an inexact science.⁶⁴ A look at the list of athletes who have obtained E.S.D.I. coverage in the past appears to show that it requires the display of exceptional talent, high opinions from scouts and a significant level of pre-draft hype.⁶⁵

Athletes can play their way into E.S.D.I. eligibility. If an athlete is evaluated before the start of a collegiate season and found to be ineligible under the E.S.D.I. program, but his play during that season subsequently elevates his status and scouts’ projections to the level necessary for eligibility, he can apply for and obtain coverage in-season.⁶⁶ The policies are written in a way that incentivizes players to want to continue playing their sport, as they will be able to earn more as a professional than they

⁶⁰ Wong & Deubert, *supra* note 13, at 506 (discussing the NCAA’s motivations for instituting the program, which also include a possible desire to increase public opinion by demonstrating a desire to “more closely look[] out for the best interests of the young men and women participating as opposed to their own financial coffers”).

⁶¹ NCAA Insurance Programs, *supra* note 2.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Gary Klein, *Premium Players*, L.A. TIMES, Feb. 20, 2005, <http://articles.latimes.com/2005/feb/20/sports/sp-leinart20>.

⁶⁵ See Wong & Deubert, *supra* note 13, at 507 n.202, for a list of several notable college athletes across each of the covered sports who purchased E.S.D.I. coverage. The vast majority of athletes listed were high profile, extremely successful as a collegian, and evaluated strongly by scouts.

⁶⁶ Klein, *supra* note 64.

would be collecting on a policy.⁶⁷

The policy carries a twenty-four month maximum term and pays out a lump sum after a twelve month “elimination period,”⁶⁸ which commences on the date the injury resulting in total disability occurred.⁶⁹ The maximum amount of the payout varies by sport. The amount of coverage each student receives is determined by the program administrator,⁷⁰ who bases his decision on the athlete’s prospective status in the upcoming draft.⁷¹ The rate is calculated per thousand dollars of coverage and is “based on the market at the time individual applications are reviewed by the program administrator.”⁷²

The policy typically only pays out for a permanent total disability, which requires that the student-athlete’s “disability results from an injury or sickness,”⁷³ that the “injury or sickness occurs while the policy is in force,”⁷⁴ and that the athlete “is under the regular care of a qualified physician . . . [and] is unable to engage in sporting activity at the professional level.”⁷⁵ In addition, the “applicable elimination period” must have elapsed⁷⁶ and the total disability must “prevent him or her from signing any employment contract with any professional team as a professional athlete in his or her sporting activity.”⁷⁷ A permanent total disability typically requires that the student-athlete be completely incapable of performing his sport for a twelve-month period following the initial injury.⁷⁸

⁶⁷ Mike Herndon, *NCAA Insurance Program Protects Elite Athletes, Future Earnings Against Injury*, AL.COM (Aug. 1, 2010), http://www.al.com/sports/index.ssf/2010/08/are_you_in_good_hands.html.

⁶⁸ NCAA Insurance Programs, *supra* note 2.

⁶⁹ *Id.* (explaining that the purpose of the delay is to provide time for the insurer to evaluate the nature of the injury or sickness and that no benefits are paid to the student-athlete during this period).

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ NCAA Insurance Programs, *supra* note 2.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ Warren K. Zola, *Transitioning to the NBA: Advocating on Behalf of Student-Athletes for NBA & NCAA Rule Changes*, 3 HARV. J. SPORTS & ENT. L. 159, 185 (2012).

The only other means of payout under the policy is a presumptive disability benefit. In order to collect, the student-athlete's disability must be "medically determined to be the result of (a) an entire and irrecoverable loss of sight of both eyes or hearing in both ears, or (b) total and irrecoverable loss of use of one hand or one foot, or (c) quadriplegia, or (d) paraplegia,"⁷⁹ all of which would serve to prevent the athlete from "ever participating in his or her sporting activity at the professional level."⁸⁰ The presumptive disability benefit includes essentially an acceleration clause that allows the injured insured to avoid having to wait for the twelve-month elimination period to pass. After ninety consecutive days from the date of injury, at the insured student-athlete's choosing, together with the approval of the insurer, the "outstanding benefits may be commuted to present value lump sum at a rate agreed upon" by the two parties.⁸¹

One of the most appealing parts of the program is its relative affordability. Because E.S.D.I. is a group program, the insurer can share administrative costs and spread risk among the participating NCAA member institutions.⁸² The result is that these premiums are almost always cheaper than alternative policies through private insurers.⁸³ While the premiums for the policy can be as much as ten thousand to twelve thousand per one million insured,⁸⁴ it contains a provision that assists student-athletes with obtaining financing, if necessary, to pay these premiums.⁸⁵ The interest rate for the pre-approved loan is "very competitive"⁸⁶ and is often better than what the student-athlete could obtain on the open market,⁸⁷ typically at 1.5% above prime.⁸⁸ To expedite the process, the

⁷⁹ NCAA Insurance Programs, *supra* note 2.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² Wong & Deubert, *supra* note 13, at 510.

⁸³ *Id.*

⁸⁴ *Id.* at 507 (explaining typical premiums for the E.S.D.I. policy). A typical \$5 million policy will often cost between \$45,000 and \$65,000. Jason Cole, *Even \$5M Insurance Policy for Jadeveon Clowney Isn't Enough to Cover NCAA's Short-Sighted Ways*, YAHOO! SPORTS (Feb. 13, 2013), <http://sports.yahoo.com/news/nfl--even--5m-insurance-policy-for-jadeveon-clowney-isn-t-enough-to-cover-ncaa-s-short-sighted-ways-223714245.html>.

⁸⁵ The loan is provided through U.S. Bank, N.A., Sports Division. NCAA Insurance Programs, *supra* note 2.

⁸⁶ *Id.*

⁸⁷ Kevin Fixler, *The \$5 Million Question: Should College Athletes Buy Disability Insurance?*, THE ATLANTIC, Apr. 11, 2013, <http://www.theatlantic.com/>

lender pays the borrowed funds directly to the insurer.⁸⁹ The purchaser is not responsible for making any payments on the loan until one of three things occurs: “(1) the student-athlete signs a professional contract, (2) the disability benefits become available due to a covered injury or sickness or (3) the coverage is no longer in effect and the loan note matures.”⁹⁰

2. Participation in E.S.D.I.

According to the NCAA, between 100 and 120 athletes participate in E.S.D.I. per season, a figure that tends to remain constant.⁹¹ A 2005 article reported that “approximately seventy-five to eighty percent of those [enrolled] are college football players.”⁹² Within those figures, it is estimated that 75% of first-round NFL and NBA draft picks are enrolled in E.S.D.I.⁹³ Potential MLB and NHL first-round picks have a much lower enrollment rate, typically falling in the 10% range.⁹⁴ Women’s basketball players hardly participate in the program, usually enrolling only one or two student-athletes per year.⁹⁵

Notable examples of recent high-profile collegiate athletes to purchase policies include former University of Stanford quarterback Andrew Luck, former University of Southern California players Reggie Bush, quarterback Matt Leinart and quarterback Carson Palmer, and former University of Florida quarterback Tim Tebow.⁹⁶ University of Texas A&M quarterback Johnny Manziel, the 2012 Heisman Trophy winner, and University of South Carolina defensive end Jadeveon Clowney, projected

entertainment/archive/2013/04/the-5-million-question-should-college-athletes-buy-disability-insurance/274915/.

⁸⁸ Herndon, *supra* note 67.

⁸⁹ Cole, *supra* note 84.

⁹⁰ *Id.*

⁹¹ Fixler, *supra* note 87.

⁹² Wong & Deubert, *supra* note 13, at 507 (quoting Gary Klein, *Premium Players: Insurance Policies Are Becoming Standard for Elite College Athletes*, L.A. TIMES (Feb. 20, 2005), at D1.).

⁹³ *Id.* at 508.

⁹⁴ *Id.*

⁹⁵ *Id.* (explaining that the low participation rate for women’s basketball players is likely because even the modestly-priced premiums are cost-prohibitive or the insurance is unnecessary given the relatively low salaries of professional women’s basketball players).

⁹⁶ Fixler, *supra* note 87.

to be a top-five pick in the 2014 National Football League Draft, both sought insurance policies prior to the start of their 2013 collegiate football seasons, though it is not clear whether they took part in the E.S.D.I. program or sought private insurance.⁹⁷

Not all high-profile college athletes have taken part in the program. The premiums are extremely high even with the NCAA's group rate, and because the program only pays out in the event of a career-ending injury, many players forego coverage.⁹⁸ Former University of Southern California quarterback Matt Barkley did not follow in his predecessors' footsteps, opting to forego any insurance coverage, including E.S.D.I., when returning for his senior season.⁹⁹

The NCAA's program is not the only option for student-athletes. The private market for this insurance is limited, but the need for it developed in the mid-1990s when professional athlete salaries began to rise substantially.¹⁰⁰ Private underwriters provide coverage for athletes who either do not qualify for E.S.D.I. or who want more coverage than the NCAA offers.¹⁰¹ Student-athletes can secure their own policies, as well as accompanying loans, with other insurers and for amounts that exceed that NCAA's \$5 million in coverage, provided that no third party is involved in the process of securing the loans.¹⁰² Former University of Kentucky center Nerlens Noel obtained private disability insurance similar to the NCAA's, reportedly paying between \$40,000 and \$60,000 to privately secure a \$10 million policy from Lloyd's of London for coverage during his freshman basketball season.¹⁰³

⁹⁷ *Id.*

⁹⁸ Herndon, *supra* note 67 (quoting former University of Auburn player Lee Ziemba in citing the policy's failure to cover loss of value injuries as a reason for not opting to purchase it).

⁹⁹ Barkley, projected as a top-10 pick had he entered the 2012 National Football League Draft after his junior season, likely would have earned upwards of \$20 million in guaranteed money. After returning for his senior season, he suffered a shoulder injury and fell to the fourth round in the 2013 draft. Darren Rovell, *Matt Barkley Dad No Insurance*, ESPN (Apr. 30, 2013), http://espn.go.com/nfl/story/_/id/9228764/matt-barkley-returned-usc-trojans-insurance-sources.

¹⁰⁰ Herndon, *supra* note 67.

¹⁰¹ *Id.*

¹⁰² Crosner, *supra* note 37.

¹⁰³ Fixler, *supra* note 87.

3. Rarity of Collecting on the Policy

Despite the availability of and consistent participation in the NCAA program, there are very few instances of successful collection by student-athletes over the past fifteen years.¹⁰⁴ The NCAA has acknowledged that fewer than half a dozen claims have been made under this policy,¹⁰⁵ but it has generally been reluctant to provide information regarding the actual number of claims and payouts made, citing confidentially concerns with the insurance providers.¹⁰⁶

There is only one widely-publicized instance of an athlete benefitting from permanent total disability coverage, either through E.S.D.I. or private insurance.¹⁰⁷ Former University of Florida defensive tackle Ed Chester opted to forego the 1998 NFL draft and return to school for his senior year.¹⁰⁸ Projected as a potential first-round pick had he come out as a junior, he was slated to be drafted in the first round.¹⁰⁹ During his senior year, Chester blew out his knee and never played again, and subsequently successfully collected \$1 million from a private policy he purchased for \$8,000.¹¹⁰

The lack of claims made on the policy is not surprising given the state of modern sports medicine and technological innovations.¹¹¹ With today's medical advances, college athletes are less likely than they have ever been to suffer a career-ending injury, which in turn makes it more unlikely that they will be able to collect on an E.S.D.I. policy. Juanita Sheely, the NCAA's Director of Travel and Insurance, acknowledged the rarity of collecting on the policy, citing that, "[a]s medical technology has advanced, there's [sic] a lot of good rehab facilities and procedures [available] that, except for the most dire of injuries, most of the time

¹⁰⁴ *Id.* (estimating the lack of successful claims through permanent total disability policies as "probably less than a dozen").

¹⁰⁵ Marc Isenberg, *The "Student-Athlete Disability Insurance Program" Isn't What the NCAA Cracks It up to Be*, COACHGEORGERAVELING.COM (Mar. 20, 2013), <http://coachgeorgeraveling.com/the-student-athlete-disability-insurance-program-isnt-what-the-ncaa-cracks-it-up-to-be/>.

¹⁰⁶ Fixler, *supra* note 87.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

[athletes] can come back from it.”¹¹² However, despite the low rate of payouts and potentially hefty price tag, student-athletes continue to purchase these policies.¹¹³

4. Legal Challenges to E.S.D.I. Policies

There has been surprisingly little litigation stemming from the E.S.D.I. program. One notable challenge came from former University of Georgia football player Decory Bryant.¹¹⁴ On October 21, 2003, Bryant, then a student-athlete at Georgia, informed an assistant athletic director (hereinafter “AAD”) that he wanted E.S.D.I. coverage.¹¹⁵ The AAD told Bryant that he would prepare the paperwork for him and then proceeded to contact Lloyd’s of London, the E.S.D.I. provider.¹¹⁶ On October 24, 2003, the AAD confirmed in a letter sent to Lloyd’s that the school sought to purchase E.S.D.I. coverage for Bryant.¹¹⁷ The AAD did not include a coverage request form signed by Bryant as required by Lloyd’s.¹¹⁸ The next day, October 25, 2003, Bryant suffered a career-ending spinal injury while playing for his football team, which left him disabled.¹¹⁹ The University of Georgia athletic department then had Bryant sign the coverage request form October 29, 2003.¹²⁰ The AAD submitted the form that same day, but Lloyd’s subsequently informed the school that it would not backdate its coverage.¹²¹ Bryant then sued the school for its failure to effectuate his E.S.D.I. coverage.¹²² After more than five years of litigation, the two sides settled for \$400,000 in 2010.¹²³

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Fireman’s Fund Ins. Co. v. Univ. of Ga. Athletic Ass’n, Inc.*, 654 S.E.2d 207 (Ga. Ct. App. 2007).

¹¹⁵ *Id.* at 210.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Bryant Reaches Insurance Settlement*, ESPN (Feb. 24, 2010), <http://sports.espn.go.com/nfl/news/story?id=4941527>.

E. NCAA'S RESTRICTIONS ON THE PURCHASE OF LOSS OF VALUE INSURANCE

There is no specific NCAA bylaw that expressly prohibits obtaining loss of value insurance.¹²⁴ Prior to 2010, the NCAA did not allow its student-athletes to obtain any form of “loss of value” insurance.¹²⁵ Following significant debate, it changed its stance that year, eventually permitting players to obtain such coverage without violating NCAA rules.¹²⁶ There are only two ways athletes can obtain loss of value insurance without committing a violation – either the student (or his immediate family) must purchase it without any outside financing¹²⁷ or the school can pay for it through its Student Assistance Fund, as Florida State University did prior to the 2014 season for Heisman Trophy winner Jameis Winston and Texas A&M University did in an attempt to keep its star offensive tackle Cedric Ogbuehi in school for one more year.¹²⁸ Since the NCAA does not offer this type of plan itself or through a partner insurer, as it does with the E.S.D.I. program, student-athletes and their families are forced to go to outside insurers. The premiums for these types of policies are significant, potentially reaching into the six-figure range.¹²⁹ The effective result is that virtually every athlete is priced out from protecting himself in

¹²⁴ See 2014–15 NCAA DIVISION I MANUAL, available at <http://www.ncaa.com/publications/productdownloads/D115.pdf> [hereinafter “NCAA Bylaws”].

¹²⁵ Zola, *supra* note 38.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ Nick Bromberg, *Florida State Paying for Jameis Winston's Loss of Value and Disability Insurance*, YAHOO! SPORTS (Aug. 5, 2014), <https://sports.yahoo.com/blogs/ncaaf-dr-saturday/florida-state-is-paying-for-jameis-winston-s-loss-of-value-and-disability-insurance-134352246.html>; Graham Watson, *Texas A&M Buys OL Cedric Ogbuehi an Insurance Policy to Keep Him in School One More Year*, YAHOO! SPORTS (July 17, 2014), <https://sports.yahoo.com/blogs/ncaaf-dr-saturday/texas-a-m-buys-ol-cedric-ogbuehi-an-insurance-policy-to-keep-him-in-school-one-more-year-142313025.html>. The “Student Assistance Fund” is designed to “assist student-athletes in meeting financial needs that arise in conjunction with participation in intercollegiate athletics, enrollment in academic curriculum or that recognize academic achievement.” *Student Athlete Benefits*, NCAA, <http://www.ncaa.org/about/resources/finances/student-athlete-benefits> (last visited May 20, 2015).

¹²⁹ Schonbrun, *supra* note 3.

this way.¹³⁰

The NCAA classifies obtaining this insurance as an impermissible or “extra” benefit, as defined below, and therefore prohibits it. The rationale is that the athlete, by virtue of having this protection, is trading on his future earnings and his status as a collegiate athlete.¹³¹ By the NCAA’s definition, this behavior constitutes an “extra benefit” expressly forbidden by NCAA rules,¹³² and compromises his amateur status as a collegiate athlete.

F. “EXTRA BENEFITS” ACCORDING TO THE NCAA

According to NCAA Bylaw 16.11.2.1, student-athletes shall not accept any extra benefits.¹³³ It goes on to define an “extra benefit” as “any special arrangement by an institutional employee or representative of the institution’s athletics interest to provide a student-athlete or the student-athlete family member or friend a benefit not expressly authorized by NCAA legislation.”¹³⁴ Bylaw 16.02.3, which contains the same definition of “extra benefit” as Bylaw 16.11.2.1, further stipulates that the athlete is not in violation of this rule if he can demonstrate that “the same benefit is generally available to the institution’s students or their family members or friends or to a particular segment of the student-body . . . *determined on a basis unrelated to athletics ability.*”¹³⁵ The rules essentially prohibit any form of pay for athletes.¹³⁶

Particularly relevant to the loss of value insurance context is NCAA Bylaw 12.1.2.1.6, which prohibits “[p]referential treatment, benefits or services because of the individual’s athletics reputation or skill or pay-back potential as a professional athlete, unless such treatment, benefits or services are specifically permitted” by the NCAA.¹³⁷ Read plainly, the rule generally prohibits an athlete from “trading on” their future earning

¹³⁰ Zola, *supra* note 41.

¹³¹ Schonbrun, *supra* note 3.

¹³² *Id.*

¹³³ See NCAA Bylaws, *supra* note 124, at art. 16.11.2.1.

¹³⁴ *Id.*

¹³⁵ *Id.* at art. 16.02.3 (emphasis added).

¹³⁶ See *id.* at art. 12.1.2 for an explanation of the numerous forms of compensation and benefits that are prohibited under NCAA rules, including, but not limited to, salary, educational expenses not otherwise permitted, awards and sponsorships.

¹³⁷ See *id.* at art. 12.1.2.1.6.

potential as a professional athlete, subject to a few exceptions. Securing loans to pay for loss of value insurance is not one of these exceptions.¹³⁸ Therefore obtaining loans to pay for loss of value insurance is a form of “trading on” an athlete’s “pay-back potential”¹³⁹ and is within the scope of the rule, making it a prohibited activity. In sum, NCAA Bylaws 16.11.2.1, 16.02.3 and 12.1.2.1.6 work in conjunction to prevent the purchase of loss of value coverage.

G. COURTS’ WILLINGNESS TO REVIEW NCAA BYLAWS AND RULES

Students have standing to sue the NCAA when they have suffered “actual injury to a legally protected interest.”¹⁴⁰ While the individual athletes may not be a party to the contract between the NCAA and its member institutions, they are entitled to bring an action based on the agreement if the parties “intended to benefit the nonparty, provided that the benefit claimed is a direct and not merely incidental benefit of the contract.”¹⁴¹ The intent to benefit the third party need not be explicit in the agreement, but rather must be apparent in the terms of the agreement, its surrounding circumstances, or both.¹⁴² The Colorado Court of Appeals reasoned that the importance of the NCAA’s function to benefit its student-athletes, coupled with its role in determining their eligibility, enabled the assumption that student-athletes were likely to succeed in establishing third-party beneficiary standing regarding the contract between the NCAA and its member institutions.¹⁴³ The Colorado Court of Appeals held that the “NCAA’s constitution, bylaws, and regulations evidence a clear intent to benefit student-athletes.”¹⁴⁴

Courts typically adopt the administrative law standard of “arbitrary and capricious” when examining NCAA rules and regulations.¹⁴⁵ Although the basis for its determination is not clear, the Kentucky Supreme Court

¹³⁸ *See id.*

¹³⁹ *Id.*

¹⁴⁰ Bloom v. Nat’l Collegiate Athletic Ass’n, 93 P.3d 621, 623 (Colo. App. 2004).

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *See, e.g., id.*; Nat’l Collegiate Athletic Ass’n v. Lasege, 53 S.W.3d 77 (Ky. 2001).

stated in *National Collegiate Athletic Association v. Lasege* that “relief from [the] judicial system should be available if voluntary athletic associations act arbitrarily and capriciously toward student-athletes.”¹⁴⁶ The court in *Lasege* hinted at the possibility of judicial review being justified “because the NCAA occupied the role of a quasi-state actor with respect to individual student-athletes.”¹⁴⁷ However, the United States Supreme Court held that the NCAA is not itself a state actor and its member institutions’ adherence to state rules does not constitute the state action required to invoke a civil rights claim.¹⁴⁸

Traditionally, courts have been reluctant to intervene in the internal affairs of voluntary associations, such as the NCAA, except on the most limited grounds.¹⁴⁹ When they do, it appears that an allegation of the violation or invasion of a civil or property right must be made in order to maintain standing.¹⁵⁰ The court in *Bloom v. National Collegiate Athletic Association* concluded that Bloom had third-party beneficiary standing to sue the NCAA,¹⁵¹ despite his status as a nonmember and his failure to assert a property right,¹⁵² because his claim of arbitrary and capricious action on the part of the NCAA asserted a “violation of the duty of good faith and fair dealing” implied in the contract between the NCAA and its member institutions.¹⁵³

III. LEGAL GROUNDS FOR CHALLENGING THE PROHIBITION – THE “ARBITRARY AND CAPRICIOUS” STANDARD

Based on the NCAA’s current bylaws, its current insurance policies and justifications, and economic stakes for its student-athletes, the NCAA should provide its student-athletes with loss of value insurance, or, in the alternative, allow them the opportunity to obtain it.

One path a potential challenger to the NCAA’s current policy could take would be through a direct challenge of the rule. The student-athlete would need to go outside NCAA rules and secure a private loan to

¹⁴⁶ See *Lasege*, 53 S.W.3d at 83.

¹⁴⁷ *Bloom*, 93 P.3d at 624.

¹⁴⁸ Nat’l Collegiate Athletic Ass’n v. Tarkanian, 488 U.S. 179, 194–95 (1988).

¹⁴⁹ *Bloom*, 93 P.3d at 624.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

purchase loss of value insurance. The NCAA would then presumably declare the student ineligible for having received an extra benefit. With his ability to participate in his sport denied, the student would then bring suit to challenge the NCAA bylaw on the grounds that it is arbitrary and capricious, similar to the path taken in *Bloom*.¹⁵⁴ In the alternative, a student could seek to protect his eligibility by obtaining a preliminary injunction against the NCAA's enforcement of its rules either before or after he purchases the insurance. Each of these tracks is discussed below.

A. THE "ARBITRARY AND CAPRICIOUS" STANDARD

When reviewing the NCAA's decisions or rules, courts will apply the "arbitrary and capricious" standard that is prevalent in administrative law.¹⁵⁵ In doing so, the court employs a narrow standard of review and is not to substitute its own judgment for that of the organization whose decisions it is reviewing.¹⁵⁶ The organization, in defending its decision, "must examine the relevant data and articulate a satisfactory explanation for its action[s]."¹⁵⁷ This examination must produce a "rational connection between the facts found and the choice made."¹⁵⁸ When reviewing the organization's decision, the court must determine whether the organization took into account the relevant factors and whether a clear error in judgment has occurred.¹⁵⁹ Examples of "arbitrary and capricious" decision-making include where the organization has failed entirely to consider a key element of the problem, offered an explanation of its decision that does not follow from the evidence before it or espouses a justification that is so implausible that it cannot possibly be "ascribed to a difference in view or the product of [organizational] expertise."¹⁶⁰

Courts are typically very deferential to the NCAA in their review

¹⁵⁴ *See id.*

¹⁵⁵ Mike Salerno, *Traveling Violation: A Legal Analysis of the Restrictions on the International Mobility of Athletes*, 25 N.Y. INT'L L. REV. 1, 25 (2012); *see, e.g., Bloom*, 93 P.3d 621; *Lasege*, 53 S.W.3d 77.

¹⁵⁶ *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

¹⁵⁷ *Id.*

¹⁵⁸ *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962).

¹⁵⁹ *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43.

¹⁶⁰ *Id.*

of its rules and regulations.¹⁶¹ In order for a rule or regulation to not be arbitrary or capricious, it must be “reasonably related to [its] intended purpose.”¹⁶² If the NCAA arbitrarily and capriciously applies rules that are otherwise reasonable, judicial intrusion into the affairs of the private, voluntary organization is warranted.¹⁶³ The adoption of such a standard is indicative of “judicial reluctance to micromanage the manner in which private associations or dedication institutions apply their policies.”¹⁶⁴ The Kentucky Supreme Court noted in *National Collegiate Athletic Association v. Lasege* that “relief from [the] judicial system should be available if voluntary athletic associations act arbitrarily and capriciously toward student-athletes.”¹⁶⁵ A private organization, such as the NCAA, is acting arbitrarily and capriciously only “where it is ‘clearly erroneous,’ and by ‘clearly erroneous’ [courts] mean ‘unsupported by substantial evidence.’”¹⁶⁶ The Supreme Court of Indiana, in analyzing a claim against a private athletic organization, defined an act as arbitrary and capricious where “it is willful and unreasonable, without consideration and in disregard of the facts or circumstances in the case, or without some basis which would lead a reasonable and honest person to the same conclusion.”¹⁶⁷

B. STANDING

Before any challenge could be brought against the NCAA and its bylaws, which exist by virtue of a contract between the NCAA and its

¹⁶¹ See Josephine R. Potuto, *The NCAA Rules Adoption, Interpretation, Enforcement, and Infractions Processes: The Laws That Regulate Them and the Nature of Court Review*, 12 VAND. J. ENT. & TECH. L. 257, 266–73 (2010).

¹⁶² Salerno, *supra* note 155, at 25 (citing Mayo Found. for Med. Educ. & Research v. United States, 131 S. Ct. 704, 711–12 (2011)).

¹⁶³ *Id.* at 25–26.

¹⁶⁴ Matthew J. Mitten & Timothy Davis, *Athlete Eligibility Requirements and Legal Protection of Sports Participation Opportunities*, 8 VA. SPORTS & ENT. L.J. 71, 130 (2008).

¹⁶⁵ Nat’l Collegiate Athletic Ass’n v. Lasege, 53 S.W.3d 77, 83 (Ky. 2001).

¹⁶⁶ *Id.* at 85 (citing Thurman v. Meridian Mut. Ins. Co., 345 S.W.2d 635, 639 (Ky. 1961)).

¹⁶⁷ Ind. High Sch. Athletic Ass’n v. Carlberg, 694 N.E.2d 222, 233 (Ind. 1997).

member institutions,¹⁶⁸ the student-athlete must establish third-party standing. The question of whether a third party to a contract has standing to bring an action upon it is a matter of state law.¹⁶⁹ The Colorado Supreme Court in *Bloom v. National Collegiate Athletic Association* noted that a “party has standing to seek relief when he or she has suffered actual injury to a legally protected interest.”¹⁷⁰ Although an individual is not an express party to a contract, he may institute an action on the contract “if the parties to the agreement intended to benefit the nonparty”¹⁷¹ so long as “the benefit claimed is a direct, and not merely incidental, benefit of the contract.”¹⁷² The intent to benefit the third party does not need to be explicitly laid out in the contract, but it must be apparent from its terms, surrounding circumstances, or both.¹⁷³ The NCAA’s constitution, bylaws, and regulations were held to “evidence a clear intent to benefit student-athletes.”¹⁷⁴ As a third-party beneficiary, the challenger would have rights that are no greater than those possessed by the original parties to the contract, which would be the NCAA and its member institutions in this context.¹⁷⁵

C. APPLYING THE STANDARD

1. Same Issue, Different Application

The first step in challenging the NCAA’s prohibition on loss of value insurance would be to attack it on the ground of disparate application of similar rules. As discussed earlier, the NCAA permits athletes to obtain outside financing to purchase total disability policies, but it places extreme

¹⁶⁸ See Potuto, *supra* note 161, at 267 (discussing the structure of the relationship between the NCAA and its member institutions as a “multi-subject contract entered into by more than a thousand members”).

¹⁶⁹ *Miree v. DeKalb Cnty.*, 433 U.S. 25, 29–34 (1977).

¹⁷⁰ *Bloom v. Nat’l Collegiate Athletic Ass’n.*, 93 P.3d 621, 623 (Colo. App. 2004).

¹⁷¹ *Id.*; see, e.g., *Bochese v. Ponce Inlet*, 405 F.3d 964, 981 (11th Cir. 2005) (applying Florida law); *Sovereign Bank v. BJ’s Wholesale Club, Inc.*, 533 F.3d 162, 172 (3d Cir. 2008) (applying Pennsylvania law).

¹⁷² *Bloom*, 93 P.3d at 623.

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *United Steelworkers of Am., AFL-CIO-CLC v. Rawson*, 495 U.S. 361, 363 (1990).

restrictions on financing loss of value insurance. The same right is at stake in both cases – protecting future earnings against harm. However, the NCAA arbitrarily prevents one while allowing another with no clear reason for the distinction.

The strongest argument to demonstrate the arbitrary nature of the prohibition is to attack the NCAA's rationale. It justifies the rule on the grounds that athletes should not be able to trade off their future earnings as athletes if they wish to maintain amateur status.¹⁷⁶ The "trade off" is in the form of the loan secured in order to pay for the loss of value policy. The belief, presumably, is that the lender is only willing to pay out such a substantial sum to a person with no current income because it is confident in the student's ability to earn enough money as a professional athlete to repay the loan. Therefore, in the eyes of the NCAA, this act constitutes trading on an individual's status as a collegiate athlete.¹⁷⁷

Where the NCAA's argument is vulnerable is that it already allows NCAA athletes to trade off their status in exactly this way but in a slightly different context. As discussed above, the NCAA has an exception, contained in its Exceptional Student-Athlete Disability Insurance Program, which allows student-athletes and their families to secure a third-party loan to pay premiums for a special insurance program.¹⁷⁸ In doing so, they are obtaining this loan purely by way of their status as a collegiate athlete. This situation is directly analogous to obtaining loss of value insurance. In both cases, student-athletes are seeking to protect their future interests regarding their earning capacity as athletes. In order to obtain this protection, they have to secure a loan that is likely only available to them because of their future earning potential as professional athletes. However, the NCAA allows one (permanent disability insurance) while denying the other (loss of value coverage). There is no readily apparent reason for this distinction, particularly in light of the NCAA's justification for why it instituted its E.S.D.I. program in the first place – to protect its student-athletes against injury and the pressures of agents to make the jump to the pros too early.¹⁷⁹

The thrust of the NCAA's argument for its right to regulate its student-athletes in this way is the emphasis it places on amateurism,

¹⁷⁶ Zola, *supra* note 38.

¹⁷⁷ It makes no difference, under NCAA rules, whether the student-athlete himself or a member of family is the one who secures the loan. *Id.*

¹⁷⁸ NCAA Insurance Programs, *supra* note 2.

¹⁷⁹ Wong & Deubert, *supra* note 13, at 506.

thereby enabling it to prohibit what it views as economic gain by its student-athletes by virtue of their athletic ability.¹⁸⁰ The NCAA considers amateurism to be its most important “core principle” and the reason that fans are drawn to college sports.¹⁸¹ By using “amateur” athletes, the NCAA distinguishes its brand from those of professional sports leagues.¹⁸² However, this stubborn adherence to amateurism is simply an excuse for the NCAA to profit from its athletes’ athletic talent without having to compensate them financially, and instead the athletes should be able to enjoy the economic benefits of their skills and abilities. The NCAA’s shifting and inconsistent definition of what it means to be an “amateur” further undermines its argument. The NCAA has changed its own definition of what it means to be an amateur numerous times since it released its first definition in 1906.¹⁸³ The NCAA Bylaws allow for different treatment of athletes depending on sport. For example, a tennis recruit can receive up to \$10,000 in prize money before he enters college and still be considered an “amateur” under NCAA rules, while a track and field recruit who receives the same would be determined to be ineligible.¹⁸⁴ A football player receiving a Pell grant that raises his total financial aid above the cost of attendance does not compromise his amateurism, but if he were to decline the grant and accept an equal amount sum as part of an endorsement deal, he would be ineligible.¹⁸⁵ Finally, it is becoming increasingly clear that amateurism has not contributed significantly to college sports’ popularity.¹⁸⁶ School loyalty and identity with a region of

¹⁸⁰ “Student-athletes shall be amateurs in an intercollegiate sport, and their participation should be motivated primarily by education and by the physical, mental and social benefits to be derived. Student participation in intercollegiate athletics is an avocation, and student-athletes should be protected from exploitation by professional and commercial enterprises.” NCAA Bylaws, *supra* note 124, at art. 2.9.

¹⁸¹ Nat’l Collegiate Athletic Ass’n v. Bd. of Regents of Univ. of Okla., 468 U.S. 85, 101–02 (1984); O’Bannon v. Nat’l Collegiate Athletic Ass’n, 7 F. Supp. 3d 955, 999–1000 (N.D. Cal. 2014), *appeals filed*, No. 14-16601 (9th Cir. Aug. 21, 2014), No. 14-17068 (Oct. 21, 2014).

¹⁸² O’Bannon, 7 F. Supp. 3d at 999–1000.

¹⁸³ *Id.* at 973–74, 1000.

¹⁸⁴ *Id.* at 1000.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 977. O’Bannon addresses the Supreme Court’s suggestion in *Board of Regents* that amateurism is necessary to preserve college sports, concluding that the suggestion is “not based on any factual findings in the trial record and did not

the country have been found to be much stronger reasons.¹⁸⁷ In essence, while NCAA steadfastly asserts it needs amateurism in order to distinguish itself, the evidence, some of which comes from the NCAA itself, shows that consumers are in large part indifferent to it.

Ultimately, the NCAA's distinction between the purchase of loss of value and disability insurance is arbitrary and capricious. While there is no particular NCAA bylaw which serves to effectuate this difference,¹⁸⁸ a court would likely find that the functional effect of the bylaws with regards to purchasing loss of value insurance is arbitrary and capricious as it relates to the purpose of promoting amateurism and preventing gains on the basis of athletic ability, particularly in light of allowing the purchase of extra disability insurance. The NCAA would likely have a difficult time showing a rational connection between its ban on loss of value coverage and the justification for it when it simultaneously allows student-athletes to use the same basis (future earning capacity as a professional athlete) to obtain another form of additional insurance. Producing a satisfactory explanation for the vastly different treatment of two very similar issues would be a challenge for the NCAA.

2. Protects One Economic Class of Athlete and Not Another

On their face, the NCAA's rules serve to effectively prevent a large, substantial class of athletes from protecting themselves from loss of value in any way. The bylaws function such that they prohibit outside loans from being secured to pay the policy's premiums ensuring that only athletes whose families possess significant wealth can insure themselves. Therefore, student-athletes who, through no fault of their own, do not have

serve to resolve any disputed issue of law" and is actually "counter to the assertions of the NCAA's own counsel in the case, who stated . . . that the NCAA . . . might be able to get more viewers and so on if it had semi-professional clubs rather than amateur clubs." *Id.* at 999 (internal quotation marks omitted).

¹⁸⁷ *Id.* at 977-78, 1001.

¹⁸⁸ See NCAA Bylaws, *supra* note 124. The NCAA's prohibition is the function of three bylaws (16.11.2.1, 16.02.3 and 12.1.2.1.6) working in conjunction. Independently, these bylaws serve to justifiably govern and prohibit certain activity by student-athletes. Striking down or enjoining these two bylaws outright could have wide-sweeping effects in other unrelated areas of college athlete regulation. To avoid this problem, a narrowly-tailored injunction would be necessary, as discussed further below.

the financial capacity to purchase the insurance and likely would benefit most are unable to protect their future careers. A subset of college athletes, chosen by way of certain criteria, is eligible for an extra benefit while a majority of players must go unprotected. The NCAA provides an extra benefit to a portion of its athletes, based solely in familial wealth, out of concern for their future earnings and well-being. The question then becomes why is that acceptable but allowing a wider base of athletes to protect themselves is unacceptable? There is no discernible reason why an athlete's eligibility for financial security should be tied to his family's economic situation.

3. Non-Athletes Can Obtain it Freely, but Student-Athletes Cannot

One of the NCAA Bylaws which works to effectuate the ban on loss of value insurance, Bylaw 16.02.3, concerns "extra benefits" received by student-athletes. As part of the definition of what constitutes an "extra benefit," Bylaw 16.02.3 includes an exception that says something is not deemed to be an extra benefit if "the same benefit is generally available to the institution's students or their family members or friends or to a particular segment of the student-body . . . *determined on a basis unrelated to athletics ability.*"¹⁸⁹ An argument against the NCAA's prohibition would be that loss of value insurance is readily available to the rest of student body or to others outside the NCAA for reasons unrelated to athletic ability.

While arguing that loss of value coverage is available in general, such as in the context of automobile insurance, is likely a losing argument, a challenger could narrow the comparison to other physical skill-related fields. For example, assuming they could find a willing insurer, loss of value insurance could be obtainable by surgeons, musicians, or other skill-related professions. This insurance, which provides the same protection as athletic loss of value insurance, is not obtainable by virtue of any athletic ability. Therefore, it would stand to reason that purchasing loss of value insurance is not an extra benefit as defined by the NCAA and purchasing it does not violate the NCAA Bylaws.

The counterargument to this position is that the other types of loss of value coverage, while similar on their faces, are in no way analogous. This promotes a narrow reading of Bylaw 16.02.3's interpretation of the

¹⁸⁹ *See id.* at art. 16.02.3 (emphasis added).

definition of “loss of value insurance” as it applies to student-athletes. A court would have to determine that the policies purchased are sports-specific and therefore not available to the general public or other students because they are presumably not elite athletes with professional potential. Inherent in this interpretation is the determination that “loss of value insurance” in this context pertains exclusively to loss of draft position coverage, and not the principle of loss of value insurance generally.

In sum, it can be argued that the NCAA’s restrictions prevent athletes from doing something that their families, other students, and the general population are free to do. It is prohibiting an activity in contravention of its own bylaws. This argument, however, is tenuous at best, given the likelihood that a court will narrowly interpret the benefit as sports-related loss of value insurance and not loss of value coverage generally, particularly in light of its deference to the NCAA Bylaws and their interpretation.¹⁹⁰

D. SUMMARY

It is difficult to predict whether a challenge to the NCAA’s prohibition on the purchase of loss of value insurance would be successful. The prohibition itself is likely arbitrary and capricious, given that athletes can already purchase very similar insurance while securing loans based on their earning capacity as athletes. Alternatively, the bylaw itself seems to be contradictory, as loss of value insurance is available to other students and non-students in various forms, though the scope of “loss of value insurance” would need to be determined. A student-athlete would appear to have a reasonable likelihood of success on either of these two legal arguments, and has a chance to earn the right to secure loans to purchase loss of value insurance.

However, overshadowing this entire process is the specter of the NCAA’s prominence and courts’ deference to their rulemaking and interpretations. This factor is the wild card in the analysis of any legal challenge, as it appears that courts are reluctant to overturn NCAA rules except in the most limited circumstances.¹⁹¹ A student-athlete can only

¹⁹⁰ See Mitten & Davis, *supra* note 164, at 119–28 (discussing courts’ general deference to the NCAA and other private athletic bodies when it comes to reviewing these organizations’ actions and rules).

¹⁹¹ See *Bloom v. Nat’l Collegiate Athletic Ass’n*, 93 P.3d 621, 624 (Colo. App. 2004).

hope that the deprivation of his ability to protect himself against the loss of millions of dollars is one such circumstance.

IV. POLICY CONCERNS

In addition to the legal grounds noted above, student-athletes could advance a number of public policy arguments to support their contention that they deserve the opportunity to obtain loss of value coverage. The strength of these arguments in many ways exceeds any legal bases they may have in seeking relief.

A. ALLOWING PEOPLE TO PROTECT THEMSELVES

In general, individuals should be allowed to protect themselves if they have the means and desire to. If a person wishes to secure some form of protection and said protection is available, he should be free to do so. People's desire to protect themselves against financial ruin and the benefits to society of allowing insurance are evidenced by the importance placed on making health coverage widely available and how most states require auto liability coverage as a requirement for driving.¹⁹² Additionally, restricting an individual's ability to purchase insurance cuts against the values of a free market and of an individual's right to contract. The decision to incur debt in order to secure this coverage – in essence, leveraging current protection against future earnings – is the right and province of the individual student-athlete and not for the NCAA to regulate. It is generally bad public policy to prevent individuals from freely securing protection for themselves if they are willing and able.

B. STUDENTS ARE, IN ESSENCE, FORCED TO PLAY IN COLLEGE, SO THEY SHOULD BE ABLE TO PROTECT THEMSELVES

The coercive elements of professional sports leagues' entry rules effectively force athletes to participate in collegiate athletics if they wish to

¹⁹² See W.C. Crais III, Annotation, *Automobile Liability Insurance: Operator's Policies*, 88 A.L.R.2d 995 (1963); see also *Motor Vehicle Insurance – Financial Responsibility and Required Minimums*, 0110 SURVEYS 68 (Thomson Reuters 2014).

pursue a professional career.¹⁹³ Unable, in many cases, to enter the professional ranks immediately after high school and with no viable alternative, athletes have nowhere to turn except to NCAA sports. In light of this, it is unfair to then prohibit these athletes from protecting themselves. They are forced to put the earning of any income on hold in order to participate in college athletics while simultaneously physically putting their bodies (and future earning capacity) at risk. It is then good policy to allow these individuals who, by virtue of rules outside of their control, cannot enter the field in which they hope to make a career to obtain protection. Athletes typically have a limited window in which they can earn a living¹⁹⁴ and forcing them to spend some of this time playing in college while also putting their future at risk is unfair and bad public policy.

C. IF STUDENT-ATHLETES CANNOT BE COMPENSATED WITH A SALARY, THEY SHOULD BE PROTECTED AGAINST LOSING FUTURE EARNINGS

Student-athletes are unable to be compensated in any way for their contributions to their schools and the NCAA other than by virtue of an athletic scholarship. The rules adopted to ensure this result are fueled by the NCAA's focus on preserving amateurism among its athletes.¹⁹⁵ Even if

¹⁹³ Athletes in many sports must wait at least one to three years after high school before being able to turn pro. NBA COLLECTIVE BARGAINING AGREEMENT, *supra* note 5; NFL COLLECTIVE BARGAINING AGREEMENT, *supra* note 6. The lack of comparable alternatives to NCAA athletics in terms of competitiveness, talent level and exposure means that student-athletes who cannot immediately enter the professional ranks must turn to the NCAA.

¹⁹⁴ See Dashiell Bennett, *The NFL's Official Spin On Average Career Length Is A Joke*, BUSINESS INSIDER (Apr. 18, 2011), <http://www.businessinsider.com/nfls-spin-average-career-length-2011-4> (citing the average length of an NFL career as 3.2 years and discussing the NFL's contention that the average length is actually 6 years); Sam Roberts, *Just How Long Does the Average Baseball Career Last?*, N.Y. TIMES, July 15, 2007, <http://www.nytimes.com/2007/07/15/sports/baseball/15careers.html> (citing the average length of a career in MLB to be 5.6 years); Dave Berri, *Why the NBA Players Keep Losing to the Owners*, FREAKONOMICS (Dec. 6, 2011), <http://freakonomics.com/2011/12/06/why-the-nba-players-keep-losing-to-the-owners/> (citing the average length of a career in the NBA to be 4.8 years).

¹⁹⁵ See NCAA Bylaws, *supra* note 124, at art. 2.9.

one concedes that the preservation of amateurism is a reasonable purpose and that athletes should not be financially compensated while in school, it still stands to reason that they should not be hindered in their post-collegiate lives. The effective ban on obtaining financing for loss of value insurance essentially prevents athletes from protecting themselves in an event – the draft – that occurs post-graduation, or, at the very least, post-college athletics.

It could be argued that it is generally bad public policy to prevent college athletes from insuring their future economic interests in their own athletic ability by purchasing loss of value insurance because unlike issues surrounding athlete compensation *during* their collegiate careers, loss of value insurance concerns his compensation *after* leaving college. The NCAA's argument that the ability to obtain a loan to pay for such coverage is only possible by virtue of their status as an NCAA athlete with professional potential is unconvincing, as it is premised on the idea that the NCAA owns an athlete's talent, not the athlete himself. If an athlete is the owner of his own talent and potential, it is unfair to permit an organization with no cognizable interest in his future earnings to prevent him from protecting himself. The NCAA has an interest – the preservation of the amateurism ideal – in the student-athlete's talent and potential only while he is in college, but not beyond. Therefore, it is bad public policy to prevent a private organization from limiting one of its member's rights to earnings in the future.

D. THE VIABILITY OF E.S.D.I. AND SIMILAR POLICIES IS VERY MUCH IN QUESTION

A final public policy argument advanced in favor of permitting the obtaining of loss of value insurance is the ineffectiveness of the NCAA's current insurance programs. As noted above, there have been very few payouts under either E.S.D.I., Catastrophic Injury Insurance, or any similar private policies.¹⁹⁶ The goal of these total disability policies – to protect an athlete's future economic interests – is thwarted by the fact that the coverage is becoming somewhat obsolete. Advances in medical technology and procedures have meant that what were once career-ending injuries are now just career-postponing ones.¹⁹⁷ A torn ACL or rotator cuff

¹⁹⁶ Fixler, *supra* note 87 (estimating the lack of successful claims through permanent total disability policies as “probably less than a dozen”).

¹⁹⁷ *Id.*

in college used to mean that an athlete's professional career was over. Now it simply means surgery, rigorous rehabilitation, and a drop in the draft.

With this new medical reality, total disability policies are unlikely to improve their payout rates, thereby frustrating the purposes for which they were instituted. While the recent rise in awareness over head injuries in college and professional sports may result in a new wave of career-ending injuries,¹⁹⁸ any increase in this area is unlikely to justify the limited scope of total disability coverage.

Therefore, in order to effectively protect vulnerable student-athletes, it is good public policy to allow them to procure loss of value insurance. It would provide a more viable alternative because athletes would be able to more accurately and efficiently insure themselves against financial loss. The limited conditions under which they can collect on total disability policies coupled with their enormous price tags make them cost ineffective. Loss of value coverage allows athletes to guard against a harm that, particularly in today's reality, is more likely to occur than a career-ending injury. No other measure can better guard their future interests.

V. REMEDIES

A. MONETARY DAMAGES

Student-athletes could first seek monetary relief from the NCAA or its member institutions as compensation. These damages would only be available in cases where the athlete was able to show an actual, already-suffered injury. The argument for monetary damages would be that if not for the NCAA Bylaws, the athlete could have properly protected himself against depreciation in his value. Therefore, due to the NCAA's arbitrary and capricious adoption of these rules, the athlete was unable to protect

¹⁹⁸ See, e.g., *David Piland's Career Ends Due to Concussions: Houston QB Decides To Stop Playing Football*, HUFFINGTON POST (Oct. 8 2013), http://www.huffingtonpost.com/2013/10/08/david-piland-concussions-career-ends-houston_n_4065436.html; Chris Carlson, *Concussions Bring Premature Close to Career of Syracuse DE Tyler Marona*, SYRACUSE.COM (Oct. 25, 2013), http://www.syracuse.com/orangefootball/index.ssf/2013/10/concussions_bring_premature_cl.html; Pete Volk, *Utah QB Travis Wilson Out for Season with Possible Career-ending Concussion*, SB NATION (Nov. 18, 2013), <http://www.sbnation.com/college-football2013/11/18/5118864/travis-wilson-injury-utah-concussion>.

himself and suffered significant financial injury.

Such a remedy would not be without its issues. First, there would likely be disputes over whether the student-athlete planned on or could have afforded the loss of value insurance in the first place. There will undoubtedly be disputes over where the athlete would have been drafted. Further, the source of the drop in the draft would surely be contested, as the NCAA and the schools could argue that a player fell for any number of reasons unrelated to the injury. Or, in the event that an injury accompanied some other potential reason for the drop, there would at least be a debate over how much of the fall was attributable to the injury and how much was the result of the other event or circumstance. Regardless, in the event of an actual injury, provided he can prove that he intended and could have afforded loss of value insurance, courts could award monetary damages to student-athletes in amounts consistent with what was lost as a result of not having a loss of value insurance policy either through loss of value calculation or actuarial analysis.

B. PRELIMINARY INJUNCTIONS

In the alternative, student-athletes could seek a preliminary injunction to prevent the NCAA Bylaws that effectively ban obtaining loans to pay for loss of value insurance from being enforced in this context. Ultimately, the student-athlete would want to seek a narrowly-tailored injunction allowing him to take out loans to purchase loss of value insurance and not a blanket injunction against the NCAA Bylaws at issue, as the latter could have significant effects beyond the scope of this problem.¹⁹⁹

In order to obtain a preliminary injunction, a plaintiff must establish: (1) “that he is likely to succeed on the merits”;²⁰⁰ (2) “that he is likely to suffer irreparable harm in the absence of preliminary relief”;²⁰¹ (3) “that the balance of equities tips in his favor”;²⁰² and (4) “that an injunction

¹⁹⁹ Enjoining the NCAA Bylaws at issue from being enforced could result in substantial impacts in other areas for schools and student athletes, as the intended purpose of these rules – to prevent students from obtaining illicit benefits and financial gains that jeopardize their amateur status by virtue of their status as athletes – is a legitimate one as it applies to most other actions.

²⁰⁰ *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

²⁰¹ *Id.*

²⁰² *Id.*

is in the public interest.”²⁰³ An injunction should only be issued when essential to protect property rights against injuries that can otherwise not be remedied.²⁰⁴ The basis for injunctive relief in federal courts has consistently been “irreparable injury and the inadequacy of legal remedies.”²⁰⁵

1. Success on the Merits

The challenging student-athlete would need to demonstrate that his claim that the NCAA Bylaws are arbitrary and capricious, with respect to the prohibition on loss of value insurance, is likely to succeed on the merits. While it is unclear whether he would successfully be able to prove his claim, he could most likely establish a likelihood of success. The NCAA prohibition is possibly arbitrary on its face, particularly in light of the exception the NCAA carved out for similar insurance coverage (E.S.D.I.), that the prohibition appears to contradict the NCAA’s own rules, and that it deprives the student-athletes of a protective measure that is of significant impact to their livelihoods. A court could reasonably find for the challenging student-athlete, and therefore his claim is likely to succeed on its merits.

2. Irreparable Harm

The challenging student-athlete should be able to demonstrate that irreparable harm is likely to occur in the absence of an injunction against the NCAA Bylaws. Because litigation can take several months and years while a career-altering injury can occur at any moment, there is a chance the athlete’s claim becomes moot before he has a chance to have his day in court. He could suffer the injury, lose millions, and never have an opportunity to protect himself. Furthermore, the athlete cannot abstain from playing his sport pending his legal challenge, as that would thwart his intentions of entering the professional ranks as pro teams prefer that athletes play and develop rather than sit out. Therefore, because time is of great importance in these situations, the student-athlete would be likely to suffer irreparable harm should the injunction not be granted.

²⁰³ *Id.*

²⁰⁴ *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982).

²⁰⁵ *Id.*

3. Balance of Equities

In balancing the equities, a court would likely come down in favor of the athletes. The impact on the NCAA if the injunction is granted is only that they must now monitor the purchase of new insurance by its member institutions' athletes. The NCAA will likely claim that prohibition furthers its interest in preserving amateurism, but the question then becomes whether the NCAA's interest in an ideal trumps the athletes' real need to protect themselves. For the athletes, the impact of denying the injunction is substantial. They could lose millions of dollars in potential earnings while putting themselves at risk for the benefit of the NCAA and while unable to play their trade anywhere else. In weighing the consequences for both sides, it is likely that the harm to the student-athletes if the injunction is denied far outweighs the harm to the NCAA if it is granted.

4. Public Interest

The public interest would likely be served by granting this injunction. It is generally good public policy to allow individuals to, if they so choose, take responsibility and protect themselves for the benefit of society. An additional policy concern specifically affecting athletes is the fact that they have a limited window in which they can earn a living from their athletic talent and it is in the public interest to allow an individual to protect their ability to earn a living. The NCAA draws no readily apparent benefit from preventing these individuals from protecting themselves. Therefore, in light of these circumstances, it appears to be sound public policy that absent a justifiable reason, college athletes should be able to protect themselves and contract with whomever they choose to achieve this goal. For these reasons, the public interest is likely served by granting a preliminary injunction.

C. PERMANENT INJUNCTION

Once the student-athlete's challenge proceeds to court, he could seek remedy in the form of a permanent injunction. Each of the four elements required for a preliminary injunction would apply, as would the same arguments and rationales, except for a few slight differences.²⁰⁶ The

²⁰⁶ *Amoco Prod. Co. v. Vill. of Gambell*, 480 U.S. 531, 544 n.12 (1987).

first element of a preliminary injunction, a likelihood of success on the merits, is replaced by actual success on the merits, which would be demonstrated by the outcome of the trial.²⁰⁷ Just like the preliminary injunction, any permanent injunction would need to be narrowly tailored to achieve the student-athletes' goal of being able to obtain loans to purchase loss of value insurance without violating NCAA rules. A blanket injunction against the bylaws in question could have a significant impact beyond just insurance concerns.²⁰⁸

VI. POTENTIAL SOLUTIONS

Addressed in this section are several suggestions for how the NCAA could go about implementing loss of value coverage for its student-athletes. While no one solution is perfect, each is a step in the right direction toward protecting the athletes. If any proposal is adopted, the NCAA could always revise it after some time to better meet the goals of providing the coverage.

A. INCORPORATE LOSS OF VALUE INTO THE CURRENTLY-EXISTING E.S.D.I. STRUCTURE

The first proposed solution for implementing a loss of value program is to automatically include it under E.S.D.I. coverage. Obviously this would require that the NCAA renegotiate its deals with Bank of America, N.A., and HCC Insurance Holdings, Inc. regarding the provision of the already-existing E.S.D.I. coverage, changing it from strictly a permanent total disability policy to one that includes a loss of value provision. The resulting premiums would be higher, as there is now an additional provision for a coverage that is more likely to be paid out, but the added benefit would be worth it. The presumption here would be that most athletes willing to obtain expensive E.S.D.I. coverage would be interested in spending a little extra in order to protect against diminished earnings.

²⁰⁷ *Id.*

²⁰⁸ See NCAA Bylaws, *supra* 124. The NCAA Bylaws at issue affect activities and actions that are far beyond the scope of loss of value insurance. For this reason, it is crucial that any injunctive relief be narrowly tailored to avoid enjoining any legitimate effects of the rules.

The problem with this solution is that it does not provide loss of value insurance to all athletes with professional potential who may want it. Because E.S.D.I. is offered to a limited pool of student-athletes, access to loss of value coverage would also be limited. To remedy this, E.S.D.I. would need to broaden its eligibility requirements.²⁰⁹ While going this route may prove to be a bigger overhaul than the NCAA and its partners are interested in performing, relaxed requirements for E.S.D.I. eligibility, combined with the automatic inclusion of a loss of value provision, would be an effective solution to the current problem.

B. EXPAND E.S.D.I. AND PROVIDE AN OPTION TO PURCHASE
ADDITIONAL COVERAGE

A slight variation on the previous suggestion is to provide loss of value coverage as an option, rather than as included, in E.S.D.I. coverage. This route also requires the relaxing of the eligibility requirements for E.S.D.I. in order to ensure that all or most who want coverage would have access to it. It would also, like the first option, require that HCC Insurance Holdings, Inc., be amenable to creating loss of value coverage. Implicit in the adoption of this option would be an express permission to obtain outside financing to secure loss of value coverage, which the NCAA currently does not permit,²¹⁰ because if athletes need loans to pay for expensive E.S.D.I. coverage, they will also need it for loss of value coverage.

Provided both of these conditions are met, the NCAA could then give student-athletes the choice to obtain additional loss of value coverage should they want it. Athletes could presumably obtain the policy at a rate lower than the market average, just as the NCAA and its partners can provide E.S.D.I. coverage more cheaply than private insurers.²¹¹ The result would be freedom on the part of the student-athletes to choose for themselves whether they want to take on additional debt in order to adequately protect themselves. If adopted, this proposal would perhaps be

²⁰⁹ See generally Joseph Stuart Knight, *Blown Coverage: Tackling Problems with the NCAA's Exceptional Student-Athlete Disability Insurance Program*, 1 MISS. SPORTS L. REV. 157 (2012) (discussing why the NCAA should make changes to its E.S.D.I. program, including providing for greater coverage for more athletes, and how it could go about doing so).

²¹⁰ Zola, *supra* note 38.

²¹¹ Wong & Deubert, *supra* note 13, at 510.

the most complete solution to the issue.

C. CREATE A LESSER ADDITIONAL TOTAL DISABILITY
COVERAGE THAT INCORPORATES A LOSS OF VALUE
PROVISION

A second proposed solution is an even larger overhaul of the current system, and may prove to be the most difficult to implement. If accomplished, however, it would address the concerns with the first and second solutions regarding the lack of access to the coverage for most student-athletes with professional prospects. Here, the NCAA would need to negotiate with its current insurer, HCC Insurance Holdings, Inc., or another insurer to provide a lesser version of E.S.D.I. The new plan would provide less financial coverage at the cost of more affordable premiums and would contain a loss of value provision. The creation of a lesser disability policy is necessary because loss of value policies usually require that a total disability policy also be obtained.²¹² The offer of a less inclusive and cheaper disability policy would fulfill this requirement, while also being affordable to those student-athletes who are less certain of their professional prospects.

The obvious hurdle facing this solution is finding an insurer willing to offer the program. More research would need to be done on the viability of this solution, but if it were offered, it could be of significant benefit to those student-athletes not quite eligible for E.S.D.I. coverage that wish to protect their professional financial interests.

D. CREATE AN EXCEPTION TO THE NCAA BYLAWS THAT
ALLOWS ATHLETES TO SECURE LOANS TO PAY FOR THEIR
OWN LOSS OF VALUE POLICIES

A final proposed solution is to simply create an explicit exception in the NCAA Bylaws that permits student-athletes to obtain outside financing to privately purchase insurance. Since the NCAA Bylaws state that any benefit not expressly authorized is forbidden,²¹³ the NCAA would need to establish an exception for this purpose. They have already done so through their development of the E.S.D.I. program itself, going so far as to help secure the loans themselves through a deal with Bank of America,

²¹² Rovell, *supra* note 16.

²¹³ See NCAA Bylaws, *supra* note 124, at art. 12.1.2.1.6.

N.A.²¹⁴

The ultimate effect of this proposal, however, would likely drive student-athletes away from the NCAA-offered E.S.D.I. program altogether and toward private insurers, where they would likely face much higher premiums.²¹⁵ The reason for this is that loss of value provisions are not typically offered independently and usually must be part of a total disability policy.²¹⁶ Therefore, if a student-athlete purchases E.S.D.I., he will not be able to independently purchase loss of value insurance from another insurer without also obtaining disability coverage from that insurer. Unless the student-athlete seeks double coverage and is willing to pay two premiums, he would be best suited to simply go with the outside insurer.

VII. IMPACT OF IMPLEMENTING LOSS OF VALUE INSURANCE

A. IMPACT FOR THE NCAA

The impact on the NCAA, should loss of value policies be allowed, is likely to be minimal. The most direct cost to the organization would be that associated with monitoring and keeping track of the purchase of these policies. It may lead to an increased need for oversight of boosters, agents and other third parties as they relate to the student-athletes. Overall, however, it should not cost the NCAA much in terms of time or money, particularly if it is wound into its already existing insurance programs.

The implementation of a loss of value policy may actually benefit the NCAA in two ways. First, it could increase athletes' incentives to stay in school and complete their degrees rather than force them to seek to cash in as early as possible.²¹⁷ Many athletes look to turn pro as soon as they become eligible due to the need for financial stability and concerns over injuries.²¹⁸ Having available protection may alleviate some students' fears and allow them to stay in school longer, thereby allowing the NCAA to benefit from their athletic success while strengthening the notion that the importance of education is paramount.

The second benefit to the NCAA could come in the form of reducing some of the vitriol over its failure to adequately compensate its

²¹⁴ See NCAA Insurance Programs, *supra* note 2.

²¹⁵ Wong & Deubert, *supra* note 13, at 510.

²¹⁶ Rovell, *supra* note 16.

²¹⁷ Zola, *supra* note 38.

²¹⁸ *Id.*

student-athletes for the financial contributions their athletic ability makes to the NCAA and its member institutions. The NCAA might not be willing to pay its players, but granting them increased freedom in the ways in which they can protect themselves during their collegiate careers would be a step in the right direction toward showing they care about their players' well-being. While creating some form of loss of value insurance is unlikely to completely quiet those criticisms, it would have some positive effect.

B. IMPACT FOR NCAA STUDENT-ATHLETES

The most substantial impact on the athletes is obvious – they would be able to effectively protect themselves, or, at the very least, have the option of doing so. Those students who leave school early in order to capitalize on and maximize the economic benefits of their athletic talents may feel less pressure to do so.²¹⁹ Students who wish to return to school for their junior or senior year in order to complete their degrees can do so knowing they are protected in the event of a serious but not career-ending injury.

An ancillary effect would be new concerns over the proper path to choose in securing loss of value coverage. It would become another factor for student-athletes to weigh, as decisions about the amount of coverage, the size of the loans and whether to purchase it at all would need to be considered.

C. IMPACT FOR THE INSURANCE INDUSTRY

The consequences for the insurance industry would likely be significant in this area, as dramatically expanding the market, which is currently very limited,²²⁰ would create incentive for more insurers to offer these policies. The pool of potential insureds would grow exponentially overnight, allowing companies already featuring these policies to offer more of them and other underwriters currently not in the market to enter the market. Lower premiums would likely result because insurers could better spread the risks of these policies and purchasers would have more options available to them. Furthermore, the increased frequency of the issuance would allow insurers to better tailor the policies to effectively protect the athletes while providing maximum value to the insurers.

²¹⁹ *Id.*

²²⁰ Crosner, *supra* note 37.

VIII. CONCERNS REGARDING THE IMPLEMENTATION OF LOSS OF VALUE POLICIES

A. THE MORAL HAZARD PROBLEM

The largest concern regarding the student-athletes and the implementation of loss of value coverage is the moral hazard problem. The belief here would be that athletes, if covered by a loss of value policy, would be free to take more chances as collegiate players because the insurance coverage protects them if anything goes wrong. While the concern may be legitimate, it is unlikely that athletes will suddenly become more reckless as a result of having a policy. For many of these athletes, professional sports are their meal ticket, and they already take risks and routinely put their bodies on the line while playing for their college teams. This approach stems from a belief at the core of sports – the concept of “team” – which encourages giving full effort in order to help your team succeed. The motivation behind going full bore can also be personal – to impress professional scouts. Either way, athletes already take chances with their bodies by virtue of being on the field. The presence of a loss of value policy is unlikely to increase their risk taking.

There will always be exceptions, but the vast majority of athletes see their bodies as the means through which they will earn a living. It would be incredibly shortsighted for them to risk their long-term health in hopes of a quick cash out. Furthermore, the policies themselves work to prevent these kinds of issues. The fact that the policies usually do not pay out full value lost in a draft fall, but only a percentage of it, works to ensure that realizing full draft potential is the more lucrative option for the athlete.

B. INCREASED LITIGATION STEMMING FROM THE POLICIES

Because athletes would be far more likely to collect on these policies as opposed to catastrophic or total disability coverage,²²¹ there is likely to be an increase in litigation. It may be difficult in some circumstances to discern whether an athlete's drop in the draft was based

²²¹ Fixler, *supra* note 87. There have been very few instances of collection under both Catastrophic Injury Insurance and E.S.D.I. This is due in large part to medical advances that turn many would-be career-ending injuries into simply limiting ones, thereby preventing payouts under those policies. *Id.*

on an injury suffered during the collegiate season or an off-the-field issue. For example, an insurer may claim it was a student-athlete's legal troubles that caused teams to choose him later, while the athlete will claim it was the injury. There is also the problem of proof, as both sides' contentions would be nearly impossible to prove either way, absent a poll of each professional team as to exactly why they passed on that specific player. It is easy to see how this process could spiral out of control.

C. LACK OF PARTICIPATION IN THE PROGRAM

One concern is that even if loss of value coverage were offered, there is no real demand for this type of protection. In other words, this is a solution without a problem. While this contention may have some merit, it may be too difficult to tell whether or not this demand exists, due in large part to the fact that it is currently prohibited. It is impossible to know what the interest would be in an environment in which student-athletes were free to pursue this type of coverage.

While it is very likely that a select few athletes would purchase these types of policies, this does not mean that there is no desire for them. E.S.D.I. coverage was instituted despite the same concern. E.S.D.I. is targeted to a very specific subset of collegiate athletes, yet it remains viable and enrollment is consistent, despite its low payout totals.²²² Loss of value policies would presumably pay out substantially more often than total disability ones, thereby increasing their attractiveness among players. Even with a relatively low enrollment, the importance of the coverage is still substantial, given that the losses being insured are often in the eight-figure range.

D. FINANCIAL BURDEN

One legitimate concern would be that the high cost of these policies and their appeal may cause athletes for whom the price of the coverage may be outside their means to pursue them. It is easy to imagine an athlete, projected in the mid-to-low rounds of his sport's professional draft, securing an expensive policy through a costly loan, and then subsequently failing to be selected in that draft due to circumstances other than injury (i.e., off-the-field issues). The athlete would still be on the hook to repay the expensive loan, but would not be able to collect on the

²²² *Id.*

policy, thereby incurring a potentially crippling amount of debt. While the concern here is certainly foreseeable, the NCAA should not use it as a rationale for denying availability. It is the province of each individual to decide for himself as to whether he wants to risk incurring substantial debt to protect his future interests.

IX. CONCLUSION

In conclusion, the NCAA's prohibition on loss of value insurance leaves its student-athletes unable to cover themselves. The organization's current bylaws and rules as they pertain to insurance are flawed. Although the NCAA provides viable insurance options, it fails to allow its student-athletes to protect themselves in an area in which there is an increasing need for protection – loss of monetary value due to lower draft position. Advances in medical technology and procedures have substantially decreased the rate of occurrence for career-ending injuries, thereby decreasing the viability of the NCAA's current total disability insurance programs. Further, it is a general principle that individuals should be allowed to protect themselves if they have the means and desire to do so, yet the NCAA disallows this. If student-athletes, by virtue of current professional draft rules, are essentially forced to play one to three years of collegiate sports and risk their physical and financial livelihood, they should be permitted to protect themselves. Whatever the outcome of the ongoing debate over paying college athletes,²²³ it is clear that even if student-athletes should not be allowed to gain something from their participation in collegiate sports, they should, at the very least, be allowed to avoid losing anything from it.

A legal challenge to the NCAA over this prohibition will likely be successful, provided the challenger can overcome the traditional high level of deference courts give to the NCAA. Monetary damages would be difficult to obtain, as they would require an athlete to suffer an injury beforehand. Student-athletes would be better served seeking injunctive

²²³ See *O'Bannon v. Nat'l Collegiate Athletic Ass'n*, 7 F. Supp. 3d 955 (N.D. Cal. 2014), *appeals filed*, No. 14-16601 (9th Cir. Aug. 21, 2014), No. 14-17068 (Oct. 21, 2014); see also Patrick Hruby, *The End of Amateurism?*, SPORTS ON EARTH (July 2, 2013), <http://www.sportsonearth.com/article/52416070/> (discussing the potential impact of *O'Bannon* on the NCAA landscape). An in-depth examination of the merits of these arguments is beyond the scope of this Note and warrants further analysis.

relief that permits them to obtain financing to purchase expensive loss of value policies.

The NCAA could implement this coverage in a number of ways, either as the result of a court decree or as a result of its own determination, ranging from providing it themselves to simply creating a rule that allows student-athletes to seek it privately. Such a move by the NCAA would not be without its consequences and concerns but is ultimately necessary given the substantial risks for student-athletes in its absence. While the market for such coverage is somewhat limited, it remains necessary due to the fact that there are millions of dollars at stake for hundreds of young men and women. For now, though, when it comes to securing their future earnings, student-athletes are finding that they cannot cover themselves.

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