# WITH LIBERTY AND REINSURANCE FOR ALL: THE DEEP CASE FOR A GOVERNMENT BACKSTOP IN HEALTH CARE

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ABSTRACT

One long-overlooked government function is the provision of reinsurance to insurers and other private entities to help absorb catastrophic costs when losses exceed what those institutions could be expected to bear. Yet the U.S. government fails to reinsure the health plans of ordinary Americans, a step that would shield them from outlier health events. Consider, by contrast, the longstanding federal guarantee to banks and depositors against unusual liquidity risk. The lack of an explicit state-sponsored backstop for health risk is often taken to reflect a national aversion to entitlements. This Article challenges that premise by calling attention to the many other realms in which the government provides robust material guarantees against catastrophic risk, if not to the individual beneficiary, then to the primary private insurer or financier who provides access to those goods or services. Federal reinsurance stabilizes the public's access to benefits that we collectively deem vital, including not just banking, but also housing, agricultural commodities, higher education, and pensions. These commitments suggest not a reluctance but instead a well-established American belief in the concept of "the government as reinsurer of last resort." In this light, the nation's failure to provide state-sponsored reinsurance for health care is an unwarranted neglect of the state's power and obligation to absorb high-magnitude losses, smoothing out and shoring up the underlying private risk market when it comes to people's health. Given all the areas in which government reinsurance is already a fact of life, health care risks should at least be on equal footing.

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## INTRODUCTION

Health policy sits at the fulcrum of political contest in our gravely polarized time. In the most recent Presidential election, Democrats hailed health coverage achievements like the Affordable Care Act (ACA) yet demanded more.[1] Meanwhile, Republicans rallied their tribe around ACA "repeal-and-replace" while cheering litigation to strike the entire law.[2] The handling of the pandemic shapes every Administration's political fortunes even as it roils the lives and livelihoods that underlie the political

1. Dylan Scott, *The Real Differences Between the 2020 Democrats' Health Care Plans, Explained*, VOX (Dec. 19, 2019, 8:00 AM), https://www.vox.com/policy-and-politics/2019/12/19/21005124/2020-presidential-candidates-health-care-democratic-debate.

2. Katie Keith, *Taking Stock of Republican Health Policy in the Trump Era*, HEALTH AFFAIRS (Aug. 21, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200821.513686/full/.

pageantry. Going forward, the potential for agreement on health coverage seems vanishingly slim.

At least one policy measure, however, has occupied a narrow ground of bipartisan agreement: government reinsurance of health coverage.[3] This Article argues for the prospects of reinsurance as an attractive grounding principle for health reform in the near term. It mounts this argument by showing how this norm of state-sponsored reinsurance has been conventionally embraced, even deeply rooted, throughout the U.S. tradition.

What is reinsurance? Some call it "insurance for insurers."[4] While primary property insurers may cover certain categories of damage as an ordinary matter, in the event of a catastrophic event like a terrorist attack, claims generally exceed what insurers can absorb.[5] Thus, after 9/11, Congress established a government-sponsored reinsurance program by passing the Terrorism Risk Insurance Act (TRIA).[6] Under the terms of TRIA, a primary insurer knew that once it paid out a set percentage (20%) of the premiums it earned in the previous year then 90% of any claims above that "attachment point" would be paid by the federal government out of funds to which all primary insurers must contribute.[7]

In the context of health coverage, government-sponsored reinsurance is the exception rather than the rule. But when it appears, it often takes the form of a per-beneficiary policy whereby the reinsurer, in this case the government, assumes the obligation to pay claims incurred by a given enrollee once those losses exceed an annual attachment point.[8] The Centers for Medicare and Medicaid Services (CMS) has, for example, quietly built a de facto reinsurance policy into its risk adjustment formula for ACA plans, kicking in 60% of medical costs beyond a million dollars in per-enrollee claims.[9]

As demonstrated by these examples, primary insurers with reinsurance protection are partially shielded from the risk of large catastrophic

3. *See* John V. Jacobi, *The Present and Future of Government-Funded Reinsurance*, 51 ST. LOUIS UNIV. L.J. 369, 370 (2007) (noting the somewhat surprising "agreement among very different advocates that catastrophic costs are properly subject to social pooling.").

4. *See infra* note 29.

5. *See infra* text accompanying notes 356–371.

6. *See* Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, 116 Stat. 2322 (2002) (codified as amended in various sections of 15 U.S.C.).

7. *See id.*; *see also* CONG. RSCH. SERV., R45707, TERRORISM RISK INSURANCE: OVERVIEW AND ISSUE ANALYSIS FOR THE 116TH CONGRESS 4 (2019). Congress has since modified the threshold and amount of government reinsurance under the Terrorism Risk Insurance Act.

8. *See infra* text accompanying notes 40–50.

9. *See* HSS Press Office, *HHS Announces New Policy to Make Coverage More Accessible and Affordable for Millions of Americans in 2023*, THE DEP'T HEALTH & HUM. SERVS. (Apr. 28, 2022), https://www.hhs.gov/about/news/2022/04/28/hhs-announces-new-policy-make-coverage-more-accessible-affordable-for-millions-americans-in-2023.html.

claims events that might otherwise require them to carry excessive capital reserves.[10]

But reinsurance as a policy device has a broader, nontechnical resonance. How do we decide when risk should be backstopped, and under what conditions? When does an outcome count as catastrophic, beyond what we expect our existing institutions to absorb? Who gets a bailout, and who must take the consequences of their bad bets? The question of who enjoys government reinsurance can help us decode the political economy of our time. As an ever-growing body of literature documents, the U.S. state exerts a strong hand in economic development and has always done so.[11] This hand, far from "invisible," has been obscured by the use of reinsurance, and this Article seeks to lift the scrim. After a brief background on reinsurance in Part I, this argument proceeds in three parts. In Part II, this Article describes how in recent years, amid efforts to disrupt the ACA's functions in stabilizing the background conditions for health care finance, reinsurance has emerged as a rare point of agreement. The Article will look at both federal and state activity. As Jeanne Lambrew, one of the architects of the ACA, has observed, "Reinsurance was the only proposal in both the Republicans' 2017 'repeal and replace' bills and the Democratic alternatives."[12]

Part III turns a historical gaze to the health sector, revealing how the norm of reinsurance can both fit and explain our history of health reform, even if this norm is yet to be fully realized.

In Part IV, I take a comparative sectoral approach, arguing that the reinsurance tool pervades other domains and should be at least as available to backstop health care. For all our vaunted hostility to entitlements, it turns out that whenever we as a nation have deemed a material interest—from housing, food crops, education, or even banking—to be crucial, we have provided state guarantees, albeit not to the individual beneficiary, but to the primary private "insurer" who bridges beneficiary access to that good or service.

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10. *See* M. Kent Ranson & Sara Bennett, *Role of Central Governments in Furthering Social Goals Through Microinsurance Units*, *in* SOCIAL REINSURANCE: A NEW APPROACH TO SUSTAINABLE COMMUNITY HEALTH FINANCING 258 (David M. Dror & Alexander S. Preker eds., 2002); *see also* Govind Persad, *Expensive Patients, Reinsurance, and the Future of Health Care Reform*, 69 EMORY L.J. 1153, 1178 (2020).

11. *See* MARIANA MAZZUCATO, THE ENTREPRENEURIAL STATE 18 (2011); *see also* SARAH L. QUINN, AMERICAN BONDS: HOW CREDIT MARKETS SHAPED A NATION 14 (2019) (citing Fred Block, *Swimming Against the Current: The Rise of a Hidden Developmental State in the United States*, 36 POLS & SOC'Y 169–206 (2008)). Other works in this broad genre include BRIAN BALOGH, A GOVERNMENT OUT OF SIGHT: THE MYSTERY OF NATIONAL AUTHORITY IN NINETEENTH-CENTURY AMERICA (2009); JACOB S. HACKER & PAUL PIERSON, AMERICAN AMNESIA: HOW THE WAR ON GOVERNMENT LED US TO FORGET WHAT MADE AMERICA PROSPER (2016); Robert C. Hockett & Saule T. Omarova, *Public Actors in Private Markets: Toward a Developmental Finance State*, 93 WASH. U.L. REV. 103 (2015).

12. Ellen Montz & Jeanne Lambrew, *The Next Big Thing in Health Reform: Where To Start?*, AMERICAN PROSPECT (Jan. 2, 2018), https://prospect.org/health/next-big-thing-health-reform-start/.

If, as I show, reinsurance is our go-to tool, we should use it openly rather than haphazardly, and across the board for health care, just as we backstop crop insurance, property in the event of terrorism or floods, employer pensions, and more. Failure to do so, even as the government backs so many other material interests, represents an un-scrutinized political decision to depreciate human health relative to other concerns including mortgages and banking.

The history of the patchwork system of health care laws in the United States has been a story of reinsurance as yet incomplete. Medicaid was established in part for "the aged, blind, and disabled,"[13] as well as the "medically needy," who often found themselves in institutional care; these categories reflect concern for some of the costliest health care utilizers whom no one else would insure.[14] The fight for Medicare was supported by unions and employers to off-load costly retiree health insurance onto the government.[15] Many of the eligibility groups later added to Medicare also exemplified the reinsurance principle whereby high-cost risks that would skew private insurance risk pools were ceded to the government.[16] For instance, in 1972, the United States granted Medicare eligibility to individuals who are permanently disabled and had qualified for Social Security for at least two years, even if they were under sixty-five years old.[17] At the same time, under sixty-five end-stage renal disease patients were added.[18] In 2001,[19] Medicare was extended to all Americans with amyotrophic lateral sclerosis (ALS).[20] Even the Employee Retirement Income Security Act (ERISA), a notoriously deregulatory federal health law, was itself an employer benefit plan (or more specifically, pension plan) reinsurance act.[21] ERISA's displacement of state laws with its own scant remedial scheme functions as limited liability for employer-sponsored

13. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

14. Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FIN. REV. 45, 47 (2005).

15. *Id.*

16. *See Using High-Risk Pools to Cover High Risk Enrollees*, AM. ACAD. OF ACTUARIES (2017), https://www.actuary.org/content/using-high-risk-pools-cover-high-risk-enrollees; *see also* SCOTT SZYMENDERA, CONG. RSCH. SERV., RS22195, SOCIAL SECURITY DISABILITY INSURANCE (SSDI) AND MEDICARE: THE 24-MONTH WAITING PERIOD FOR SSDI BENEFICIARIES UNDER AGE 65 2 (Jan. 7, 2009).

17. *See* Social Security Act of 1972, Pub. L. 92-603 §§ 201, 299I, 86 Stat. 1329, 1373, 1463; *see also* SZYMENDERA, *supra* note 16, at 2.

18. *See* Paul W. Eggers, *Medicare's End Stage Renal Disease Program*, 22 HEALTH CARE FIN. REV. 55, 55–60 (2000).

19. José F. Figueroa, Xiner Zhou, & Ashish K. Jha, *Characteristics and Spending Patterns of Persistently High-Cost Medicare Patients*, 38 HEALTH AFFS. 107, 109 (2019) (observing that end-stage renal disease patients were among the categories of consistently high-cost Medicare patients).

20. Louise Norris, *Medicare Eligibility for ALS and ESRD Patients*, MEDICARERESOURCES.ORG (July 2, 2021), https://www.medicareresources.org/medicare-eligibility-and-enrollment/medicare-eligibility-for-als-and-esrd-patients/.

21. *See* U.S. DEPT. OF LABOR, FAQS ABOUT RETIREMENT PLANS AND ERISA, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/retirement-plans-and-erisa-for-workers.pdf (last visited Oct. 28, 2022).

health plans.[22] Thus, in the health context, ERISA constitutes a government-sponsored risk ceiling that distributes the risks of benefit denial across patient–beneficiaries rather than employers.[23]

This Article then explores the possibility that if the United States was to finally embrace health care as part of the social compact, doing so in the form of a duty to reinsure health would fit with our history and a distinctively American idiom of affirmative state provision.[24]

As one might suspect from my stated strategy of advocating from deeply rooted familiarity, health reinsurance is not a "new" proposal. As Mark Hall has observed, the interest in health reinsurance is cyclical,[25] and we are on the upswing of the cycle now. We are only in a position to consider it seriously because of all the groundwork that scholars have laid throughout prior cycles.[26] The fortunes of this idea have waxed and waned. It is time to consider it anew.

## I. WHAT IS REINSURANCE?

### *A. State-Sponsored or Private Reinsurance?*

Above I discussed two highly circumscribed examples of government-sponsored reinsurance in the health, property, and casualty insurance sectors, describing its use to protect primary insurers against some defined layer of catastrophic loss. Throughout this piece, I will contend that when the government provides a backstop against extreme losses to stabilize the underlying private risk market, the state is furnishing a form of government-sponsored reinsurance. State-sponsored reinsurance establishes a risk ceiling above which private risks are transferred to the government to be spread or in some way publicly distributed.[27]

Primary insurers seek out reinsurance when loss exposure outpaces insurers' willingness to carry risk.[28] "Insurance for insurers"[29] is commercially available for private purchase.[30] In this Article, I focus on state-

22. *See* Marie-Laure Djelic & Joel Bothello, *Limited Liability and Its Moral Hazard Implications: The Systemic Inscription of Instability in Contemporary Capitalism*, 42 THEORY & SOC'Y 589, 590–92 (2013) (suggesting that limited liability and insurance share a number of features, including moral hazard: "This leads us . . . to argue that the two notions have become structurally connected over time in the particular form of capitalism that dominates our contemporary world and that this is having highly significant consequences.").

23. *See* Mark A. Hall, *Government-Sponsored Reinsurance*, 19 ANNALS HEALTH L. 465, 467 (2010) [hereinafter *Government-Sponsored*].

24. *See generally* DAVID A. MOSS, WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER (2002).

25. *Government-Sponsored*, *supra* note 23, at 465–67.

26. Katherine Swartz, Randall Bovbjerg, Mark Hall, John Jacobi, and Amy Lutsky, to name just a few.

27. *See Government-Sponsored*, *supra* note 23, at 465–67.

28. KATHERINE SWARTZ, COMMONWEALTH FUND, REINSURANCE: HOW STATES CAN MAKE HEALTH COVERAGE MORE AFFORDABLE FOR EMPLOYERS AND WORKERS vii (2005) (discussing Healthy New York, a state reinsurance program).

29. Mark A. Hall, *The Three Types of Reinsurance Created by Federal Health Reform*, 29 HEALTH AFFS. 1168, 1168 (2010) [hereinafter *Three Types of Reinsurance*].

30. *Government-Sponsored*, *supra* note 23, at 472.

sponsored rather than private reinsurance in part because the commercial reinsurance market in the United States escapes many of the laws that otherwise govern health insurers, including those prohibiting health-status-based exclusions or underwriting. Therefore, private reinsurance in its current form has not shown itself capable of affordably backstopping health-based risk.[31] Government-sponsored reinsurance can perform the same function by collecting assessments (in lieu of premiums) and pooling them in a state-organized fund that shields the primary insurer from risks beyond a designated attachment point.[32] Apart from organizing such a fund, the government can also subsidize that fund from sources like general tax revenue.[33]

### *B. Basic Design of Reinsurance*

#### 1. Primary Features

Reinsurance policies have what is called an attachment point, which is a threshold condition that triggers reinsurance coverage.[34] An attachment point corresponds to a deductible under a primary insurance policy.[35] Both mark the threshold of expenditure that the insured must incur before the third party's payment obligations take effect.[36] For instance, the Medicare prescription drug benefit, added by then-President George W. Bush in 2003, features a deductible of $445, meaning that Medicare seniors receiving a "standard" benefit in a stand-alone private prescription drug plan in the 2021 policy year must first spend $445 in drug costs out of their own pocket before their plan begins to pay claims.[37]

However, under Medicare Part D, the private plan itself also enjoys a measure of insurance—in this case, the proverbial "insurance for insurers."[38] Once the enrollee's total pharmaceutical expenditures reach an attachment point of $10,048, qualifying as catastrophic, the prescription drug insurer enjoys partial protection from claims.[39] The federal government absorbs 80% of the drug costs that the enrollee incurs above that catastrophic threshold.[40] The fraction of loss that the reinsurer agrees to

31. *See* Persad, *supra* note 10, at 1174.
32. *See* Ranson & Bennett, *supra* note 10, at 258.
33. *Id.* (noting that "[g]overnment may set up a reinsurance scheme (or solidarity fund). Participating [insurers may] contribute to this pool, . . . [g]overnment may establish this fund but not contribute to the pooled resources or establish the fund and make some contribution to the pooled resources (a combination of reinsurance and subsidy).").
34. *Government-Sponsored*, *supra* note 23, at 467.
35. *Id.*
36. *Id.*
37. *An Overview of the Medicare Part D Prescription Drug Benefit*, KFF (Oct. 13, 2021), https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/ [hereinafter *Overview*]; Thomas R. Oliver, Philip R. Lee, & Helene L. Lipton, *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 288 (2004).
38. *Overview*, *supra* note 37.
39. *Id.*
40. *Id.*

pay above the attachment point is 80% in this Medicare drug example.[41] Meanwhile, the fraction that the private insurer retains is called coinsurance.[42] In the Medicare Part D benefit, the coinsurance turns out to be only 15%, with the other 5% of costs reverting to the Medicare beneficiary.[43] This continuing beneficiary cost burden of 5% of prescription drug expenses even above the catastrophic threshold is finally set to be eliminated in 2024 because of the Biden Administration's recently passed Inflation Reduction Act.[44]

Some reinsurance policies are not open-ended. They can feature a cap or ceiling beyond which loss passes back to the primary insurer.[45] Moreover, reinsurance characteristically reimburses post hoc for actual expenses that the insurer incurs, as compared to risk adjustment or other risk stabilization devices that distribute money to insurers based on their predicted losses.[46]

In the health insurance world, reinsurance can take the form of an "aggregate" stop-loss policy, or a "specific excess" (also called an "excess of loss") policy.[47] Aggregate policies "define the [attachment point by the] total amount of benefits paid to all participants or beneficiaries beyond which the insurance company will indemnify the plan," whereas "specific" policies "define [it by] the level of benefits paid to individual beneficiaries beyond which the insurance company will indemnify the plan."[48]

Sometimes an insurer will avail itself of both aggregate and specific excess protection because these two devices have slightly different functions. Medicare's Inpatient Prospective Payment System (IPPS) helps illustrate this point. Under the IPPS system, Medicare pays a preset average payment to any given hospital for every episode of illness that the hospital treats.[49] Because the average payment disregards the actual medical resources consumed in any given patient's case, this system forces the hospital to act as a partial insurer against high hospitalization costs generated

41. *See* Cynthia Cox, Ashley Semanskee, Gary Claxton, & Larry Levitt, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, KFF (Aug. 17, 2016), https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

42. *Id.*

43. *Overview*, *supra* note 37.

44. The Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 11201(b), 136 Stat. 1818, 1878, (2022) (codified as amended in 42 U.S.C. § 1395w–115(b)).

45. *Government-Sponsored*, *supra* note 23, at 467.

46. KATHERINE SWARTZ, REINSURING HEALTH: WHY MORE MIDDLE-CLASS PEOPLE ARE UNINSURED AND WHAT GOVERNMENT CAN DO 102 (2006) [hereinafter REINSURING HEALTH].

47. REINSURING HEALTH, *supra* note 46, at 104 (describing another form, quota loss (or quota share) reinsurance, as "not as prevalent in connection with health insurance . . . ."); *see also* Harry L. Sutton, *The Role of Reinsurance Under Health Reform*, 20 REC. SOC'Y ACTUARIES 741, 746 (1994). The policy rationale for this is that it sharpens the effect of reinsurance against the "primary insurer's" strong incentives to engage in risk selection. *See* Emmett B. Keeler, Grace M. Carter, & Sally Trude, *Insurance Aspects of DRG Outlier Payments*, 7 J. HEALTH ECON. 193, 196 (1988); *see also Outlier Payments*, CMS, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier (last visited Oct. 28, 2022).

48. Am. Med. Sec. v. Bartlett, 111 F.3d 358, 361 (4th Cir. 1997) (emphasis added).

49. Keeler et al., *supra* note 47, at 193.

by Medicare beneficiaries.[50] However, Medicare also backs that hospital with two kinds of "reinsurance." When transitioning to an IPPS, Medicare typically provides a transitional period where it limits the total annual hospital losses under the new payment system.[51] This protection amounts to an aggregate stop-loss policy.

Medicare additionally makes "specific loss" payments to hospitals for "outlier" cases exceeding some fixed loss, set at roughly $27,000 per case for fiscal year 2021.[52] Commentators have explained that a reinsurance threshold defined in terms of an anomalously expensive individual case is better suited to the policy goal of reducing discrimination against sicker patients:

> In addition to reducing financial risk to hospitals, outlier payments . . . make payments more equitable by giving additional money to hospitals that treat sicker and more expensive patients than average . . . reduc[ing] the problems of access for patients who can be identified by hospitals as likely to need very expensive treatment. . . . These other goals explain why the government [] has kept outlier payments on a case-by-case basis, even though hospital risk . . . is minimized by payments that set a limit on annual hospital losses.[53]

2. Functional Purposes of Reinsurance

The description of what reinsurance is foreshadows the discussion of its functions in the context of medical loss.

Medical losses are notoriously expensive, driving significant economic dislocation.[54] And the distribution is highly skewed to the right tail, meaning that relatively rare, extreme medical catastrophes consume the bulk of overall national health spending.[55] In 2019, only 2.5% of enrollees in the individual market exceeded a theoretical attachment point of $20,000.[56] But this 2.5% represents nearly half of this population's medical expenditures.[57] Meanwhile, half the population spends close to nothing

50. *Id.* at 203, 209–10, 212–13. *See also infra* text accompanying notes 240–247.

51. *See, e.g.*, CMS, MEDICARE CLAIMS PROCESSING MANUAL ch. 3, § 190.4.2.1 (2020).

52. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 85 Fed. Reg. 58,432, 59,056 (Sept. 8, 2020) (setting the outlier payment at $27,195 for fiscal year 2021).

53. *See* Keeler et al., *supra* note 47, at 194.

54. Andrea S. Christopher, David U. Himmelstein, Steffie Woolhandler, & Danny McCormick, *The Effects of Household Medical Expenditures on Income Inequality in the United States*, 108 AM. J. PUB. HEALTH POL'Y 351, 351–54 (2018); *see* Raymond Kluender, Neale Mahoney, Francis Wong, & Wesley Yin, *Medical Debt in the US, 2009–2020*, 326 JAMA 250, 250–56 (2021).

55. *See, e.g.*, Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 HEALTH AFFS. 9, 9–10 (2001).

56. Lynn Blewett, Coleman Drake, & Brett Fried, SHADAC, Modeling State-Based Reinsurance: One Option for Stabilization of the Individual Market, Presentation at Association for Public Policy and Management (APPAM) Conference, at 13 (Nov. 6, 2018).

57. *Id.* at 16.

each year in medical costs, incurring just 3% of national health expenditures.[58]

This character of medical costs, featuring high-loss, low-frequency events, lends itself to insurability.[59] Why then do medical insurers need reinsurance? One purpose of reinsurance is to reduce an insurer's unwanted exposure to correlated (covariant) loss.[60] For instance, crop insurers seek reinsurance because crop failure is often caused by weather events that contemporaneously impose losses upon many enrollees.[61] Those losses are not statistically independent of one another as all farms in a region experience the same weather.[62] Is health coverage typically afflicted by correlated loss? Indeed, Medicare's financing woes testify to how an aging society can generate cost exposures that are not stochastically independent.[63] The task of insuring a new population, such as those now enrolled in Obamacare, inevitably carries correlated risk.[64] More broadly, health insurance in America confronts correlated risk whenever regulatory conditions foster greater market concentration among providers or more generous regulatory monopolies for the pharmaceutical industry.[65] These circumstances lead to sector-wide profiteering and cost inflation.[66]

Mark Hall has cleanly catalogued several other public policy justifications for reinsurance. Reinsurance can serve to (1) reduce premiums, (2) prevent insurer discrimination against higher risk populations, and (3) boost private insurer participation in "new government programs that alter basic market conditions . . . ."[67]

These public policy functions help more than just the most visible beneficiaries, i.e., the catastrophically ill patients who rack up medical bills; they also benefit low-risk individuals:

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58. William W. Yu & Trena M. Ezzati-Rice, *Statistical Brief #81: Concentration of Health Care Expenditures in the U.S. Civilian Noninstitutionalized Population*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (May 2005), https://meps.ahrq.gov/data_files/publications/st81/stat81.shtml.

59. *See, e.g.*, *Insurable Risk*, SOC'Y OF ACTUARIES ACTUARIAL TOOLKIT (2022), https://actuarialtoolkit.soa.org/tool/glossary/insurable-risk.

60. David M. Dror, *Reinsurance of Health Insurance for the Informal Sector*, 79 BULL. WORLD HEALTH ORG. 672, 677 (2001).

61. Joseph W. Glauber, *Crop Insurance Reconsidered*, 86 AM. J. OF AGRIC. ECON. 1179, 1179–95 (2004).

62. *Id.* at 1182–85.

63. *See* THEODORE R. MARMOR, THE POLITICS OF MEDICARE 11–15, 127–31 (James D. Wright ed., 2d ed. 2000). *See also* THE BD. TRS. FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TR. FUNDS, The 2020 ANNUAL REPORT 1–3, 5, 12 (2020).

64. *Government-Sponsored*, *supra* note 23, at 472 (describing how reinsurance is especially useful when insurers are entering new markets).

65. *See, e.g.*, JAIME S. KING, SAMUEL M. CHANG, ALEXANDRA D. MONTAGUE, KATHERINE L. GUDIKSEN, AMY Y. GU, DANIEL ARNOLD, & THOMAS L. GREANEY, PREVENTING ANTICOMPETITIVE HEALTHCARE CONSOLIDATION: LESSONS FROM FIVE STATES 6, 7–10, 14–15, 21–22 (2020); *see also* ROBIN FELDMAN, DRUGS, MONEY, AND SECRET HANDSHAKES: THE UNSTOPPABLE GROWTH OF PRESCRIPTION DRUG PRICES 26–29, 34–41 (2019).

66. FELDMAN, *supra* note 65, at 28.

67. *Three Types of Reinsurance*, *supra* note 29, at 1169.

> Reinsurance [helps low-risk individuals] in at least five distinct ways. First, if the government injects funds for reinsurance, the low-risk enrollees shed some of the economic burden of subsidizing the highest medical costs. Second, reinsurance reduces volatility for primary insurers so they need not load on an additional risk premium, making health coverage more affordable. Third, by eliminating the advantages of [discriminatory] risk selection, reinsurance helps primary insurers trim the expense of aggressive risk selection activities. Fourth, to the extent that reinsurance blunts incentives for risk selection, it benefits not only high-risk individuals who might otherwise be excluded from coverage, but also the low-risk consumer who has access to a better product. According to the famous Rothschild–Stiglitz model, reducing risk selection benefits healthier low-risk individuals insofar as they might otherwise have been offered only bare-bones products on the insurance market. Finally, to the extent that more private insurers are encouraged to enter the market, price competition can exert downward pressure on premiums.[68]

By addressing the claims of the most medically expensive patients, we improve the stability, affordability, and appeal of health coverage for all Americans.

How reinsurance performs relative to other policy tools directed at these same goals is, of course, contingent upon the circumstances. Even now, for instance, the Biden Administration's COVID-19 relief measures have extended tax credits to nearly all enrollees on the ACA exchanges.[69] These circumstances blunt the force of measures like reinsurance or the public option aimed at reducing premiums, because virtually all exchange consumers will be protected from paying any more than 8.5% of their income for benchmark silver coverage.[70] But even under different background conditions, reinsurance could prove less efficient at reducing premiums compared to equivalent spending on direct premium subsidies,[71] which themselves are less efficient at ensuring coverage than Medicaid.[72] This relative inefficiency of reinsurance as a premium-reduction tool is because medical, in contrast to other lines of insurance, is driven

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68. Christina S. Ho, *Health Reinsurance as a Human Right*, INS. & HUM. RTS (forthcoming) (manuscript at 7 n.19), http://ssrn.com/abstract=3608424 (citing Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. OF ECON. 629, 629–49 (1976)).

69. American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9661-3, 135 Stat. 4, 8–9 (2021) extended in The Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 12001(b), 136 Stat. (2002).

70. Jason Levitis & Daniel Meuse, *The American Rescue Plan's Premium Tax Credit Expansion—State Policy Considerations*, BROOKINGS (Apr. 19, 2021), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/04/19/what-does-the-american-rescue-plans-premium-tax-credit-expansion-and-the-uncertainty-around-it-mean-for-state-health-policy/ (arguing still that states should not turn away from reinsurance because the COVID-19 premium tax credit expansions are as yet temporary).

71. *See Government-Sponsored*, *supra* note 23, at 470; *Three Types of Reinsurance*, supra note 29, at 1171.

72. *See, e.g.*, CONG. BUDGET OFF., 56571, FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER 65: 2020 TO 2030 1–2 (2020) (showing lower average federal subsidies for recipients by type of health insurance for Medicaid than for nongroup coverage).

comparatively less "by the relatively few 'catastrophic' or extraordinarily high expenses at the top end of the distribution,"[73] Hall explains. He continues, "Instead, changes in cost are driven mainly by a larger number of people in an intermediate zone with moderately or substantially high costs. Therefore, to reduce overall claims costs substantially, it is necessary to set the attachment point at a much lower level than is often imagined."[74]

Even if costs are not driven primarily by high-cost enrollees, risk-selection may be,[75] and to the extent that reinsurance is intended to affect risk-discrimination rather than costs, it may be a relatively more promising policy fit than premium vouchers or tax credits, which are aimed at the most price-sensitive insurance consumers, who represent a relatively healthier segment of the population.[76]

3. Reinsurance Versus High-Risk Pools: Distinctions and Overlap

Some of the most recent policy proposals in this space have been variously termed reinsurance proposals or "invisible high-risk pools."[77] High-risk pools offer coverage to those already risk-classified, and thereby excluded or priced out of other products.[78] As Swartz puts it, "Reinsurance characteristically reimburses post hoc, for actual losses incurred. This feature generally distinguishes reinsurance from other types of risk stabilization, such as risk adjustment, which distributes money to insurers based on their *ex ante*, predicted losses."[79] Some may protest that health sector observers use the term "reinsurance" loosely, eliding the distinction between reinsurance and high-risk pools. Arguably, one type of so-called reinsurance program, where the cession of claims is based on an attachment point defined by the beneficiary's high-cost diagnosis, should be called an invisible high-risk pool instead.[80]

Alaska, along with other U.S. states, sought waivers of otherwise applicable federal requirements in order to experiment with their administration of the ACA.[81] Indeed the vast majority of the § 1332 waivers that states sought were for reinsurance programs to stabilize the exchanges.[82] In Alaska's waiver, though, the "reinsurance" program is structured to pay 100% of the cost of claims associated with any of thirty-three health conditions.[83] These "attachment point" conditions, flagged as significant cost-

73. *Government-Sponsored*, *supra* note 23, at 470.
74. *Id.* at 468–71.
75. *Id.* at 471.
76. *See* Michael Geruso & Timothy J. Layton, *Selection in Health Insurance Markets and Its Policy Remedies*, 31 J. ECON. PERSPECTIVES 23, 32–37 (2017).
77. *See infra* text accompanying notes 102–84.
78. REINSURING HEALTH, *supra* note 46, at 86–87.
79. *Id.* at 102 (emphasis omitted).
80. Persad, *supra* note 10, at 1177–78.
81. *See infra* text accompanying notes 148–183.
82. *See Resource: State-Based Reinsurance Programs via 1332 State Innovation Waivers*, SHADAC, https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers (last visited Oct. 28, 2022).
83. Persad, *supra* note 10, at 1176–78.

drivers, include cystic fibrosis, blood diseases like hemophilia, bone marrow disorders, and end-stage renal disease.[84]

Some might argue that a design where diagnosis triggers payment is technically a program based on *ex ante* risk rather than actual post hoc loss. Therefore, what Alaska and others refer to as "health reinsurance" in this context is perhaps more akin to a high-risk pool. However, the distinction matters little if indeed the conditions, like end-stage renal disease, are certain to be medically costly.[85] I will follow the use of "reinsurance" to include programs whose attachment points are defined by diagnosis.[86] I argue that these policies, though they might fall outside the strictest sense of the term, perform the function of reinsurance, whereby catastrophic losses beyond a certain threshold are off-loaded to stabilize the primary private risk market.

## II. HEALTH REINSURANCE IN THE RECENT POLICY LANDSCAPE

### *A. At the Federal Level*

The ACA itself featured a reinsurance provision designed to serve a classic reinsurance function, namely, the enticement of private plan entry into an unknown market.[87] Because the ACA inaugurated a new breed of private health plan—one that covered a slate of essential health benefits available to virtually all purchasers in the individual market regardless of health status—the implementation of the ACA exchanges came with irreducible uncertainty.[88] By ending exclusions based on health status and preexisting conditions, the ACA could well have uncorked a flood of high-cost enrollees into this new market.[89] To reassure private insurers and encourage them to offer exchange plans nonetheless, the ACA included three premium stabilization programs: a risk-adjustment measure, a risk corridor provision, and a transitional reinsurance provision.[90] Under this temporary reinsurance program, primary insurers owed per-enrollee assessments to a fund that was statutorily set to total $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016.[91] This assessment was pejoratively

84. *Id.* (citing 3 Alaska Admin. Code tit. 3, § 31.540).
85. *See* Figueroa et al., *supra* note 19, at 107–09, 113.
86. Persad, *supra* note 10, at 1174 (describing the vernacular use).
87. *See* Cox et al., *supra* note 41.
88. HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409, 15,411 (Mar. 11, 2013) ("The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented and Exchanges facilitate increased enrollment. The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' risk associated with high-cost enrollees.").
89. *Id.*
90. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, §§ 1341–43, 124 Stat. 119, 209–213 (2010).
91. *Id.* § 1341(b)(3)(B)(iii).

nicknamed the belly-button tax and calculated at $63 per covered life for 2014, $44 for 2015, and $27 for 2016.[92]

The funds were used in turn to reimburse ACA plans 80% of the cost of claims exceeding the per beneficiary attachment point of $45,000.[93] Federal absorption of these costs capped out when the beneficiary's claims reached $250,000.[94] In the latter years of the program, the attachment point rose (to $90,000 for FY 2016), and the federal share of the claims above the attachment point dropped to 50%.[95]

Though the reinsurance provision in the ACA lasted just three years, federal and state officials alike scrambled to extend it. For instance, § 1343 of the ACA authorized risk adjustment, another premium stabilization program, and did so without any statutory time limitation.[96] Therefore, once the ACA reinsurance provision expired, the Obama Administration modified risk adjustment to incorporate the CMS provision this Article describes earlier, assuring government absorption of 60% when enrollee claims exceed $1 million.[97] This provision rolls a layer of reinsurance into the permanent risk adjustment infrastructure of the ACA.

In 2016, when Republicans gained control of both Congress and the Presidency, efforts to undermine the ACA took the form of "repeal-and-replace" legislation.[98] Reinsurance featured prominently in these Republican

92. HHS Notice of Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,120, 73,152, 73,157 (Dec. 7, 2012) (to be codified at 45 C.F.R. 153) (applying the assessment to all commercial lines of business and even when the health plan is acting as a third-party administrator to employer self-insured plans); Louise Radnofsky, *Belly-Button Tax: In or Out of Budget Deal?*, WALL ST. J. (Oct. 14, 2013, 7:20 PM), https://www.wsj.com/articles/BL-WB-41135.

93. AM. ACAD. OF ACTUARIES, ISSUE BRIEF: DRIVERS OF 2015 HEALTH INSURANCE PREMIUM CHANGES 1–4 (2014), https://www.actuary.org/sites/default/files/files/2015_Premium_Drivers_Updated_060414.pdf (estimating that "[r]einsurance program payments for 2014 generally reduced projected net claim costs by about 10 to 14 percent."). *See also* DEP'T OF HEALTH & HUM. SERVS., CENTER FOR MEDICARE AND MEDICAID SERVICES, TRANSITIONAL REINSURANCE PROGRAM: PRO RATA ADJUSTMENT TO THE NATIONAL COINSURANCE RATE FOR THE 2014 BENEFIT YEAR (2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf.

94. *Id.*

95. HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,752 (Feb. 27, 2015).

96. DEP'T OF HEALTH & HUM. SERVS., SUMMARY REPORT ON PERMANENT RISK ADJUSTMENT TRANSFERS FOR THE 2021 BENEFIT YEAR 11 (2022).

97. Kevin Counihan, *Building on Premium Stabilization for the Future*, CMS BLOG (Jan. 11, 2017), https://ccf.georgetown.edu/wp-content/uploads/2016/08/Building-on-Premium-Stabilization-for-the-Future-_-The-CMS-Blog.pdf.

98. LEIGHTON KU, ERIKA STEINMETZ, ERIN BRANTLEY, NIKHIL HOLLA, & BRIAN K. BRUEN, COMMONWEALTH FUND, THE AMERICAN HEALTH CARE ACT: ECONOMIC AND EMPLOYMENT CONSEQUENCES FOR STATES 2 (2017); American Health Care Act of 2017 (AHCA), H.R. 1628, 115th Cong. (2017) (serving as the main legislative vehicle for repeal-and-replace; the bill passed the House but not the Senate). During Senate consideration of H.R. 1628, leadership sought to replace the language of H.R. 1628 with various substitutes, including the Better Care Reconciliation Act of 2017 (BCRA), H.R. 1628, 115th Cong. (2017). BCRA was not introduced as stand-alone legislation, but a version of BCRA was dubbed "skinny repeal," and introduced as an amendment to AHCA. *See* American Healthcare Act of 2017, S. Amdt. No. 667 (2017) (defeated 49–51.); *Motion to Proceed on H.R. 1628: American Health Care Act of 2017*, HEALTHREFORMVOTES.ORG.,

proposals, though in the end, none of them mustered enough support to pass the Senate.[99] Even the pared down "skinny repeal" effort failed ultimately on John McCain's dramatic middle-of-the-night thumbs-down vote.[100]

But it is still noteworthy that H.R. 1628, the Republican House-passed version of the repeal-and-replace legislation, contained a "Patient and State Stability Fund" in § 132, providing up to $15 billion a year to support reinsurance/invisible high-risk pooling and other state programs.[101] Any state that did not establish such a program could rely on a federally-administered fallback paying 75% of claims above a $50,000 attachment point and featuring a $350,000 claims ceiling.[102] An additional $15 million would be available for the Federal Invisible Risk Sharing Program, which would cover claims above an attachment point for individuals with certain conditions who would be ceded to the program.[103]

On the Senate side, the Republican Health Education Labor and Pensions Committee Chair, Lamar Alexander, championed a provision that he called "Alaska for All."[104] It was incorporated into the Better Care and Reconciliation Act text, which never reached a Senate vote.[105] This provision grew to total $132 billion for grants to states to undertake stabilization programs like reinsurance.[106] Senator Susan Collins of Maine, whose state had erected a successful reinsurance/invisible high-risk pool, was a vocal proponent.[107]

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https://www.healthreformvotes.org/congress/roll-call-votes/s167-115.2017 (last visited Oct. 28, 2022).

99. Leigh Ann Caldwell, *Obamacare Repeal Fails: Three GOP Senators Rebel in 49–51 Vote*, NBC (July 27, 2017, 11:45 PM), https://www.nbcnews.com/politics/congress/senate-gop-effort-repeal-obamacare-fails-n787311.

100. Peter W. Stevenson, *The Iconic Thumbs-Down Vote that Summed Up John McCain's Career*, WASH. POST (Aug. 27, 2018, 12:18 PM), https://www.washingtonpost.com/politics/2018/08/27/iconic-thumbs-down-vote-that-summed-up-john-mccains-career/.

101. The American Health Care Act, H.R. 1628, 115th Cong. § 132 (2017); *see also* Joel Allumbaugh, Tarren Bragdon, & Josh Archambault, *Invisible High-Risk Pools: How Congress Can Lower Premiums and Deal with Pre-Existing Conditions*, HEALTH AFFS. (Mar. 2, 2017), https://www.healthaffairs.org/do/10.1377/forefront.20170302.059003.

102. H.R. 1628 § 132.

103. Frederick (Fritz) Busch & Paul R. Houchens, *Reinsurance and High-Risk Pools: Past, Present, and Future Role in the Individual Health Insurance Market*, MILLIMAN (June 6, 2017), https://us.milliman.com/en/insight/reinsurance-and-highrisk-pools-past-present-and-future-role-in-the-individual-health-i#.

104. Erica Martinson, *Murkowski Emerges at Center of Bipartisan Senate Health Care Deal*, ANCHORAGE DAILY NEWS (Oct. 18, 2017), https://www.adn.com/politics/2017/10/18/murkowski-emerges-at-center-of-bipartisan-senate-health-care-deal/. An earlier version of this provision was filed officially as Senate Amendment No. 649 to AHCA, H.R. 1628.

105. H.R 1628 S. Amdt. No. 649 (2017) (history of actions showing that the amendment was not voted on).

106. H.R. 1628, 115th Cong. § 106 (Discussion Draft 2019).

107. KATHLEEN E. ELY, THOMAS D. MURAWSKI, & WILLIAM J. THOMPSON, THE FEDERAL INVISIBLE HIGH RISK POOL: EFFECT ON PREMIUM RATES, INDIVIDUAL MARKETPLACE ENROLLMENT AND USE OF FEDERAL FUNDS 4 (2017); *see also* Mark Hall & Nicholas Bagley, *Making Sense of 'Invisible Risk Sharing'*, HEALTH AFFS. (Apr. 12, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170412.059601/full/; *see also* Patty Wight, *Secret Sauce in Maine's*

Democrats have also favored reinsurance. Representatives Angie Craig and Scott Peters introduced a stand-alone ACA reinsurance bill, proposing $10 billion a year for state reinsurance programs.[108] The funds were fully federal and projected to reduce premiums by 8%.[109] The bill, like the Republican repeal-and-replace bill, the American Health Care Act of 2017, contained a default federal fallback.[110] H.R. 1425 later became the underlying vehicle for an entire slate of ACA enhancements, dubbed "ACA 2.0," that the Democratic House passed 274–179 and which prominently featured reinsurance.[111]

While the Senate failed to take up ACA 2.0 enhancements or any further repeal-and-replace bills, Congress had, by the end of 2017, passed President Trump's Tax Cuts and Jobs Act (TCJA), stripping the individual mandate which had functioned as a key risk ACA stabilization device.[112] In the aftermath, various constituencies espoused reinsurance to fill in the gap. Former Wisconsin Governor Scott Walker, a staunch conservative, signed into law a $200 million reinsurance measure even as he authorized continued challenge to the ACA[113] through the case that culminated in *California v. Texas*.[114] Republican Senator Susan Collins initially demanded reinsurance as a condition of her vote in favor of the Trump tax bill.[115] Fifteen states have since sought and received the flexibility to

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*Successful High-Risk Pool: Enough Money*, ME. PUB. RADIO (May 17, 2017), https://khn.org/news/secret-sauce-in-maines-successful-high-risk-pool-enough-money/.

108. Patient Protection and Affordable Care Enhancement Act, H.R. 1425, 116th Cong. § 106 (2020) (placed on calendar in the Senate); *see also* Charles Gaba, *#ACA2.0 Gets a Vote at Last: A Deep Dive into #HR1425, the Affordable Care Enhancement Act*, ACA SIGNUPS.NET (June 23, 2020, 1:48 AM), https://acasignups.net/20/06/24/aca20-gets-vote-last-deep-dive-hr1425-affordable-care-enhancement-act; *Rep. Peter's Bill to Lower Health Costs Leads Affordable Care Enhancement Push, Passes House*, REP. SCOTT PETERS (June 29, 2020), https://scottpeters.house.gov/media-center/press-releases/rep-peters-bill-to-lower-health-costs-leads-affordable-care-enhancement.

109. H.R. 1425, 116th Cong. § 106 (2020); CONG. BUDGET OFF., COST ESTIMATE: H.R. 1425, STATE HEALTH CARE PREMIUM REDUCTION ACT 3 (2019); *see also Hearing on "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access": Hearing Before the Comm. on Energy & Com. on H.R. 1425, H.R. 1386, and H.R. 1385, 116th Cong. (2019)* (describing the provision as authorizing $10 billion so that states, or Centers for Medicare and Medicaid Services, on behalf of states, can establish a state reinsurance program or other cost-reducing initiatives).

110. H.R. 1425, 116th Cong. § 106 (2020), amending Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1353(b), 124 Stat. 119 (2010).

111. Dan Diamond, *Biden Unveils Health Care Plan: Affordable Care Act 2.0*, POLITICO (July 15, 2019, 1:10 PM), https://www.politico.com/story/2019/07/15/joe-biden-health-care-plan-1415850; H.R. 1425.

112. Tax Cuts and Jobs Act of 2017 (TCJA), Pub. L. No. 115–97, § 11081, 131 Stat. 2054 (2017); *see* Galen Hendricks & Seth Hanlon, *The TCJA 2 Years Later: Corporations, Not Workers, Are the Big Winners*, CAP (Dec. 19, 2019), https://www.americanprogress.org/article/tcja-2-years-later-corporations-not-workers-big-winners/.

113. *Update: Wisconsin Gov. Signs Health Reinsurance Bill; State Joins* '*Obamacare*' *Suit*, INS. J. (Feb 28, 2018), https://www.insurancejournal.com/news/midwest/2018/02/28/481836.htm.

114. California v. Texas, 141 S. Ct. 2104, 2112–13 (2021).

115. Prior to passage of the TCJA Act of 2017, Senator Susan Collins proposed some conditions for her support for the tax proposal, including passage of Alexander-Murray and her own Collins-Nelson proposal containing reinsurance provisions. Ledyard King, *Nelson Scores Victory on Insurance Plan but It Helped Passage of GOP Tax Bill He Dislikes*, USA TODAY (Dec. 5, 2017, 6:44 PM), https://www.usatoday.com/story/news/politics/2017/12/05/nelson-scores-victory-insurance-plan-but-helped-passage-gop-tax-bill-he-dislikes/924623001/; *see, e.g.*, Dwyer Gunn, *Can the Collins*

institute their own reinsurance programs.[116] Two other states were preparing to do so, and another two applied for § 1332 waivers but then withdrew their applications.[117]

Within the first fifty days in office, the Biden Administration pushed through the American Rescue Plan (ARP), a COVID-19-relief bill of unprecedented dimensions that included temporary health coverage expansions as well.[118] Chief among these provisions was the elimination of the income cap on eligibility for ACA premium tax credits, which were formerly available only to those enrollees between 100% and 400% of the federal poverty line.[119] While Americans under the federal poverty line ("FPL") remain ineligible, and others still cannot access exchange subsidies because of immigration status, many more Americans will, for now, be subsidized on the exchange as a result of ARP.[120]

The ACA exchange subsidies do not provide one set amount.[121] Instead, they vary to ensure that enrollees will never have to spend more than a set percentage of income to afford benchmark coverage (the second-lowest-cost silver plan).[122] Under the original ACA, this set percentage scaled from 2% to 9.5% as income rose from 100% to 400% of poverty.[123] ARP expanded the size and eligibility for those subsidies: now recipients contribute nothing at 100% FPL and no more than 8.5% of income at 400% FPL and above.[124] But to cap enrollee spending at these promised levels, the size of the tax credit automatically increases as benchmark premiums increase.[125] Thus, subsidized enrollees enjoy increased buying power when prices rise and are perversely harmed by any measure that reduces premiums.[126]

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*Compromise Save the Affordable Care Act?*, PAC. STANDARD (Nov. 29, 2017), https://psmag.com/news/can-the-collins-compromise-save-the-affordable-care-act.

116. SHADAC, *supra* note 82.

117. *Id.*

118. *See* American Rescue Plan Act of 2021, Pub. L. No. 117–2, § 9661, 135 Stat. 183 (2021). *See also* The Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 12001(b), 136 Stat. 1818 (2022) (codified as amended in the Internal Revenue Code of 1986 § 36B(c)(1)(E)) (2022)) (extending these subsidies through the end of 2025).

119. *Id.*; Daniel McDermott, Cynthia Cox, & Krutika Amin, *Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums*, KFF (Mar. 15, 2021), https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/.

120. *See* McDermott et al., *supra* note 119.

121. *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, KFF (Oct. 29, 2021), https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

122. 26 U.S.C § 36B; *Explaining Health Care Reform*, *supra* note 121.

123. 26 U.S.C § 36B.

124. *See* McDermott et al., *supra* note 119.

125. Justin Giovannelli, JoAnn Volk, Rachel Schwab, & Emily Curran, *The Benefits and Limitations of State-Run Individual Market Reinsurance*, COMMONWEALTH FUND (Nov. 11, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/benefits-limitations-state-run-individual-market-reinsurance.

126. *Id.*

Even now, with the premium-reduction proposals in abeyance because of this dynamic, the New Democrat Coalition of centrists in the House nevertheless listed national reinsurance first in their letter to President Biden outlining health care priorities to include in any additional infrastructure-related legislation.[127]

*B. At the State Level*

Even as federal reinsurance proposals worked themselves to this strange impasse, states had long ago forged ahead. Prior to the most recent state reinsurance boom, "Seven states [] had established mandatory reinsurance pools [for small group plans] and [nineteen had] voluntary reinsurance pools . . . ."[128]

In the 1990s, New Jersey tried a conditional reinsurance scheme under the auspices of its Individual Health Coverage Program, designed to leverage insurers into selling policies on the individual market.[129] If an insurer decided not to participate in this regulated individual market, it would have to pay assessments that would then be redistributed to the participating carriers who had claims overruns.[130] However, the gaming of this system by small carriers led to its demise.[131]

New York had considered state reinsurance as far back as 1989 with the Universal New York Health Care plan.[132] The idea reemerged a decade later when Healthy New York was launched using tobacco settlement funds to provide subsidized reinsurance to those private plans offering affordable coverage for uninsured lower-income individuals and small business employees.[133] The state required all health management organizations to participate, and small employers had to pay at least 50% of premiums.[134] The program halved premiums in this risk-selection-plagued segment of the pre-ACA market and inspired John Kerry to feature reinsurance in his health care presidential platform, a proposal discussed later in this Article.[135]

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127. Letter from Kim Schrier & Terri A. Sewell, New Democratic Coal., to President Joseph R. Biden (Apr. 21, 2021).

128. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST, & ROBERT SCHWARTZ, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 649 (7th ed. 2013) (citing BLUE CROSS BLUE SHIELD ASSOCIATION, STATE LEGISLATIVE HEALTH CARE AND INSURANCE ISSUES: 2012 SURVEY OF PLANS (2012)).

129. REINSURING HEALTH, *supra* note 46, at 95.

130. *Id.*

131. *Id.* at 96.

132. *Id.* at 178–79, n.23 (citing Dan E. Beauchamp & Ronald L. Rouse, *Universal New York Health Care—A Single-Payer Strategy Linking Cost Control and Universal Access*, 10 NEW ENG. J. MED. 644 (1990)).

133. *Id.* at 145. Individuals making up to $32,000 a year, adjusted annually, were eligible. *Id.* Small employers were eligible where 30% of the payroll earned $32,000 a year or less. *Id.*

134. RANDALL R. BOVBJERG, WIS. FAM. IMPACT SEMINARS, HOW HAVE STATES LIKE NEW YORK AND ARIZONA USED REINSURANCE TO HELP BUSINESSES CONTROL THE COST OF HEALTH INSURANCE? 22 (2007).

135. *Id.*

Maine's program, like New York's earlier example, was invoked frequently by national policymakers as a model.[136] In 2011, Maine's legislature authorized the Maine Guaranteed Access Reinsurance Association (MGARA), a private nonprofit entity, to operate a reinsurance program for Maine's pre-ACA individual health insurance market.[137] MGARA collected $4 per member per month from all health insurers, including those merely processing claims for employer self-insured plans.[138] It then paid for "high-risk" enrollees identified as having one of eight diagnoses (including chronic obstructive pulmonary disease and rheumatoid arthritis) or as otherwise determined through a medical questionnaire.[139] For cumulative claims within the $7,500 to $32,500 range, MGARA would pay 90% on behalf of "ceded" individuals.[140] The rate dialed up to 100% once claims hit $32,500.[141] But the insurers also had to turn over 90% of the premiums they collected for these "ceded" individuals to MGARA.[142]

Through this program, Maine sought to offer affordable individual market options to enrollees with preexisting conditions in the period before the ACA went live.[143] And it achieved notable premium savings, though perhaps not from reinsurance alone but rather in conjunction with other concurrent policies.[144]

When the ACA's major insurance market provisions switched on in 2014, two provisions addressed reinsurance as a health policy tool. The first was the transitional federal reinsurance provision, § 1341, described above.[145] The second was § 1332, which allowed states to apply for waivers from major ACA requirements to undertake state-specific innovation.[146] Such waivers are granted subject to assurances that the state waiver plan would achieve at least as much coverage as the unaltered ACA scenario, and that the coverage would be as comprehensive and affordable as it would have been otherwise without adding to the federal deficit.[147]

Reinsurance became a key pillar of many § 1332 waiver proposals.[148] With the individual mandate neutered, reinsurance proved a handy tool to restabilize state exchanges. The idea also gained traction because Tom Price, President Trump's first Secretary of Health and Human Services,

136. *See, e.g.*, Patty Wight, *Secret to Maine's Touted High-Risk Pool? Enough Money*, NPR (May 17, 2017, 10:51 AM), https://www.npr.org/sections/health-shots/2017/05/17/527960631/the-idea-the-gop-s-health-care-bill-borrows-from-maine.

137. *See* Hall & Bagley, *supra* note 107; *Maine Individual Health Reinsurance*, MGARA, https://mgara.org (last visited Oct. 28, 2022).

138. Hall & Bagley, *supra* note 107.

139. *Id.*

140. Scott E. Harrington, *Stabilizing Individual Health Insurance Markets with Subsidized Reinsurance*, 21 PA. LEONARD DAVIS INST. HEALTH ECON. 1, 4 (2017).

141. *Id.*

142. *Id.*

143. *See* Hall & Bagley, *supra* note 107.

144. *See id.*

145. 42 U.S.C. § 18061 (2010).

146. 42 U.S.C. § 18052 (2010).

147. *Id.*

148. *See* SHADAC, *supra* note 82.

and his CMS Administrator, Seema Verma, "invit[ed] states to pursue approval of waiver proposals that include high-risk pool/state-operated reinsurance programs," citing Alaska's proposal as an example.[149]

Alaska's waiver was approved on July 7, 2017.[150] Individual market premiums had been rising 30%–40% per year,[151] and in 2017, Premera remained the sole ACA plan.[152] Premera faced a skewed enrollee pool, with just thirty-seven patients consuming a quarter of claims costs.[153] Alaska's reinsurance program stepped in. The program raised $55 million, which it devoted to paying the costs of any enrollee who had one of thirty-three high-cost conditions, including hemophilia, HIV/AIDS, and multiple sclerosis.[154] Premiums actually decreased for 2020 and 2021, luring an additional plan back onto the market.[155]

Fifteen states have, as of this Article, proposed their own reinsurance plans under § 1332 authority.[156] Two additional states (Iowa and Oklahoma) submitted but later withdrew their applications.[157] Some suggest that their waivers faltered for the crudest of political expediencies.[158] The Trump Administration delayed Oklahoma and Iowa's approvals because of its desire to highlight rather than address the dysfunctions of Obamacare and thereby make the case for repealing what would then appear a poorly functioning regime.[159] A few additional states (Connecticut, Idaho, Louisiana, and Wyoming) have publicly considered reinsurance waivers but have not yet submitted proposals.[160]

Because these § 1332 reinsurance programs reduce premiums, they save the U.S. Treasury from paying higher tax credits on behalf of

149. Press Release, U.S. Dep't Health & Hum. Servs., Secretary Price and CMS Administrator Verma Take First Joint Action: Affirm Partnership of HHS, CMS, and States to Improve Medicaid Program (Mar. 14, 2017), https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html; Letter from Thomas E. Price, Sec'y Health & Hum. Servs., to the Governors (Mar. 13, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.

150. SHADAC, *supra* note 82.

151. *See* Louise Norris, *Alaska Health Insurance Marketplace Guide 2022*, HEALTH INSURANCE (Jan. 19 2022), https://www.healthinsurance.org/health-insurance-marketplaces/alaska/.

152. Timothy Jost, *Alaska Reinsurance Plan Could Be Model for ACA Reform, Plus Other ACA Developments*, HEALTH AFFS. (June 16, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160616.055420/full/.

153. *Id.*

154. STATE OF ALASKA DEP'T COM., CMTY., & ECON. DEV. DIV. OF INS., ALASKA 1332 WAIVER APPLICATION 1, 3 (2016).

155. *See* Norris, *supra* note 151.

156. SHADAC, *supra* note 82.

157. *Id.*

158. *See* Joel Ario, *Failure to Approve Oklahoma Waiver Undermines Trust Between HHS and States*, HEALTH AFFS. (Sept. 30, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170930.062255/full/.

159. Alison Kodjak, *Administration Sends Mixed Signals on State Health Insurance Waivers*, NPR (Oct. 19, 2017, 5:01 AM), https://www.npr.org/sections/health-shots/2017/10/19/558310690/administration-sends-mixed-signals-on-state-health-insurance-waivers.

160. SHADAC, *supra* note 82; *see also* Persad, *supra* note 10, at 1178.

subsidized enrollees.[161] Under the § 1332 waiver terms, the federal government then passes those savings through to the waiver states.[162] States may reinvest those funds into the reinsurance programs that generated those savings in the first place.[163] Alaska has received more than enough in pass-through funds to finance its reinsurance program, while some other states have had to kick in additional financing.[164] Many states rely on insurer assessments to fund their contributions to the reinsurance funds.[165] Other states collect funds from providers.[166] New Jersey generated revenue by imposing a state individual mandate penalty to replace the federal penalty that was zeroed out in the Trump Administration's TCJA.[167] Colorado, Delaware, and Maryland raised funds from a premium tax, taking advantage of the expiration of the federal premium tax.[168]

Many states have adopted specific excess-of-claims benefit structures, with a few states following Alaska's condition-based system. Delaware, for instance, pays 75% of claims between $65,000 and $215,000, while Minnesota pays 80% between $50,000 and $250,000.[169] Oklahoma's program would have kicked in at just $15,000 per beneficiary claims.[170] Idaho, in its aborted waiver plan, proposed a condition-specific attachment point. Idaho was notable insofar as it sought a dual ACA/Medicaid waiver that proposed to off-load the top twenty most costly conditions, amounting to 2,500 cases, onto Medicaid.[171] This risk shift would have decreased premiums by 20% for the remaining 94,000

161. CONG. BUDGET OFF., COST ESTIMATE: BIPARTISAN HEALTH CARE STABILIZATION ACT OF 2018 5 (2018); Sarah Lueck, *Reinsurance Basic: Considerations as States Look to Reduce Private Market Premiums*, CTR. BUDGET & POL'Y PRIORITIES (Apr. 3, 2019), https://www.cbpp.org/research/health/reinsurance-basics-considerations-as-states-look-to-reduce-private-market-premiums.

162. 42 U.S.C. § 18052(a)(3). Congressional Budget Office's March 2018 score of the last-ditch Bipartisan Health Care Stabilization Act projected that 60% of the federal cost of extending reinsurance would be offset by reductions in other costs, mainly premium tax credits. CONG. BUDGET OFF., COST ESTIMATE: BIPARTISAN HEALTH CARE STABILIZATION ACT OF 2018 5 (2018).

163. 42 U.S.C. § 18052(a)(3).

164. Persad, *supra* note 10, at 1177–84.

165. Giovannelli et al., *supra* note 125.

166. Lynn A. Blewett, *Minnesota's 1332 Reinsurance Waiver Dilemma*, HEALTH AFFS. (Dec. 7, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171204.352539/full/; *see also* Marianne Goodland, *Last-Minute Negotiations Shake Up Reinsurance Bill*, COLO. POLS. (June 13, 2020), https://www.coloradopolitics.com/legislature/last-minute-negotiations-shake-up-reinsurance-bill/article_e9e1a704-ad17-11ea-a8e5-3f177a158267.html.

167. Giovannelli et al., *supra* note 125; *Briefing Book: How Did the Tax Cuts and Jobs Act Change Personal Taxes?*, TAX POL'Y CTR., https://www.taxpolicycenter.org/briefing-book/how-did-tax-cuts-and-jobs-act-change-personal-taxes (last visited Oct. 28, 2022).

168. Louise Norris, *Alaska Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Dec. 16, 2020), https://www.healthinsurance.org/health-insurance-marketplaces/alaska/.

169. Christopher Snowbeck, *Minnesota Extends* '*Reinsurance*' *Program*, STAR TRIBUNE (June 3, 2019, 9:16 PM), https://www.startribune.com/minnesota-extends-reinsurance-program/510776452/; *see also* Blewett, *supra* note 166; Louise Norris, *Delaware Health Insurance Marketplace 2023 Guide*, HEALTH INS. (Aug. 30, 2022), https://www.healthinsurance.org/health-insurance-marketplaces/delaware/.

170. TERRY L. CLINE, SEC'Y HEALTH & HUM. SERVS., 1332 STATE INNOVATION WAIVER APPLICATION FOR THE STATE OF OKLAHOMA 12 (2017).

171. William L. Spence, *Health Committee Revives 'Dual-Waiver' Plan*, LEWISTON TRIBUNE (Mar. 20, 2018), https://lmtribune.com/northwest/health-committee-revives-dual-waiver-plan/article_7f48540c-6507-5b80-95b6-83b2c1ce39ca.html.

Idahoans in the ACA market.[172] Idaho's program would have flopped anyway because it included a Medicaid work requirement of the kind that has been struck by courts.[173] As it turned out, the deal was scuttled by those with pharmaceutical interests who did not want to be paid at the discounted Medicaid rate for high-cost pharmaceuticals.[174] Idaho's example nevertheless suggests the ready-made role that Medicaid could play in reinsurance.

Other states also considered extending government reinsurance, but only at government-set pricing. For instance, Colorado originally proposed limiting reinsurance payments to 150%–200% of Medicare rates.[175] However, provider opposition and Trump Administration hostility squelched that initiative.[176] Instead, providers agreed to contribute by paying assessed fees to finance the reinsurance fund.[177]

By implementing reinsurance, Alaska famously reduced premiums by over 30%.[178] Maryland's rates fell by nearly 40% in the first year of operation.[179] Oregon saw 7%–8% reductions, Montana cut 9%, and Rhode Island, 4%.[180] In New Jersey, "[i]nstead of increasing by 12.6% . . . ave[rage] premiums dropp[ed] by 9.3% . . . or around $1,500 per unsubsidized enrollee for the year."[181] "Nearly $1,000 of that average drop is thanks to the reinsurance program; the other $470 is due to reinstating the mandate penalty."[182] In its first year of operation, people across Colorado saved 22% on insurance premiums on the individual market.[183]

## III. HISTORY OF REINSURANCE IN U.S. HEALTH CARE

This flurry of recent activity should not deflect our attention from how pervasive (and underrecognized) the reinsurance principle has been throughout the history of the U.S. health system.

In the history of America's quest for national health insurance, President Harry Truman looms large. President Truman sought to complete President Franklin Delano Roosevelt's (FDR) unfinished project by

172. JOINT FIN. APPROPRIATION COMM., IDAHO HEALTH CARE PLAN DUAL WAIVER STRATEGY, IDAHO LEGIS. SESS. (2018).

173. *See* Gresham v. Azar, 950 F.3d 93, 102 (D.C. Cir. 2020); Spence, *supra* note 171 (describing Idaho's waiver plan).

174. Pat Kelley, Exec. Dir. of Health Idaho, remarks at HIX conference at the University of Pennsylvania (Mar. 5–6, 2019).

175. Marianne Goodland, *Colorado House Committee Approves 'Reinsurance' Bill Intended to Lower Health Premiums*, COLO. POLS. (Feb. 27, 2019), https://www.coloradopolitics.com/news/colorado-house-committee-approves-reinsurance-bill-intended-to-lower-health-premiums/article_a9769748-3b02-11e9-9376-e7273614913b.html.

176. *Id.* For Trump Administration opposition, see Giovannelli et al., *supra* note 125.

177. Goodland, *supra* note 175.

178. Giovannelli et al., *supra* note 125.

179. *Id.*

180. *Id.*

181. Charles Gaba, *New Jersey: Does Seema Verma Have a Point for Once?? Nah, Probably Not.*, ACASIGNUPS.NET (Jan. 30, 2019, 9:22 PM), https://acasignups.net/19/01/30/new-jersey-does-seema-verma-have-point-once-nah-probably-not.

182. *Id.*

183. Giovannelli et al., *supra* note 125.

adding compulsory health insurance to the protections offered by Social Security.[184] His famous defeat at the hands of a galvanized, red-baiting American Medical Association (AMA), in concert with the insurance and business lobbies, led national health insurance advocates to revise their strategy.[185] They focused on particular groups like elderly Americans and those with disabilities, whom no private insurer wished to enroll.[186]

But the historic Truman defeat also led President Dwight Eisenhower to propose health reinsurance as the alternate conservative path. In his 1954 State of the Union Address, Eisenhower put it thus:

> I am flatly opposed to the socialization of medicine. . . . The Federal Government can do many helpful things and still carefully avoid the socialization of medicine. . . . A limited Government reinsurance service would permit the private and non-profit insurance companies to offer broader protection to more of the many families which want and should have it.[187]

The mid-century hegemony of the employer-sponsored coverage system, and the political coalition of AMA with insurers and business, centered private insurance as the dominant source of health coverage. But this reliance on private insurance left unavoidable gaps in the system corresponding to the groups that private insurers found unavailing.[188] The categories of "elderly" and "disabled" insurance-seekers were the most visible examples of those whom insurers wished to either exclude or add only grudgingly at higher rates to reflect their medical risk.[189] These applicants were doubly disadvantaged by their lower rates of participation in the formal employment sector, constraining their finances and access to job-based coverage.[190]

Other groups lacking resources for private insurance included lower-income Americans, dependent children, and their caregivers.[191] When commercial insurers entered the health insurance market mid-century to compete with the provider-organized Blue Cross Blue Shield (BCBS) plans, they brought with them actuarial tables from their accumulated expertise offering life insurance.[192] Using these techniques, they

184. This story has been well-told. *See, e.g.*, MARMOR, *supra* note 63, at 65–67.

185. *Id. See* Peter Ubel, *How Truman's Medicare Efforts Were Foiled by Red Baiting*, FORBES (Jan. 15, 2014, 10:49 AM), https://www.forbes.com/sites/peterubel/2014/01/15/how-trumans-medicare-efforts-were-foiled-by-red-baiting/?sh=41b4cc8d32b4.

186. MARMOR, *supra* note 63, at 65–67.

187. President Dwight D. Eisenhower, State of the Union Address (Jan. 7, 1954).

188. *See* JILL QUADAGNO, ONE NATION, UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE 54–56 (2006).

189. *Id.*

190. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 27–28 (Transaction Publishers 2003) (1974) (explaining that "[f]or the elderly, rising costs were of special concern, or at least of special interest in view of the fact that they frequently had fixed incomes.").

191. *Id.* at 19–22.

192. John A. Cogan, Jr., *Does Small Group Health Insurance Deliver Group Benefits? An Argument in Favor of Allowing the Small Group Market to Die*, 93 WASH. L. REV. 1121, 1145–46 (2018).

could medically "underwrite" their coverage products, i.e., use demographic and other predictive factors to identify when to reject applicants, when to limit or exclude coverage for preexisting conditions, and when to charge higher rates commensurate with the applicant's risk.[193] BCBS (the Blues), in accordance with its provider origins, initially lacked this risk-selection expertise.[194] Later, as a condition of the various tax and regulatory exemptions associated with their quasi-public status, the Blues were required to offer flat community rating and guaranteed issue to all members, regardless of health risk.[195] The lion's share of high-loss health claims predictably fell to the Blues.[196] A BCBS executive thus proposed government reinsurance as a way to avoid a destabilizing cost spiral, and Eisenhower jumped aboard.[197]

Eisenhower's proposed legislation offered private insurers a deal: if private plans would broaden benefits and reduce discrimination against relatively riskier enrollees, the government would protect them from any resulting unmanageable costs.[198] But the House shelved the proposal with a resounding 238–134 vote, a defeat that the *New York Times* laid at the hands of the AMA.[199]

This episode did not mark the end of reinsurance as a policy theme in health care.

### *A. History of Medicaid*

Leading up to the Kerr–Mills Act of 1960, certain populations were identified for special concern, including children, people who are blind, and the elderly.[200] One reason for the salience of these groups is that they represented the traditional categories of eligibility for cash assistance welfare in the United States, grounded in notions of which among us were

193. *See* QUADAGNO, *supra* note 188, at 56.

194. *See* Cogan, *supra* note 192, at 1145–46.

195. QUADAGNO, *supra* note 188, at 56 ("Pink complained that Blue Cross was rapidly losing business to commercial insurers who experience-rated their premiums to attract young, healthy customers, leaving the Blue Cross plans with the older, sicker individuals. Some plans were forced to raise their rates. Others abandoned community rating, where all policyholders would pay the same rate (regardless of health risk), and started basing premiums on health risk.").

196. *Id.*

197. Jacob Stewart Hacker, Boundary Wars: The Political Struggle over Public and Private Social Benefits in the United States (Dec. 2000) (Ph.D. dissertation, Yale University) (*cited in* QUADAGNO, *supra* note 188, at 45–49).

198. *"To Your Health"*, HARV. CRIMSON (Feb. 21, 1955), https://www.thecrimson.com/article/1955/2/21/to-your-health-pmany-of-our/ ("Insurance companies would reject no-one as a 'poor risk' under the Administration medical bill. Fiscal hocus-pocus called 'reinsurance' will enable them to sell policies even to the victims of cancer, diabetes, and polio . . . ."); John D. Morris, *Eisenhower Plan for Health Funds Rejected in House*, N.Y. TIMES (July 14, 1954), https://www.nytimes.com/1954/07/14/archives/eisenhower-plan-for-health-funds-rejected-in-house-in-surprise-move.html ("Companies and groups reinsuring their policies would have stood to recover from the fund up to three-fourths of their 'abnormal' losses.").

199. Morris, *supra* note 198.

200. STEVENS & STEVENS, *supra* note 190, at 6.

"deserving" of assistance.[201] Robert and Rosemary Stevens traced the ideological lineage thus:

> Impoverished old people, underfed children, and the unemployable blind could scarcely be blamed for their condition nor envied for being recipients of relief. . . . These early categorical programs are important because the divisions were carried over into the Social Security Act of 1935, to become—with the addition of a further category for the totally and permanently disabled in 1950—the framework on which Medicaid was drafted.[202]

This heritage, as the above passage suggests, has carried through into Medicaid today.

But another throughline runs alongside and explains the persistence of these "categories" as the subjects of collective health aid: these categories make sense according to a reinsurance and not just a welfare medicine rationale. As traced by the Eisenhower narrative above, the rise of employer-sponsored health coverage (which at its peak covered 80% of Americans under sixty-five) successfully papered over the uninsured problem to such an extent that comprehensive universal health care as a policy goal receded from view.[203] The problem of health coverage was instead reframed as that of addressing those specific groups who were not privately insurable.[204] The situation of the elderly took on special prominence in this context as the population represented risks that private insurance could not take on.[205] Less than 15% of the elderly had any form of health insurance in the late 1950s, the inverse of the percentage of insured working-age Americans.[206]

This concern over the extreme medical needs of particular groups characterized nearly all of the traditional categories for cash assistance that were eventually folded into Medicaid.[207] When it came to the elderly, people who are blind or persons who are permanently and totally disabled, and dependent children with their families, all but the last category drew not just from a welfare story of "deserving" status among the poor but also

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201. *Id.*

202. *Id.* at 6–7.

203. *See generally* ROBIN A. COHEN, DIANE M. MAKUC, AMY B. BERNSTEIN, LINDA T. BILHEIMER, & EVE POWELL-GRINER, CDC, NATIONAL HEALTH STATISTICS REPORT: HEALTH INSURANCE COVERAGE TRENDS, 1959-2007: ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY (2009).

204. STEVENS & STEVENS, *supra* note 190, at 20–21.

205. *Id.* at 39 n.26 (citing U.S. Public Health Service, Health Statistics from the U.S. National Healthy Survey: Older Persons, Selected Health Characteristics, July 1957–June 1959, Public Health Service Pub. No. 584-c4 (1960)) (stating that the reason is that "because of their high medical risk [they] were unable to buy health insurance at prices they could afford.").

206. Thomas Bodenheimer & Kevin Grumbach, *Paying for Health Care*, 272 JAMA 634, 634 (1994).

207. STEVENS & STEVENS, *supra* note 190, at 57.

from the reinsurance rationale that some medical needs would exceed ordinary expectations within the insurable range.[208]

This line of reasoning drove other early characteristics of Medicaid as well. In Kerr–Mills, the pre-cursor program to Medicaid,[209] a new eligibility category emerged, that of the "medically indigent," sometimes referred to as the "medically needy."[210] "Medical indigence" represented a new concept of need, separate from "deserving" poverty.[211] Medically indigent beneficiaries "were defined as elderly or blind persons or totally disabled persons . . . who were not on public assistance and . . . might be above state eligibility levels for cash assistance but who nevertheless had incomes insufficient to meet their medical bills."[212] What was notable was not how poor they were, but how crushing their medical costs were. In practice, these individuals were often those whose medical conditions led to institutionalization. Medical need or indigence, a concept Medicaid employs even today, captures the intuition that catastrophic medical circumstances, without regard to poverty per se, should trigger the responsibility of the state. Unfortunately, Congress promptly trimmed back the implications of this policy in 1967 when, afraid of unexpectedly high state spending on the open-ended promise of federal matching funds, it limited the category of the medically needy to those whose incomes fell below 133.33% of the Aid to Families with Dependent Children grant eligibility level.[213]

Medicaid, as a government program, has historically shouldered costly institutional care, perceived as requiring resources beyond any ordinary family's means.[214] Under the Kerr–Mills program preceding Medicaid, leading states such as California prioritized the provision of this expensive outlier care ahead of more basic medical services.[215]

Medicaid also took on a reinsurance function amid Medicaid's managed care revolution. While Medicaid initially contemplated direct state

208. *Id.* at 29.
209. *Id.* at 28–29.
210. *Id.* at 29 (explaining the addition in 1960 of medically needy beneficiaries under Kerr–Mills Act's Medical Assistance to the Aged, followed by the 1962 extension of this concept to recipients who were blind and disabled in Title XVI). *Id.* at 62–65 (describing the optional eligibility category of the "categorically related medically needy" as defined by both high medical bills and membership in one of the traditional eligibility categories, despite income otherwise exceeding the prevailing means-test level). The authors go on to explain that this concept was expanded by the state option category of "non-categorically related medically needy" and by the Ribicoff Amendment to all children, regardless of whether they were categorically qualified. *Id.* The mechanism that states used to operationalize and define this threshold of "medical indigence" was the spend-down provision, which sweeps individuals into the ambit of eligibility despite their higher incomes if their medical bills "spend-down" so much of their income that the remaining portion falls at or below the means threshold. *See* Social Security Act § 1902(a)(17), 42 U.S.C. § 1396a(a)(17).
211. STEVENS & STEVENS, *supra* note 190, at 29.
212. *Id.*
213. *Id.* at 29, 61–65.
214. *Id.* at 57.
215. *Id.* at 32–34.

payment for health services,[216] it has since become a program that operates largely through state payments to intermediary managed care organizations that organize health care provision on Medicaid's behalf.[217] Kaiser Family Foundation tells us that as of July 2019, forty states used capitated managed care models to deliver services in Medicaid and over "two-thirds (69%) of all Medicaid beneficiaries received their care through comprehensive risk-based [managed care organizations (MCOs)]."[218] With this transformation, many state Medicaid programs instituted formal reinsurance for the private risk-bearing entities that they contracted to deliver care.[219] Medicaid itself sometimes serves as the stop-loss insurer,[220] but "[m]any states that began providing public reinsurance to Medicaid managed care plans ended by allowing plans to buy private [reinsurance] coverage instead."[221] CMS guidance has also long required that if a Medicaid managed care plan places risk on providers, as in physician incentive programs (where the physician makes or retains more compensation if they meet certain targets for savings or quality), then the managed care plan must provide some kind of reinsurance for the physician.[222]

We have long used Medicaid to backstop catastrophic risks in other ways as well. Because of its open-ended matching structure, it serves as an automatic countercyclical fiscal stabilizer in economic downturns.[223] We also turned to Disaster Relief Medicaid after catastrophic events like 9/11 and major hurricanes.[224] Medicaid may, more than any other aspect of our health care system today, exemplify the reinsurance impulse.

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216. *See id.* at 90–100 (recounting the example of New York's original program).

217. *See* Social Security Act § 1915(g), 42 U.S.C. § 1396(g).

218. *See, e.g.*, Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KFF (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

219. 42 C.F.R. § 438.1–438.7 (2022) (requiring that payments to Medicaid MCOs must be actuarially sound. Actuarial soundness means that the "capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the [managed care plan] for the time period and the population covered under the terms of the contract.").

220. For examples of state reinsurance provisions, see generally *Reinsurance*, GEORGE WASH. UNIV. HEALTH POL'Y & MGT. DEP'T, https://publichealth.gwu.edu/departments/healthpolicy/CHPR/nnhs4/GSA/Subheads/gsa246.html (last visited Oct. 28, 2022); *see, e.g.*, *Stop Loss Program*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/facilities/hospital/reimbursement/stoploss/ (last visited Oct. 28, 2022) (New York Medicaid's stop loss website, offering state-based reinsurance that Medicaid managed care plans can purchase from the state).

221. RANDALL R BOVBJERG & ELLIOT WICKS, IMPLEMENTING GOVERNMENT-FUNDED REINSURANCE IN THE CONTEXT OF UNIVERSAL COVERAGE 19 (2006).

222. DEP'T HEALTH & HUM. SERVS. HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL PART 2—STATE ORGANIZATION AND GENERAL ADMINISTRATION § 2087.9 (2000).

223. Moira Forbes & Chris Park, *Presentation at MACPAC Public Meeting*, *A Countercyclical Medicaid Financing Adjustment: Moving Towards Recommendations*, MACPAC 3–4 (Dec. 10, 2020), https://www.macpac.gov/publication/a-countercyclical-medicaid-financing-adjustment-moving-towards-recommendations/.

224. Christina S. Ho, *Medicaid for All Who Face the Coronavirus*, SLATE (Mar. 6, 2020, 10:42 AM), https://slate.com/technology/2020/03/we-must-give-medicaid-to-all-who-face-coronavirus.html.

*B. History of Medicare*

Yet, Medicare exhibits strong signs of a reinsurance frame as well. Wilbur Cohen, the architect of Medicare, understood the entire project of the Social Security Act along reinsurance lines. According to Marmor:

> [Cohen] actively campaigned for disability insurance covering workers over the age of 50. He did so on the assumption that by slowly expanding the number of impoverishing conditions insured against by social security, the risk of catastrophic health expenses would be left as the obvious major omission within the social insurance program requiring remedial legislation.[225]

When President Truman's advisors regrouped after 1950, they narrowed their sights to focus on the elderly first.[226] They did so because the incidence of high-cost claims concentrated among the elderly who therefore struggled to find private insurers willing to offer affordable coverage.[227] Even the decision by the Johnson Administration to prioritize hospital costs first (ultimately Medicare "Part A") signaled that their primary concerns were the catastrophic episodes that resulted in large hospital bills.[228]

Political support for Medicare legislation was bolstered by the benefits that reinsurance would bring to unions and employers. These strange bedfellows favored relief from the increasing burden of retiree health insurance, and they were happy to off-load these costs onto the government.[229]

The version of Medicare that eventually passed addressed more than just large hospital bills. Having taken that portion of the Administration's proposal and called it Medicare Part A, Ways and Means Chairman Wilbur Mills co-opted two competing proposals and, in a strategic flourish, appended them to the Medicare package.[230] The result was the proverbial "three-layer cake," comprised of Medicare Part A, Medicare Part B, and Medicaid.[231] The two co-opted proposals had been intended by opponents of Medicare as narrower substitutes for Medicare.[232] The Republican ranking member, John Byrnes, advocated so-called "better-care," a proposal for premium subsidies that the elderly could use to purchase voluntary insurance.[233] Wilbur Mills took that structure and applied it to seniors'

225. MARMOR, *supra* note 63, at 23–24.
226. *See id.* at 10–11.
227. *Id.* at 12.
228. *Id.* at 24, 27 (attributing these views to Wilbur Cohen and the House Ways and Means sponsor, Representative Aime Forand).
229. *See, e.g.*, QUADAGNO, *supra* note 188, at 57, 148 (making this point regarding employers); TOM DASCHLE, SCOTT S. GREENBERGER, & JEANNE M. LAMBREW, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 57 (2008).
230. MARMOR, *supra* note 63, at 49–52.
231. *Id.* at 49, 51–52.
232. *See id.* at 49.
233. *Id.* at 48–49.

physician costs to constitute Medicare Part B.[234] The AMA-backed "Eldercare" proposal, which would have devolved the problem of coverage gaps to states by merely expanding the existing Kerr–Mills state grants-in-aid, was added to the bill as Medicaid.[235] The efforts of Medicare's opponents to sidetrack the proposal ended up expanding it even beyond what the Johnson Administration dared ask for.

After Medicare's passage, additional eligibility categories were occasionally approved, and virtually all of these groups exemplified the principle of reinsurance.[236] These populations represented high-cost patients who would skew insurance risk pools and Medicare eligibility meant government absorption of these risks.[237] For instance, workers who were totally and permanently disabled and qualified for Social Security Benefits for at least two years were added to the Medicare rolls in 1972, as were end-stage renal disease patients who needed expensive dialysis.[238] In 2001, Medicare was extended to patients with ALS.[239] According to Marmor, this pattern of prioritization distinguishes the United States from all other industrialized countries, which covered the formal working sector first.[240]

Due to unsustainable hospital costs, Medicare in the 1980s sought to curb spending by switching to a prospective payment system (PPS).[241] Instead of paying a la carte for each service delivered to a Medicare patient, the government started "essentially pay[ing] hospitals the national average cost[] . . . for each patient admitted to the hospital" within that particular illness or diagnosis-related group (DRG).[242] This form of payment shifts some of the risk of a Medicare beneficiary's high service use from the government insurer to the hospital instead, which, as noted above, renders the hospital a quasi-insurer. The hospital would in theory now face an incentive to control its spending. From the very outset, the formula for these averaged DRG payments contained an adjustment for "outliers," as described earlier.[243] These outlier payments could be described as insurance that the hospitals "purchase" to protect against high-cost cases: "Outlier payments can be viewed as insurance against excessive losses on a case. They are intended to cover the marginal costs of care beyond the outlier threshold (a deductible on losses) and are financed by a tax on reimbursement of non-outlier patients (a per-case premium)."[244]

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234. *See id.* at 49–52.
235. *Id.* at 46–47, 51–52.
236. *See, e.g.*, Social Security Act of 1972, Pub. L. 92–603, §§ 201, 299I, 86 Stat. 1329, 1373, 1463.
237. *See id.*
238. *See id.*; *see also* SZYMENDERA, *supra* note 16, at 1, 3; Eggers, *supra* note 18, at 55.
239. *See* Consolidated Appropriations Act of 2001, Pub. L. No. 106–554, § 115, 114 Stat. 2763, 2763A–474 (2000) (codified as amended at 42 U.S.C. § 426(h)).
240. Theodore R. Marmor & Kip Sullivan, *Medicare at 50: Why Medicare-for-All Did Not Take Place*, 15 YALE J. HEALTH POL'Y L. & ETHICS 141, 145 (2015).
241. *See* Keeler et al., *supra* note 47, at 193.
242. *Id.*
243. *See supra* text accompanying notes 46, 52–53.
244. Keeler et al., *supra* note 47, at 193.

This "per-case premium" takes the form of an overall reduction in each DRG payment by 5% to finance the outlier payments.[245] Generally, that payment is structured to cover 80% of costs above the "deductible," thus mirroring the coinsurance structure common in reinsurance policies.[246] A study from the early days of outlier payments showed who in the end benefited from this policy:

> Individuals with end-stage renal disease or diabetes as secondary complications to their current stay . . . were more apt to generate large losses. Being [B]lack also predict[ed] large losses, but this effect [was] substantially reduced when we control[led] for the hospital. These characteristics could easily be known to the hospital at admission time, and thus the hospitals could discriminate against these patients if they ch[o]se to do so.[247]

Thus, outlier payments functioned as reinsurance insofar as they acted not merely to smooth volatility thereby reducing overall costs but also to increase beneficiaries' access to the institutions that absorb risk, especially for those groups vulnerable to risk-discrimination. This antidiscrimination function remains relevant, even in the ARP's premium expansion context, which otherwise dulls the premium reduction effects of reinsurance.

Starting as early as the 1980s, Medicare was buffeted by the same forces that pushed Medicaid toward greater managed care intermediation.[248] In its current incarnation, Medicare incorporates managed care by paying private "at-risk" plans a prospective capitated lump sum to provide comprehensive Medicare services (usually Part A, B, and D) for any given enrollee.[249] This mode of furnishing Medicare is now referred to as Medicare Advantage, though it previously went by "Medicare Part C" and "Medicare+Choice."[250] Medicare does not provide reinsurance to the private plans, arguably because the statute "requires [these Medicare Advantage Organizations (MAOs)] to 'assume full financial risk . . . for the provision of [] health care services.'"[251] But nearly all MAOs purchase their own reinsurance.[252]

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245. *Id.* at 197.

246. REINSURING HEALTH, *supra* note 46, at 132 ("Medicare pays a hospital 80 percent of its costs above the threshold that defines an outlier case.").

247. Keeler et al., *supra* note 47, at 210.

248. *See, e.g.*, James C. Beebe, *An Outlier Pool for Medicare HMO Payments*, 14 HEALTH CARE FIN. REV. 59, 59 (1992).

249. YASH M. PATEL & STUART GUTERMAN, COMMONWEALTH FUND, THE EVOLUTION OF PRIVATE PLANS IN MEDICARE 1, 2 (2017).

250. *Id.* at 2, 4.

251. Bruce Merlin Fried, *CMS: Quota Share Reinsurance "Not Permissible" for Medicare Advantage Plans*, DENTONS (Feb. 14, 2017), https://www.dentons.com/en/insights/alerts/2017/february/13/cms-quota-share-reinsurance-not-permissible-for-medicare-advantage-plans (quoting 42 U.S.C. § 1395w-25(b)).

252. *Id.*

Medicare Advantage, in its own perverse way, however, enjoys a de facto government high-risk pool. The healthiest seniors are skimmed by private plans and traditional Medicare with government risk-absorption catches the residual pool.[253] Indeed, this dynamic was well-known and widely expected at the time these programs were designed:

> In 1996, for example, the most expensive 10 percent of program beneficiaries averaged $37,000 in medical expenditures and accounted for 75.5 percent of all program costs. In the new Medicare market, private insurers could be expected to compete aggressively to avoid enrolling such costly patients, leaving them for the public Medicare program.[254]

In 2003, after decades of political clamoring for Medicare to add prescription drug coverage, the Bush Administration finally did so by creating Medicare Part D.[255] However, this $400 billion benefit came with the stipulation that prescription drug coverage could only be delivered by private plans, either through the MAOs described above, or by private stand-alone prescription drug plans, which did not yet exist.[256] Unlike with Medicare Parts A and B, passed in 1965, the government was disabled from directly financing medical costs under Medicare Part D.[257] It could only contract with private plans to provide coverage. In other words, the primary insurer was never the government, but always private plans from the outset. But the government faced the challenge of inducing private actors to offer an unprecedented form of insurance in an entirely new market. As one commentator recounted:

> When the Medicare Modernization Act of 2003 (MMA) created an outpatient prescription drug benefit, there was doubt about whether a viable insurance market would form because drug-only insurance was not offered commercially; uncertainty arising from the lack of credible data on Medicare beneficiary drug utilization and spending put insurers at high risk . . . .[258]

Therefore, Congress braided reinsurance into the design of Medicare Part D to reassure and thereby induce insurers to participate in the new Medicare Part D program.[259] This reinsurance had no built-in sunset and

253. MARMOR, *supra* note 63, at 143.

254. *Id.* at 143–44 (citation omitted).

255. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066 (codified as amended at 42 U.S.C. § 1395w-101).

256. See, for example, the so-called "non-interference" clause. Social Security Act § 1860D-11(i), 42 U.S.C. § 1395w-111(i). For the near $400 billion over ten year price tag, see *Estimating the Cost of the Medicare Modernization Act: Hearing Before the Comm. on Ways & Means*, 108th Cong. 1–2 (2004) (statement of Douglas Holtz-Eakin, Director, Cong. Budget Off.).

257. Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 HEALTH CARE FIN. REV. 11, 18, 21 (2005). JUDITH A. STEIN, ALFRED J. CHIPLIN, JR., & KATA M. KERTESZ, MEDICARE HANDBOOK 11–13 (2021 ed. 2020).

258. Steven M. Lieberman, *Adapting Medicare Advantage Bidding for COVID-19-Related Uncertainty on Claims: A Proposal*, HEALTH AFFS. (May 15, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200513.916922/full/.

259. *See id.*

offered greater backstopping to private insurers compared to the ACA's three-year, time-limited reinsurance measure.[260] Part D reinsurance was also comparatively generous. For instance, the FY 2019 out-of-pocket threshold clocked in at $5,100.[261] For prescription drug costs above that point, the federal government would directly cover 80% of costs, and the private Part D plans would pay only 15% in coinsurance.[262] Beneficiaries remained responsible for the remaining 5% of prescription drug costs.[263] This government relief proved so generous that MedPAC has warned that it may fuel excessive pricing by pharmaceutical companies for their specialty drugs.[264]

One Medicare episode might defy this characterization of Medicare as reinsurance; namely, the failure of the Medicare Catastrophic Coverage Act of 1988. The legislation, championed by Otis Bowen and then Democratic House Ways and Means Chair Dan Rostenkowski, would have lifted the limit on the number of hospital days covered and established ceilings on Medicare patients' cost-sharing, apparently backstopping seniors' exposure to high medical costs.[265] But upon examination of the benefits and burdens, the policy seemed less like loss-spreading reinsurance and more like forced contribution to supplemental coverage, especially concentrating the burdens on affluent seniors. Rather than drawing from general funds and payroll taxes, the proposal ended up requiring Medicare recipients themselves (already on a fixed income and bearing the risk exposure that justified Medicare in the first place) to pay extra premiums to self-fund additional benefits.[266] Those benefits included not only catastrophic insurance but a number of other items opportunistically added to this legislation, including prescription drugs.[267] This financing source was not original to the Bowen conception but forced upon him by the hardline antispending Reagan Administration.[268] Reagan had signaled that he would not block catastrophic coverage for seniors per se.[269] However, he would oppose any additional commitments of federal spending.[270] This constraint forced Representative Dan Rostenkowski to raise offsetting pay-fors from the Medicare recipients themselves.[271] Rostenkowski managed to get the bill passed, but the backlash was legendary, producing indelible footage of Rostenkowski fleeing his car pursued by angry senior

260. *See supra* text accompanying notes 89–145.
261. Joshua Cohen, *New Reinsurance Model in Medicare Part D*, FORBES (Feb. 11, 2019, 8:32 AM), https://www.forbes.com/sites/joshuacohen/2019/02/11/new-reinsurance-model-in-medicare-part-d/.
262. *Id.*
263. *Id.*
264. MEDPAC, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 158, 167 (2015).
265. *See* MARMOR, *supra* note 63, at 110; QUADAGNO, *supra* note 188, at 150–51.
266. *See* QUADAGNO, *supra* note 188, at 153.
267. *Id.*
268. *See* MARMOR, *supra* note 63, at 112.
269. *See id.* at 110–12.
270. *Id.* at 112.
271. *Id.*

mobs.[272] Congress repealed the measure within eighteen months of passage.[273] As Marmor explains, the true objection was not to the capping of medical financial exposure above a certain threshold, but to where the burden fell for financing that policy.[274] Rather than spreading risk, it surcharged those most at risk of catastrophic health events, especially those seniors who were affluent and needed government reinsurance the least, because many already had private secondary coverage.[275] In 1986, for instance, 80% of all seniors were covered under supplemental Medigap policies, which were either paid for by the seniors themselves or enjoyed as a retirement benefit accruing from their previous employer.[276] Moreover, the proposed benefits swelled to include prescription drugs, which were at the time considered more routine than catastrophic, even as the legislation failed to protect against the costs of needed long-term care, which seniors dreaded as a ruinous expense.[277] Arguably, the backlash was not to the concept of reinsurance itself, but instead to the ways that the policy design departed from true reinsurance. Meanwhile, the addition of pharmaceutical benefits to the bill not only added to the bill's expense but also galvanized the pharmaceutical industry to spend $3 million lobbying against the prospect of government regulation.[278]

Jill Quadagno sums up the reinsurance significance of Medicare best: "Politically, Medicare filled the remaining gap that negotiated plans could not cover, removing all pressure for national health insurance. Immediately, as the burden of the older, otherwise uninsured population was removed, Blue Cross began lowering its rates across the country."[279]

### *C. History of ERISA in Health Care*

ERISA, enacted in 1974, was a pension guaranty statute that also governed other fringe benefits like employer-sponsored health coverage.[280] Yet, the drafters of ERISA gave far less thought to the governance of health benefits than they did to traditional pensions.[281] As Bill Sage so memorably noted in 1996, "Although in its text 'hospital' appears only once and 'physician' not at all, ERISA may be the most important law affecting health care in the United States."[282]

Though ERISA's role in the U.S. health sector has always posed something of a puzzle, I will argue here that understanding ERISA as an

272. CBS News, *'Buried In The Archives,' The Original Town-Hall Battle*, YOUTUBE (Aug. 10, 2009), https://www.youtube.com/watch?app=desktop&v=qre7DzEtxyc&feature=emb_logo.
273. QUADAGNO, *supra* note 188, at 158.
274. MARMOR, *supra* note 63, at 112–13.
275. *Id.*
276. QUADAGNO, *supra* note 188, at 150.
277. *Id.* at 150–59.
278. *Id.* at 154.
279. *Id.* at 75.
280. *Id.* at 142.
281. William M. Sage, *'Health Law 2000': The Legal System and the Changing Health Care Market*, 15 HEALTH AFFS. 9, 10–15 (1996).
282. *Id.* at 11.

imperfect reinsurance measure for employer-sponsored health benefits may supply the key.

I begin with the observation that the federal health-related protections in ERISA have been scant, lacking any "substantive federal requirements for private health care plan coverage and benefits."[283] Background state laws governing pension annuities generally offer less protection than federal ERISA standards.[284] But in the health context, the situation is reversed: state substantive and remedial protections actually surpass the federal protections of ERISA.[285] This imbalance is evident in the statute's structure. As Medill observes, ERISA's Title I is divided into parts and the substantive coverage and benefits standards of Parts 2 and 3 apply to pension plans alone.[286] Only Parts 1, 4, and 5 extend to health benefit plans as well.[287] These health-salient provisions, however, originally contained no substantive benefit standards, speaking only to procedural and formal matters, such as annual reporting, disclosure, documentation, the handling of plan assets, and the assignment of fiduciary responsibility to plan administrators.[288] Even this last protection is illusory, as the plan administrator, working on behalf of the employer, is unavoidably conflicted, as the court not only recognizes but accommodates.[289] Part 5 establishes a federal enforcement scheme and most notably, with strong preemption provisions.[290] Thus, without providing any substantive federal health standards, ERISA still operates to displace virtually all state governance. The effect of this "most important law affecting health" has therefore been largely deregulatory.

The scope of preemption has proven extraordinary. The express preemption terms are broad, as some recent commentators note:

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283. Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 488 (1998).

284. *Id.* at 488–89.

285. *See id.* at 487–89.

286. *Id.* at 490.

287. *Id.*

288. 29 U.S.C. §§ 1102–12.

289. Paul M. Secunda & Brendan S. Maher, *Pension De-Risking*, 93 WASH. U. L. REV. 733, 760 (2016) ("It has long been recognized that many ERISA fiduciaries are, in practice, conflicted because they are employed, controlled, or beholden to the plan sponsor.") (citing Metro Life Ins. Co. v. Glenn, 554 U.S. 105, 120 (2008)) (conceding that in most ERISA cases, fiduciaries are under a conflict of interest).

290. *See* Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 327 (2016) (Thomas, J., concurring).

> When state laws conflict with federal ones, preemption doctrine generally displaces the state law in favor of the federal. But the express . . . preemption in ERISA [Section 514(a)] sweeps even further, purporting to invalidate "any and all" state laws that "relate to" an employee benefit plan, not merely those which unavoidably conflict.[291]

To be sure, the express preemption provision contains an exception that purports to "save" state laws that "regulate insurance" from the force of ERISA's sweeping preemption clause.[292] However, this savings clause is in turn limited by the "deemer clause."[293] Under the deemer clause, insurance regulations might be saved, but any employer health plans that are self-insured (rather than purchased from a third-party insurer) cannot be "deemed" to be insurance or treated as coming under the purportedly saved state regulations.[294] Unsurprisingly, employers have chosen to self-insure their way out of regulation, and now less than one-third of employees with employer-sponsored coverage actually come under state law.[295]

The force of ERISA preemption does not end there. The Supreme Court has found that ERISA effectuates, in Justice Thomas's words, a "still stronger" preemption than mere conflict or express.[296] The "complete" preemption posited by the Court is not found in the text of the § 514 preemption clause. Instead, the Court reasons that the structure of the list of remedies available in ERISA under § 502 implies that any additional state remedies, regardless of whether they conflict with the text of ERISA or relate to an employee benefit plan, are displaced.[297] As Justice O'Connor argues, "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."[298]

This unfortunate strong-form preemption blocks state remedies when often what is at stake in these suits is precisely the level of remedy. The federal enforcement scheme under § 502 includes a federal cause of action

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291. Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 392 (2020).

292. 29 U.S.C. § 1144(b)(2)(A).

293. *Id.* § 1144(b)(2)(B).

294. Russell B. Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 89 (2005).

295. Gary Claxton, Anthony Damico, Matthew Rae, Gregory Young, Daniel McDermott, & Heidi Whitmore, *Health Benefits in 2020: Premiums in Employer-Sponsored Plans Grow 4 Percent; Employers Consider Responses to Pandemic*, 39 HEALTH AFFS. 2018, 2018–21 (2020).

296. Aetna Health Inc. v. Davila, 542 U.S, 200, 209 (2004) (declaring:
"The pre-emptive force of ERISA § 502(a) is still stronger."). *See also* Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 65–66 (1987) (determining ERISA civil enforcement is a provision with "extraordinary pre-emptive power" because of the similarity of language used in the Labor Management Relations Act (LMRA), 1947, combined with the "clear intention" of Congress "to make § 502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in a manner similar to § 301 of the LMRA," together this established that ERISA § 502(a)(1)(B)'s preemptive force mirrored the preemptive force of LMRA § 301).

297. *Aetna Health*, 542 U.S. at 209.

298. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

for denial of benefits by employee benefit plans, stripped of compensatory or punitive relief.[299] Section 502(a)(1)(B) merely allows the "participant or beneficiary . . . to recover benefits due [to them] under the terms of [the] plan."[300] "Put another way, if a patient were to die from a brain tumor following a routine denial of a diagnostic procedure, the patient's survivors could recover no more than the value of the [diagnostic] test itself."[301]

The employer effectively enjoys a limit on their liability for administering employee health benefits.[302] This government-assured risk ceiling is a form of reinsurance. Writing of ordinary limited liability for corporations, David Moss explains, "[L]imited liability is actually a remarkably simple risk management device. All that it does is shift a portion of default risk from shareholders to creditors—in many ways, mimicking an insurance policy."[303] He goes on to describe how limited liability, like reinsurance, helps lure greater participation in the private risk market, just as the body of ERISA doctrine embraces the goal of encouraging employers to offer health benefits.[304] As a final parallel to reinsurance, the excess risk transferred by limited liability is spread broadly to backstop private capital:

> [T]he only real losers from [the introduction of] limited liability law were involuntary creditors, who were forced to assume additional default risk without compensation of any kind. This meant that a tiny bit of additional risk fell on every member of society, since just about anyone could become the victim of a corporation in one way or another.[305]

Under ERISA, the "tiny bit of additional risk" is the possibility that inability to finance medical expenses can spiral into grave health consequences. ERISA takes this risk, which employers would otherwise absorb by furnishing health benefits as contracted, and instead distributes it among all employee–beneficiaries.[306]

### *D. History of John Kerry's Failed Presidential Campaign Proposal*

Our accidental health governance regime, propped up by Medicare, Medicaid, and ERISA, left major gaps and distortion. However, state governments, hobbled by scale and ERISA preemption, were limited in what they could do to patch the holes as ever more Americans lost

299. Sara Rosenbaum & Joel Teitelbaum, *Law and the Public's Health*, 119 PUB. HEALTH REPS. 510, 510 (2004); *see also* Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 136 (1985).

300. 29 U.S.C. § 1132(a)(1)(B).

301. Rosenbaum & Teitelbaum, *supra* note 299, at 511.

302. *Id.* at 512 ("ERISA plan fiduciaries are shielded from any serious financial consequences for what might be an arbitrary and capricious denial of coverage.").

303. MOSS, *supra* note 24, at 83.

304. *Id.*; *see also infra* note 412.

305. MOSS, *supra* note 24, at 84.

306. *See id.*; *see also infra* note 308.

employer-sponsored or other forms of coverage.[307] John Kerry, in his ill-fated 2004 presidential run, proposed to address some of these coverage gaps through health reinsurance for employers.[308] Reinsurance would serve to entice employers to provide and maintain health benefits for all their workers.[309]

The Kerry campaign website described the plan thus:

> Under this proposal, the pool would reimburse . . . employer and group health insurance plans that meet certain qualifications for a portion of catastrophic costs. "Catastrophic costs" would be defined as the annual claims for an individual that exceed a certain threshold. This catastrophic threshold would be set so that the average estimated savings would be approximately 10[%] for qualifying plans nationwide.[310]

This catastrophic threshold formula translated into an attachment point of $30,000 a year for 2006 and an estimated $50,000 by 2013.[311] If a beneficiary ran costs above that point, the government would absorb 75%, leaving the employer to pay only one-fourth of the costs.[312] This approach would trim an estimated $1,000 a year off the cost of employer-based family coverage.[313]

An employer "pay-or-play" model, one of the leading approaches to health reform for over a decade by that point, would have employed a tax penalty as a stick against employers failing to cover their workers. [314] The Kerry reinsurance policy, much like the Eisenhower plan, offered a carrot to employers to extend coverage.[315] If employer plans met certain standards, they would receive the benefit of this government backstop for each employee.[316] It was estimated that "less than half of 1[%] of private insurance claims hit Kerry's $50,000 catastrophic threshold [and yet] this small fraction devoured 15% of all medical services provided in 2000."[317]

Kerry's reinsurance-based proposal was crafted for its broad acceptability and smooth fit with the existing social and political landscape, showing once again how the concept of reinsurance is a heretofore unremarked throughline in the history of the American health sector. In the

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307. Elizabeth Y. McCuskey, *State Cost-Control Reforms and ERISA Preemption*, COMMONWEALTH FUND (May 16, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption.

308. *John Kerry's Plan to Make Health Care Affordable to Every American*, KERRY-EDWARDS, http://web.archive.org/web/20040828055342/http:/www.johnkerry.com/issues/health_care/health_care.html (last visited Oct. 29, 2022) [hereinafter *Kerry Campaign Website*].

309. *Id.*

310. *Id.*

311. *Id.*

312. Ceci Connolly, *Kerry Plan Could Cut Insurance Premiums*, WASH. POST (June 5, 2004), https://www.washingtonpost.com/wp-dyn/articles/A16748-2004Jun4.html.

313. *Kerry Campaign Website*, *supra* note 308.

314. *See, e.g.*, DASCHLE ET AL., *supra* note 229, at 76–77 ("As the 1992 election drew closer, the pay-or-play model emerged as the most promising approach.").

315. *See* Connolly, *supra* note 312.

316. *Kerry Campaign Website*, *supra* note 308.

317. Connolly, *supra* note 312.

end, George W. Bush proceeded to win a second term,[318] defeating John Kerry and cutting off prospects for this next incremental step in the health reinsurance project.

## IV. REINSURANCE IN NON-HEALTH DOMAINS

Looking beyond the realm of health policy, one finds that reinsurance has deeper roots, forming a vast risk-management system that spans policy domains.

It is hardly an exaggeration to say that whenever the United States sought to guarantee the availability of a crucial service, it turned to reinsurance. The policies may appear under different names but have recognizably similar structures. This Part will show the ubiquity and deep entrenchment of the role of the U.S. government in establishing risk ceilings above which private risks are transferred to the public.

This observation is in one sense commonplace. Though it may not use the word "reinsurance," a vast body of cross-disciplinary scholarship establishes this claim. To cite just a few examples, I point to sociologist Sarah Quinn, who writes: "[T]he federal government has bolstered nearly every sector of the economy, with extensive backing harnessed for core industries: first agriculture, then housing, and most recently education."[319] Meanwhile, law and political science scholars William Eskridge and John Ferejohn argue that in the United States, the government assurance of the security of bank notes and deposits, as well as environmental security, retirement security, and the stability of markets, form a set of "'small c' constitutional 'commitments embodied in federal statutes.'"[320] Legal historian Michele Landis Dauber examines the role of the U.S. state in providing baseline rescue from catastrophic disaster loss.[321] She recovers a history of congressional appropriations based on the principle of disaster relief for "blameless victims" of providence which predates even the New Deal, and in doing so, meticulously chronicles the treatment of such claims as not only permitting but also compelling legislative action based on the precedent of relief for similarly situated claimants.[322] In his sweeping book *When All Else Fails: Government as the Ultimate Risk Manager*,[323] economist David Moss supplies yet more examples of government-as-risk-backstop, including the Federal Reserve, the Federal Deposit Insurance Corporation (FDIC), limited liability for corporations, and the Superfund.[324] Political scientist Jacob Hacker and policy adviser Ann O'Leary

318. *See* George W. Bush, THE WHITE HOUSE, https://www.whitehouse.gov/about-the-white-house/presidents/george-w-bush/ (last visited Oct. 29, 2022).

319. QUINN, *supra* note 11, at 5.

320. *See generally* WILLIAM N. ESKRIDGE, JR. & JOHN FEREJOHN, A REPUBLIC OF STATUTES: THE NEW AMERICAN CONSTITUTION (2010).

321. *See generally* MICHELE LANDIS DAUBER, THE SYMPATHETIC STATE (2013).

322. *Id.*; *see also* Floyd D. Shimomura, *The History of Claims Against the United States: The Evolution from a Legislative Toward a Judicial Model of Payment*, 45 LA. L. REV. 625, 652–53 (1985).

323. MOSS, *supra* note 24.

324. *See generally id.*

offer precedents and proposals for government risk-backstopping across numerous sectors in their edited volume, *Shared Responsibility, Shared Risk*.[325]

I proceed to examine several of these non-health precedents and tease out the ways they correspond to government reinsurance. I will show that various price supports, limited liability schemes, derivatives, or securities can be functionally equivalent to reinsurance. By illuminating the deployment of government "reinsurance" in non-health programs, a few insights are gained. First, I show the prevalence of reinsurance in other domains. By revealing the similarities, its absence in the health sector is rendered less a matter of prudent government reluctance to commit to an expensive, discretionary privilege. This false characterization of health backstopping as a privilege puts the burden on health proponents to justify such an expensive payout. Instead, the fact of across-the-board assurances in other material sectors and a conspicuous de-privileging of the value of human health then shifts the burden to those who should have to explain why these other areas are backstopped, but not human health. Finally, this cross-sectoral examination gives us a chance to look at what has worked, and what lessons to draw for better implementation in the health sector.

I start with crops, housing, and higher education.

### *A. Crops*

Price supports represent one type of government guarantee in agriculture, socializing the risk of price volatility. One major system of price supports administered by the Commodity Credit Corporation (CCC) arose during the New Deal.[326] The corporation existed first under Delaware charter, then was reincorporated within the U.S. Department of Agriculture (USDA) in 1948 under the Commodity Credit Corporation Charter Act.[327] Price supports are among its chief functions.[328] The government sets a threshold price for certain crops, and through the CCC farmers are assured that they can sell for no less than that amount.[329]

The CCC carries out this program by lending money to farmers with the farmer's crop as collateral.[330] The program then gives farmers several options for satisfying their debt. First, as one might expect, farmers can pay back the outstanding loan at the price support rate plus interest. If the market price of the crop exceeds the government's price, the creditor farmer sells at that higher price and repays the government loan amount

325. JACOB HACKER & ANN O'LEARY, SHARED RESPONSIBILITY, SHARED RISK: GOVERNMENT, MARKETS AND SOCIAL POLICY IN THE TWENTY-FIRST CENTURY (1st ed. 2012).

326. *Commodity Credit Corporation*, USDA, https://www.usda.gov/ccc (last visited Oct. 28, 2022); *see also* QUINN, *supra* note 11, at 137–38.

327. *Commodity Credit Corporation*, *supra* note 326; *see also* QUINN, *supra* note 11, at 138.

328. *Commodity Credit Corporation*, *supra* note 326.

329. QUINN, *supra* note 11, at 138.

330. CONG. BUDGET OFF., ESTIMATING THE COSTS OF ONE-SIDED BETS: HOW CBO ANALYZES PROPOSALS WITH ASYMMETRIC UNCERTAINTIES 9–10 (1999).

plus interest out of the proceeds.[331] However, if the price falls below the price support threshold the creditor will obviously lose money without the reinsurance-like policy that the CCC provides. Quinn explains the risk-shield thus: "If the market price falls below the government price, then the farmer simply defaults on the loan, and the government keeps the crop."[332] She goes on to explain: "These instruments are called 'non-recourse' loans because the government has agreed, in case of default, to seek no repayment for the loan beyond the crops already pledged as collateral."[333] The farmer is protected from ever having to suffer the losses from prices falling below the government-set price.[334] CCC borrowers have a third option: they can also pay back the government at the prevailing market rate, which could be lower than the rate at which they borrowed.[335] The amount they pocket if the prevailing rate is lower is called a "marketing loan gain."[336]

This option set resembles reinsurance insofar as the government establishes a limit on the risks of downward crop price fluctuation. If the farmer faces losses as a result of market prices dipping below a certain threshold, the government will absorb those losses and spread them across U.S. taxpayers.[337] This federal funding commitment is actually classified as an entitlement; it is listed on the mandatory side of the budget and is impervious to yearly appropriations.[338]

But price supports are not the only protection that government affords farmers. In the late 1930s, FDR instituted crop insurance for "selected crops in selected counties."[339] This program finally assumed its modern form in 1980:

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331. *Id.*

332. QUINN, *supra* note 11, at 138.

333. *Id.* (continuing, "According to Jesse Jones, this plan came down personally from Roosevelt, who got the idea from Mississippi cotton planter Oscar Johnson. . . . In 1939 the CCC was transferred to the Department of Agriculture, and in 1948 it was reorganized as a federal corporation.").

334. CONG. BUDGET OFF., *supra* note 330, at 9–11 (describing this basic structure as the result of the 1985 Farm Bill, otherwise known as The Food Security Act of 1985, Pub. L. No. 99–198).

335. *Id.* at 10.

336. *Id.*

337. CONG. RSCH. SERV., R44606, THE COMMODITY CREDIT CORPORATION: IN BRIEF 4–7 (2016) (describing how the CCC was initially capitalized by the U.S. Treasury, is authorized to borrow from the U.S. Treasury, and runs losses that are then paid off by Congress periodically through appropriations).

338. 7 U.S.C. §1516(a)(2), enacted in the Consolidated Appropriations Act, 2017, Pub. L. No. 115–31 (2017); *see* RICHARD KOGAN, DOTTIE ROSENBAUM, & ZOE NEUBERGER, PROTECTING SNAP AND CHILD NUTRITION PROGRAMS FROM APPROPRIATIONS LAPSES 3 n.5 (2020) (explaining some of the idiosyncrasies of the appropriations status of CCC's entitlement programs thus: "Although annual appropriations are made to the Commodity Credit Corporation, those payments reimburse the corporation for prior losses and are not needed to finance current benefits because the corporation can borrow as needed from the Treasury as long as its outstanding debt does not exceed $30 billion.").

339. MOSS, *supra* note 24, at 261.

> The Federal Crop Insurance Improvement Act of 1980 . . . replac[ed] a standing disaster assistance program with subsidized crop insurance. To encourage sales, private companies were enlisted to deliver the product. . . . Almost overnight, the crop insurance program was converted from a pilot program offering limited coverage to a limited number of crops . . . to a nationwide program covering most major field crops in most major growing regions.[340]

Farmers growing insurable crops purchase insurance through the Federal Crop Insurance Corporation (FCIC), selecting the level and type of coverage.[341] In the mid-1990s, the purchase of at least minimum catastrophic (CATP) coverage was compulsory in order to combat adverse selection, mirroring the rationale behind the individual mandate in the ACA.[342] Farmers pay a portion of the premium, depending on their coverage level.[343] If the farmer had selected CATP coverage only, the government would have covered 100% of the premium with the farmer merely paying a flat fee.[344] Should the farmer "buy-up" to a higher level of coverage, the government's share of the premium would decline.[345] Government premium subsidies averaged 62% of the premium cost in 2014.[346] ACA subsidies by contrast averaged 86% of premiums for those eligible for premium tax credits.[347] As with the ACA, the FCIC insurance policies are sold and serviced through private insurance companies called Approved Insurance Providers.[348] Finally, and this is the point of this Part, USDA reinsures the insurance companies' losses under terms laid out in a Standard Reinsurance Agreement (SRA).[349] This government "[r]isk sharing was seen as an inducement to encourage companies to participate in the program."[350] The loss-sharing takes the form of a layered "quota share" reinsurance contract.[351] Assume that an insurer's "loss ratio" lies between 1 and 1.60, meaning that the insurer pays out more in claims than it collects in premiums, up to the point where the insurer faces 60% more in payouts than in collected premium revenue. Under the SRA, the insurer does not have to bear the entire loss. For the year 2020, for instance, the federal government would reimburse 35% of the loss, more depending on the state

340. Glauber, *supra* note 61, at 1179.
341. *See generally* 7 U.S.C. §§ 1501–1524.
342. Glauber, *supra* note 61, at 1182 (stating that participation was mandatory between 1994 and 1996).
343. DENNIS A. SHIELDS, CONG. RSCH. SERV., FEDERAL CROP INSURANCE: BACKGROUND 7 (2015).
344. *Id.*
345. *Id.*
346. *Id.* at 13.
347. CTR. MEDICARE & MEDICAID SERVS., EARLY 2020 EFFECTUATED ENROLLMENT SNAPSHOT 1–2 (2020).
348. *About the Risk Management Agency*, USDA (Aug. 2021), https://www.rma.usda.gov/en/Fact-Sheets/National-Fact-Sheets/About-the-Risk-Management-Agency.
349. 7 C.F.R §§ 400.161–400.169; SHIELDS, *supra* note 343.
350. Glauber, *supra* note 61, at 1187.
351. *Id.* at 1189 tbl.7.

at issue.[352] Insurers with higher aggregate losses above that layer were reinsured by the government to an even greater extent.[353] The final layer of reinsurance in 2020 kicked in if the loss ratio exceeded five.[354] All losses above that level were fully reimbursed by the federal government.[355]

Aggregate reinsurance is thus a "one-sided risk corridor." Crop insurance, however, is two-sided. It incorporates not only downside government loss-sharing (which reinsures and thereby cushions private primary insurer loss) but also some measure of upside gainsharing with the government. Private insurers must pay in some of the upside underwriting gains. This risk corridor is not designed to be perfectly symmetrical; the amount that insurers receive from the government for underwriting losses is larger than the amount the government recoups through gainsharing.[356] The difference represents federal subsidy. This system of crop insurance cost the government $14.1 billion in FY 2012 alone[357] and totaled $72 billion from 2007 to 2016.[358] "Federal outlays for crop insurance exceed those for the commodity support programs, making crop insurance the most significant cost component of the farm safety net."[359] As Joseph Glauber has observed, the experience of crop insurance "suggests an alternative role for government as regulator and reinsurer of catastrophic risks rather than as a provider of individual risk protection through the sale of retail risk products."[360]

A third type of reinsurance for farmers, beyond price supports and crop insurance, takes the form of government backing for farmers' mortgages.[361] This indirect supply-side support dates back to at least the Progressive Era and represents the peculiarly roundabout way that Americans use government to secure material provision in a crucial sector.[362] These land finance supports arose not from concern for mortgage lenders, the most immediate beneficiaries of this government backstop, but out of "[c]oncerns about the social well-being of rural America [which] drew . . . attention to the problem of farm credit. . . . Mounting food prices further reminded a burgeoning middle class that the decline of the countryside came at the expense of the entire nation."[363]

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352. UNITED STATES DEPARTMENT OF AGRICULTURE, STANDARD REINSURANCE AGREEMENT 15 (2019), https://www.rma.usda.gov/-/media/RMA/Regulations/Appendix-2020/20sra.ashx?la=en, (shows for State Group I, the commercial insurer retains only 65% of the underwriting loss).

353. *Id.* at 15–17.

354. *Id.*

355. *Id.* at 17.

356. Alan R. Jung & Cyrus A. Ramezani, *Insurance and Reinsurance Contracts as Complex Derivatives: Application to Multiple Peril Policies*, at 89, 14 (July 24, 1999), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=170689#references-widget.

357. SHIELDS, *supra* note 343.

358. CONG. RSCH. SERV., R45193, FEDERAL CROP INSURANCE: PROGRAM OVERVIEW FOR THE 115TH CONGRESS (2018).

359. SHIELDS, *supra* note 343.

360. Glauber, *supra* note 61, at 1192.

361. QUINN, *supra* note 11, at 71.

362. *See id.* at 72.

363. *Id.* at 71.

What could be seen as a bailout for lenders or insurers was partially motivated by a desire to assure the supply of food for Americans. This same approach pertains to government support for housing as well. I now turn from the government's backstopping of risk relating to mortgages for farmland to risk backstopping as applied to residential housing.

*B. Homeownership and Mortgages*

Support for homeownership looms large in the U.S. history of government-backed risk management. Mortgages themselves constitute a primary safeguard.[364] For the creditor, the security interest in the real property shields them from the debtor's default, and for the debtor at risk of default, non-recourse mortgages have made foreclosure a fallback means of discharging the debt.[365] But, the government has always had a hand in shaping and supporting mortgages as private risk management devices.[366]

Here, I focus on the major federal programs that backstop mortgages. The basic infrastructure of these programs grew out of the Great Depression.[367] Home lending had cratered and default risks overflowed the capacity of existing institutions.[368] Between the late 1920's and 1933, homes lost 30% to 40% of their value.[369] The government surveyed a subset of cities in 1934 and "found that 45[%] of owner-occupied mortgaged homes were in default."[370] Debtors could not pay, and creditors froze lending. Congress responded with multiple measures including the National Housing Act (NHA).[371]

The 1934, the NHA created the Federal Housing Authority (FHA) to provide lenders with the assurance they needed to reextend and expand credit to Americans for homes.[372] FHA did so in part by furnishing mortgage insurance to approved lenders when they offered qualifying

364. *See, e.g.*, *Mortgage Key Terms*, CFPB, https://www.consumerfinance.gov/consumer-tools/mortgages/answers/key-terms/ (last visited Oct. 29, 2022).

365. *Id.* As a result of the Great Depression, some states passed antideficiency statutes that restricted the lenders' recourse to deficiency judgments for any debt in excess of the proceeds of the foreclosure, but these cover a relatively small share of mortgages. *See generally* John Mixon & Ira B. Shepard, *Antideficiency Relief for Foreclosed Homeowners: ULSIA Section 511(b)*, 27 WAKE FOREST L. REV. 455, 455 (1992); *see also* John Mixon, *Fannie Mae/Freddie Mac Home Mortgage Documents Interpreted as Nonrecourse Debt (with Poetic Comments Lifted from Carl Sandburg)*, 45 CAL. W.L. REV. 35, 86–87 (2008); *see also* Danielle D'Onfro, *Limited Liability Property*, 39 CARDOZO L. REV. 1365, 1387–92 (2018).

366. QUINN, *supra* note 11, at 106.

367. FED. HOUS. FIN. AGENCY, OFF. OF THE INSPECTOR GEN., A BRIEF HISTORY OF THE HOUSING GOVERNMENT-SPONSORED ENTERPRISES 1 (2011).

368. KENNETH T. JACKSON, CRABGRASS FRONTIER: THE SUBURBANIZATION OF THE UNITED STATES 193 (1987).

369. Steven D. Levitt, *Economist Price Fishback: The Real Facts About the Original Home Owners' Loan Corporation (and What They Mean for a Modern Incarnation)*, FREAKONOMICS (Oct. 17, 2008), https://freakonomics.com/2008/10/17/economist-price-fishback-the-real-facts-about-the-original-home-owners-loan-corporation-and-what-they-mean-for-a-modern-incarnation/.

370. QUINN, *supra* note 11, at 139.

371. *Id.* at 140.

372. *Id.*; *see also* National Housing Act, Pub. L. No. 479, 48 Stat. 1252 (1934) (codified as 12 U.S.C. § 1716).

mortgages.[373] The agency placed conditions on the mortgages it would insure, essentially setting a product standard resulting in market prevalence of low down payment thirty-year mortgages with amortized repayment of capital.[374] Short-term mortgages had rendered American families vulnerable, and the structure of the FHA mortgage obviated the need for multiple stacked mortgages to cope with high down payments and the prospect of balloon payments.[375] As Quinn observes, the policy served both families with housing needs and lenders issuing mortgages:

> For families, a longer repayment period and a lower down payment lessened the risk of foreclosure during market crises and eliminated the need for second or third mortgages. For lenders, insurance managed the risk of default. For the Roosevelt administration, it was a low-cost way to promote lending for new homes and repairs for the estimated 13 million homes in need of improvements in 1934.[376]

After World War II, "the G.I. Bill authorized the VA to guarantee mortgages for veterans . . . [and] [b]y 1955, 41[%] of the nation's mortgages were backed by the FHA or VA."[377]

FHA mortgage insurance is financed by premiums that borrowers pay over part of the course of the mortgage.[378] That fund is used to pay lenders for mortgages that have defaulted and can reimburse lenders for "deficiencies" or shortfalls when the value of the foreclosed property does not cover the debt.[379] These deficiencies typically proliferate during market downturns when property values crash systemically, which in reinsurance terms suggests covariant loss.[380] Unless the loans are stipulated as "non-recourse" either by contract or statute, mortgage lenders can generally pursue the borrowers for such deficiencies, but often to little avail, because a homeowner facing foreclosure likely cannot pay off any additional sums.[381] FHA mortgage insurance thus protects the borrower from these deficiency judgments that compound the catastrophe of default and foreclosure.[382] Meanwhile, it protects lenders from the risk of uncollectible debt, which arises because of the correlated risk environment of a market collapse.[383] It also benefits many other homeowners by encouraging

373. QUINN, *supra* note 11, at 140.

374. *Id.* at 142; *see also* Troy Segal, *Federal Housing Administration (FHA) Loan: Requirements, Limits, How to Qualify*, INVESTOPEDIA (July 11, 2022), https://www.investopedia.com/terms/f/fhaloan.asp.

375. *Id.*

376. *Id.*

377. *Id.*

378. CONG. RSCH. SERV., RS20530, FHA-INSURED HOME LOANS: AN OVERVIEW 7 (2022).

379. *Id.* at 11.

380. *See* Kimbriell Kelly, *Lenders Seek Court Actions Against Homeowners Years After Foreclosure*, WASH. POST (June 15, 2013), https://www.washingtonpost.com/investigations/lenders-seek-court-actions-against-homeowners-years-after-foreclosure/2013/06/15/3c6a04ce-96fc-11e2-b68f-dc5c4b47e519_story.html.

381. *See id.*

382. *See* CONG. RSCH. SERV., RS20530, FHA-INSURED HOME LOANS: AN OVERVIEW 10–11 (2022).

383. *See id.* at 1.

greater mortgage lending so that more households can purchase homes.[384] The functional parallels between mortgage insurance and reinsurance are striking. But the FHA did not perform this function for all families. Indeed, FHA policies as to the lenders and loans that it would back encoded racial segregation. The FHA's system of redlining excluded Black families from homeownership opportunities, with the *Underwriting Manual* of the FHA declaring that "incompatible racial groups should not be permitted to live in the same communities."[385] The government decided whose risks to backstop based on race, selectively abandoning others to the consequences of their bad bets.[386]

Mantled in FHA insurance, lenders still found the risk environment intractable, particularly given the overall context of the Great Depression. I will discuss two further aspects of mortgage risk that required government safety nets.

While the FHA could improve matters for the new FHA loans going forward, what about non-FHA loans? The Great Depression, after all, was characterized by a flood of troubled mortgages issued prior to the FHA. Who would mop up those risks? The federal government stepped in to buy non-FHA loans. In 1933, the Home Owners' Loan Corporation (HOLC) was created and funded with $200 million in government-backed bonds.[387] HOLC then traded those bonds for troubled mortgages to refinance, leaving borrowers with easier terms.[388] Multiple constituencies benefited, while some were invidiously excluded. HOLC notoriously deployed its soft power of standard-setting and norm-building to map home-lending risk,[389] creating the redlined maps by which HOLC and FHA "reproduced a set of racist underwriting standards that benefited white families in white neighborhoods."[390]

The private mortgage landscape continued to lack an ongoing secondary market for buying and reselling the broader spectrum of mortgages. As Quinn observes, "FHA insurance protected against credit risks, but its long-term mortgages tied up funds for [fifteen] or so years. This created a significant liquidity problem, and it heightened the need for a working secondary market where investors could off-load their mortgages."[391]

The assurance that the lender could sell mortgages to the government added another reinsurance-like backstop. In 1934, Congress still hoped the

384. REINSURING HEALTH, *supra* note 46, at 142.
385. Terry Gross, *A 'Forgotten History' of How the U.S. Government Segregated America*, NPR (May 3, 2017, 12:47 PM), https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america; RICHARD ROTHSTEIN, THE COLOR OF LAW: A FORGOTTEN HISTORY OF HOW OUR GOVERNMENT SEGREGATED AMERICA 65–66 (2017).
386. ROTHSTEIN, *supra* note 385, at 66, 83.
387. QUINN, *supra* note 11, at 141.
388. *Id.*
389. JACKSON, *supra* note 368, at 197–99.
390. QUINN, *supra* note 11, at 141.
391. *Id.* at 142.

private sector could perform this function and wrote specific authority into the NHA to charter private national associations for this purpose, even offering tax exemptions, lower reserve requirements, and other regulatory flexibilities to entice private interest.[392] The government promised investment by authorizing the Reconstruction Finance Corporation, an FDR vehicle for jolting the country out of the Depression, to buy stock in these associations.[393] However, "[t]he market was too broken, and conservative investors too wary."[394] Finally, the government had to amend the NHA in 1938 to create the Federal National Mortgage Association (FNMA or "Fannie Mae") as a government entity at the outset to furnish some kind of secondary market.[395]

One might say that Fannie Mae and its later siblings served as something like a "public option" to absorb mortgage risk regardless of private market participation.[396] Fannie Mae, Freddie Mac, and Ginnie Mae were endowed with the capacity to issue bonds to attract even more private funding into the credit market.[397] As one observer explains, "Fannie and Freddie don't issue mortgages. Instead, they buy loans from lenders and package the debt into bonds [mortgage-backed securities] that are sold to investors with guarantees of interest and principal. The process makes housing more affordable, while keeping the mortgage market humming."[398] The guarantees behind these mortgage-backed securities are funded by guarantee fees that all lenders pay into the U.S. Treasury.[399] This fund helps assure the timely payment of principal and interest to the security holders if too many underlying borrowers miss payments on their mortgages.[400] Fannie, which Congress spun off the government's balance sheet into a fully for-profit, shareholder-owned company in 1968,[401] now serves this function for conventional mortgages issued by the larger commercial banks while Freddie performs as the counterpart for smaller thrift savings banks and credit unions.[402] Ginnie Mae (Government National Mortgage Association) guarantees the payment of principal and interest on mortgage-backed securities for FHA, VA, and USDA loans, and unlike

392. *Id.* at 142–43.
393. *Id.* at 143.
394. *Id.*
395. *Id.*
396. QUINN, *supra* note 11, at 144.
397. Austin Weinstein, *Fannie-Freddie May Be Freed Without Congress, Calabria Says*, BLOOMBERG (May 8, 2019, 11:19 AM), https://www.bloomberg.com/news/articles/2019-05-08/fannie-freddie-may-be-released-without-congress-calabria-says#xj4y7vzkg; *3 Things to Know About Fannie Mae, Ginnie Mae, and Freddie Mac*, ATL. BAY MORTG. GRP. (Feb. 2017), https://www.atlanticbay.com/knowledge-center/3-things-to-know-about-fannie-mae-ginnie-mae-and-freddie-mac/.
398. *Id.*
399. FED. HOUS. FIN. AGENCY, DIV. OF HOUS. MISSION & GOALS, FANNIE MAE AND FREDDIE MAC SINGLE-FAMILY GUARANTEE FEES IN 2016 2–3 (2017).
400. *Id.* at 2.
401. U.S. GOV'T ACCOUNTABILITY OFF., GAO-09-782, FANNIE MAE AND FREDDIE MAC: ANALYSIS OF OPTIONS FOR REVISING THE HOUSING ENTERPRISES' LONG-TERM STRUCTURES 13 (2009).
402. FED. HOUS. FIN. AGENCY, *supra* note 367, at 3–4.

the pre-2007–2008 Fannie and Freddie, did so with the express backing of the U.S. Treasury.[403]

The solvency of Fannie and Freddie, though not explicitly guaranteed by the government, was, however, tinged with vague government associations, and this implicit government backing in fact materialized during the mortgage crisis of 2007–2008.[404] With too few mortgage payments incoming and inadequate fees to make good on all the guarantees to investors, Fannie Mae was bailed out by the Federal Treasury and placed under conservatorship in September 2008.[405] Thus, "investors consider Fannie and Freddie securities to be as safe as Treasuries, partly because as long as the companies remain in conservatorship, most bondholders assume the government would make good on any losses."[406]

These government reinsurance-like entanglements come with the opportunity and, indeed, the duty to set policy with care. The FHA cultivated certain mortgage terms as benchmarks while constructing racist conditions for mortgage insurance eligibility.[407] The HOLC reified norms by drawing the redlining maps that were used in turn by the FHA to condition their backing.[408] These examples show the opportunity as well as the peril of government reinsurance, which is too often transacted behind the scenes, obscured from public view. Indeed, the goal of this Article is in large part to foreground the stakes and subject these government interventions to public deliberation. Government should account for its use of backstops to effect standards. When the NAACP, Urban League, and others in the 1950s revealed these racist standards and pressed FHA to "withdraw its support for redlining and racial covenants," they ultimately prevailed.[409] But, norms and patterns had already been inscribed into the "riskscape."[410]

Government's selective decision-making about whom to bail out is precisely what is concealed by the fragmentation of these analogous programs across different policy arenas with different names. What I seek to do here is ask why certain kinds of risks, heretofore ignored, do not merit

403. 12 U.S.C. § 1721(g)(1) ("In the event the issuer is unable to make any payment of principal of or interest on any security guaranteed under this subsection, the Association shall make such payment as and when due in cash . . . ."); U.S. GOV'T ACCOUNTABILITY OFF., GAO-09-782, FANNIE MAE AND FREDDIE MAC: ANALYSIS OF OPTIONS FOR REVISING THE HOUSING ENTERPRISES' LONG-TERM STRUCTURES 13 (2009).

404. *See generally* NICHOLAS F. BRADY, REPORT OF THE SECRETARY OF THE TREASURY ON GOVERNMENT SPONSORED ENTERPRISES 1 (1990) ("Government-sponsored enterprises [GSEs] are entities . . . established . . . by [Congress] to perform specific credit functions . . . but are . . . privately owned . . . . The market perception of Federal backing for GSEs weakens the normal relationship between the availability and cost of funds to the GSEs and the risk that these enterprises assume.").

405. Donald H. Layton, *When Will Government Control of Freddie Mac and Fannie Mae End?*, STOOP: NYU FURMAN CTR. BLOG (July 6, 2022), https://furmancenter.org/thestoop/entry/when-will-government-control-of-freddie-mac-and-fannie-mae-end. *See* Jonathan G. Katz, *Who Benefited from the Bailout?*, 95 MINN. L. REV. 1568, 1586, 1594 (2011).

406. Weinstein, *supra* note 397.

407. QUINN, *supra* note 11, at 163–65.

408. *Id.* at 141, 164.

409. *Id.* at 165.

410. *Id.*

bailout as well. In 1954, the NAACP-Urban League coalition demanded the creation of a Voluntary Home Mortgage Credit Program to provide loans for prospective borrowers who had twice been denied.[411] This embryonic but visionary program points to the road not taken. Rather than treat the harms of race-based underwriting as a given, the United States could have decided to build a guaranteed floor under Black prospective homeowners to protect them against the harms of systemic racism—limiting the extent of suffering and the opportunities they could be denied on account of the correlated risk of societal racism.[412] This program, however, was time-limited from its inception, sunsetting on June 30, 1957.[413] Though extended several times, the program terminated in 1965.[414]

### *C. Higher Education*

The United States has enabled access to higher education through government backing of student loans. By 1981–1982, loans predominated the student financing landscape.[415] They remain "the second largest category of consumer debt behind home mortgages."[416] Any loan carries default risk, and with education as "human capital," that risk can never be mitigated through collateralization by mortgage.[417] The student-side risk that higher education policies purport to manage is the risk that "the returns to their education [in the labor market] will not justify the investment."[418] Given the positive public externalities that education generates, however, the government has repeatedly intervened.[419] Some of the risk-management methods suggest parallels with health care policies. For instance, government-backed student loans are not underwritten for risk factors like a student's major or their school, just as individual insurance cannot be underwritten based on health status.[420]

The student loan system evolved over time, with the government providing aid first to veterans through the "GI Bill" of 1944,[421] later

411. *Home Financing is Accelerated: Voluntary Home Mortgage Credit Program Aids Small Town Buyers*, N.Y. TIMES (Apr. 1, 1956), https://www.nytimes.com/1956/04/01/archives/home-financing-is-accelerated-voluntary-home-mortgage-credit.html; Housing Act of 1954, Pub. L. No. 83–560, § 601–602, 68 Stat. 590, 637 (1954); QUINN, *supra* note 11, at 165.

412. *See* QUINN, *supra* note 11, at 165.

413. Housing Act of 1954, Pub. L. No. 83–560, § 610, 68 Stat. 590, 640 (1954).

414. Housing Act of 1961, Pub. L. No. 87–70, § 903, 75 Stat. 149, 191 (1961) (codified as amended 12 U.S.C. § 1750jj).

415. WILLIAM ZUMETA, DAVID W. BRENEMAN, PATRICK M. CALLAN, & JONI E. FINNEY, FINANCING AMERICAN HIGHER EDUCATION IN THE ERA OF GLOBALIZATION 77 (2012).

416. John R. Brooks & Adam J. Levitin, *Redesigning Education Finance: How Student Loans Outgrew the "Debt" Paradigm*, 109 GEO. L.J. 5, 8 (2020).

417. Lance J. Lochner & Alexander Monge-Naranjo, *The Nature of Credit Constraints and Human Capital*, 101 AM. ECON. REV. 2487, 2499 (2011).

418. Jan Libich & Martin Macháček, *Insurance by Government or Against Government? Overview of Public Risk Management Policies*, 31 J. ECON. SURVS. 436, 440 (2017).

419. *See id.* at 441.

420. Brooks & Levitin, *supra* note 416, at 10; 42 U.S.C. § 300gg-4(a)(1).

421. Servicemen's Readjustment Act of 1944, Pub. L. No. 78–346, 58 Stat. 284, 284 (repealed 1956); QUINN, *supra* note 11, at 157.

extending this benefit to civilians as well.[422] The structure of education aid bore strong overtones of government reinsurance. Like ACA coverage, federal student loans were offered through private entities, at least until 2010.[423] Yet, private banks proved insufficiently willing to lend for higher education, in part because the debt could not be collateralized.[424] Therefore, in 1965, federal guarantees were introduced among a suite of inducements.[425] Family Federal Education Loan (FFEL) loans came with a federal "guarantee" such that when an attachment point like borrower default or permanent disability was triggered, the federal government would take over the loan and pay off virtually all of the principal to the lender.[426]

This roundabout subsidy proved expensive. One measure of the steep cost is evident in the flip-side savings that were expected when, in 2009, President Obama finally proposed to end the FFEL program.[427] He replaced the subsidies with direct government lending instead. [428] That historic swap was estimated by the Congressional Budget Office to claw back $61 billion over ten years.[429]

But what can be said about the federal student loan guarantee prior to its hard-won reform? What did it represent in our collective understanding of the governmental role? Sarah Quinn notes, "In the 1970s, student loans shifted from an antipoverty program to a middle-class entitlement," and part of that shift took the form of the Higher Education Act of 1972, which established Pell Grants and the Student Loan Marketing Association (SLMA).[430] Pell Grants signal one model of government provision: a form of direct grant to students that President Obama tried unsuccessfully to convert into an entitlement in 2010.[431]

The institution of SLMA, called "Sallie Mae," showcases another model. Like Fannie Mae, Sallie Mae was created to provide a secondary market for government-insured education loans.[432] The government

422. *See* SUZANNE METTLER, THE SUBMERGED STATE 71 (2011); John R. Brooks, *Income-Driven Repayment and the Public Financing of Higher Education*, 104 GEO. L.J. 229, 245, 247 & n.100 (2016).

423. METTLER, *supra* note 422, at 75.

424. *See* QUINN, *supra* note 11, at 157.

425. *Id.*

426. Higher Education Act of 1965, Pub. L. No. 89–329, § 430(a), 79 Stat. 1219, 1244 (1965); *see also* ALEXANDRA HEGJI, CONG. RSCH. SERV., R43351, THE HIGHER EDUCATION ACT (HEA): A PRIMER 14 (2016).

427. *See* METTLER, *supra* note 422, at 69.

428. *See id.* at 75.

429. *See id.* at 76, 83.

430. QUINN, *supra* note 11, at 157.

431. The failures are due in part to the need to pass the education reform provisions in the same reconciliation vehicle as the ACA, which was not budget neutral, and the need to find sufficient savings to meet the budget caps necessary for the bill to pass under the filibuster-proof reconciliation rules. That is a tale well-told in METTLER, *supra* note 422, at 83–84.

432. H.R. REP. NO. 92–554, at pt. F (1971); *see* U.S. GOV'T ACCOUNTABILITY OFF., GAO/HRD-84-51, SECONDARY MARKET ACTIVITIES OF THE STUDENT LOAN MARKETING ASSOCIATION 1 (1984); *see also* 20 U.S.C. § 1087–2(a) (articulating the purpose "to establish a private corporation which will be financed by private capital and which will serve as a secondary market and warehousing facility

guaranteed Sallie Mae's obligations until 1984.[433] But, Sallie Mae also enjoyed Congressional authority to undertake "other activities," which it construed liberally.[434] Now a fully private entity, its functions have drifted from secondary market services; Sallie Mae has morphed instead into merely another private issuer of student loans.[435]

Prior to the 2010 student loan reforms, private banks took the lead in lending, with the federal government acting as their guarantor.[436] The government now issues 90% of the loans directly, in a model that approaches "single lender," with a nod to "single-payer."[437] This transformation was accomplished by Title II of the Health Care Education Reconciliation Act of 2010, which also ensured the ACA's passage into law.[438]

Yet, even now, the government's role still bears a reinsurance imprint. Students can presently opt to fulfill their obligations under the terms of an income-driven repayment (IDR) program.[439] Under IDR programs, including Income-Based Repayment (IBR) and Pay As You Earn (PAYE), students are protected against monthly repayments higher than 10% of discretionary income.[440] Any balance after a maximum of twenty years under that repayment structure is forgiven.[441] That period reduces by half if the student undertakes public interest work.[442]

It is not hard to see how this structure protects the student against the risk of "the returns to their education [in the labor market]" falling short of the repayment obligations.[443] The labor market is, in one sense, the payer of first resort, but only up to a certain threshold or attachment point. The government-as-reinsurer protects the student from post hoc risks once the graduate's income, considering the benefits of higher education, is realized.[444]

What is particularly interesting about the education story is that it demonstrates that the government's affirmative provision of an indirect guarantee can pave the way to a more direct subsidy, backstopping the

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for student loans, including loans which are insured by the Secretary under this part or by a guaranty agency, and which will provide liquidity for student loan investments . . . .").

433. U.S. DEP'T OF THE TREASURY, OFF. OF SALLIE MAE OVERSIGHT, LESSONS LEARNED FROM THE PRIVATIZATION OF SALLIE MAE: DRAFT 3 (2006).

434. *Id.* at 136.

435. QUINN, *supra* note 11, at 157; *see* U.S. DEP'T OF THE TREASURY, OFF. OF SALLIE MAE OVERSIGHT, LESSONS LEARNED FROM THE PRIVATIZATION OF SALLIE MAE: DRAFT 3 (2006).

436. *See* METTLER, *supra* note, 422 at 69.

437. Brooks, *supra* note 422, at 251 n.125 ("For the 2013–2014 academic year, private lenders originated only $10 billion out of $106 billion in all student loans; the federal government thus originated over 90% of all student loans . . . .").

438. *Id.* at 251 & n.124 (describing how the legislation "ended the government subsidy for private student loans, increased the amount of public loans available, and expanded and redefined the IBR program.").

439. *See id.* at 230.

440. *Id.* at 253.

441. *Id.* at 230.

442. *Id.* at 253.

443. Libich & Macháček, *supra* note 419, at 440.

444. Brooks, *supra* note 422, at 233.

end user directly, rather than the private intermediary.[445] President Obama himself explained his agenda thus in April 2009, "Under the FFEL program, lenders get a big government subsidy with every loan they make. And these loans are then guaranteed with taxpayer money, which means that if a student defaults, a lender can get back almost all of its money from the government."[446] While "[s]tudents received loans nominally from private lenders [which] . . . would . . . be more expensive without government guarantees. . . ."[447] Obama explained the cost of such an approach: [W]e could be reinvesting that same money in our students, in our economy, and in our country" [rather than] "paying banks a premium to act as middlemen."[448]

By the end of March 2010, in the same fraught vehicle as the ACA, President Obama finally succeeded in using the savings from this de-privatization to increase Pell Grants and furnish the repayment options that protected borrowers from repayments exceeding 10% of income.[449]

*D. Government Reinsurance in Other Non-Health Domains*

Beyond crops, mortgages, and higher education, there are other vast domains characterized by well-known government backstops. I only describe a few of them here to suggest the extensive use of the reinsurance approach.

1. Bank Reinsurance for Money Risk

Banking and money supply are deemed crucial services whose availability has long required a program of federal government guarantees. The transition from precious metal specie to paper money, as Moss explains, had a basic structure, which gave rise to risks:

> When people stored gold coins in their pockets and purses, they gained liquidity (that is, the ability to spend their wealth anytime or anywhere they pleased), but they also immobilized precious capital. No one else could use this wealth for productive purposes if it was rattling around in someone's pocket. Bank notes were quite different, however. So long as individuals held onto these notes, banks could lend out most of the underlying funds to worthy borrowers. It was a neat trick. Although the notes were technically redeemable in specie, the real backing was the loans themselves.[450]

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445. METTLER, *supra* note 422, at 70, 72, 85–86.

446. President Barack Obama, *Remarks by the President on Higher Education*, WHITE HOUSE (Apr. 24, 2009), https://obamawhitehouse.archives.gov/the-press-office/remarks-president-higher-education.

447. John R. Brooks, *Quasi-Public Spending*, 104 GEO. L.J. 1057, 1090 (2016).

448. METTLER, *supra* note 422, at 69.

449. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–52, § 2213, 124 Stat. 1029, 1081 (2010).

450. MOSS, *supra* note 24, at 89.

This arrangement posed certain risks: banks face both default risk from making bad loans and liquidation risk, which Moss describes as the risk that "note holders and depositors would occasionally demand specie for their notes . . . far beyond [the bank's] ability to pay."[451] Nowadays, liquidation risk is addressed by a number of institutions, one of which is the FDIC, an independent agency created during the New Deal to collect premiums from banks that are then used to insure deposits.[452] Banks covered by this insurance are subject to required capital levels and other matters of financial soundness.[453]

The FDIC performs this oversight function even for those state-chartered banks outside the Federal Reserve System.[454] For member banks, however, the Federal Reserve System is the crucial backstop for depositor risk, serving as the "lender-of-last-resort" so that commercial banks can borrow if necessary to meet the demands for liquidity.[455] Indeed, the Federal Reserve System has authority in unusual or exigent circumstances to perform that same backstopping function for numerous other entities as well under the notorious § 13(3) of the Federal Reserve Act.[456]

I argue here that the lender-of-last-resort (LOLR) function is an instance of the broader reinsurance function,[457] and indeed one that belongs distinctively to government. This argument about the comparative advantage of government as LOLR should be comfortable and familiar. Long associated with nineteenth century British businessman Walter Bagehot,[458] this allocation of duties has even garnered arch free-marketeer Milton Friedman's support.[459]

According to Moss, "The notion of banks as insurers was first formalized [by] Douglas W. Diamond and Philip H. Dybvig."[460] Part of the interest that borrowers pay to banks is a premium for the banks to pool and spread default risk.[461] Part of the return foregone when depositors place their money with the bank is a premium for certainty and liquidity.[462] Not only were banks acting as insurers, but the Federal Reserve System, as the

451. *Id.*

452. *See About FDIC: What We Do*, FDIC (May 15, 2020), https://www.fdic.gov/about/what-we-do/.

453. Statement of Sheila C. Bair, Chairman Federal Deposit Insurance Corporation on the Causes and Current State of the Financial Crisis Before Financial Crisis Inquiry Commission (Jan. 14, 2020), https://www.fdic.gov/news/speeches/chairman/spjan1410.html.

454. FED. RSRV., THE FED EXPLAINED: WHAT THE CENTRAL BANK DOES 77 (2021).

455. Gary Gorton & Andrew Metrick, *The Federal Reserve and Panic Prevention: The Roles of Financial Regulation and Lender of Last Resort*, 27 J. ECON. PERSPS. 45, 46 (2013).

456. 12 U.S.C. § 343(3)(A).

457. Djelic & Bothello, *supra* note 22, at 595 (ascribing the lender-of-last-resort function as "a term attributed to English merchant banker turned Member of Parliament, Henry Thornton . . . .").

458. *Id.*

459. Ivan Pongracic, Jr., *The Great Depression According to Milton Friedman*, FEE (Sept. 1, 2001), https://fee.org/articles/the-great-depression-according-to-milton-friedman/.

460. MOSS, *supra* note 24, at 361 n.4 (citing Douglas W. Diamond & Philip H. Dybvig, *Bank Runs, Deposit Insurance, and Liquidity*, 91 J. POL. ECON. 401 (1983)).

461. Diamond & Dybvig, *supra* note 460, at 401–19.

462. *Id.*

banker to the banks, was providing the proverbial "insurance for insurers," with all the too-big-to-fail pathology that this backing entailed.[463] One commentator quips, "The practice of a state-sponsored LLR [(lender of last resort)] function became institutionalized and by extension moral hazard was systemically inscribed in the financial and monetary sphere. *Effectively, this function acted as insurance* . . . ."[464]

The government reinsured systemically significant banks both implicitly and explicitly to keep them humming. But reminiscent of the reasons cited for health reinsurance and federal backing for farm mortgages, the justification for state provision of this reinsurance invoked not just supply-side protection of the banks themselves, but ultimately, the protection of the individual depositors. In the debate over FDIC and bank backstopping during the Great Depression, Representative Robert Luce of Massachusetts importuned:

> I have seen insurance extended in every direction . . . and I fail to understand why the depositors in a bank, persons who have no opportunity to know, who have in fact no knowledge about the interior affairs of the bank . . . should not be insured against mischance that they cannot guard against and prevent.[465]

Tim Geithner, former U.S. Secretary of the Treasury, attempted the modern equivalent of this argument. In his book, he defends his bailout of the banks, whom he calls the "arsonists" of the last financial crisis, as ultimately intended to "protect the innocent" Americans whose deposits, credit, and jobs were at stake in the systemic risk cyclone that was the Great Recession.[466] Geithner's mistake was to assume that the backstopping role did not then give him leverage to discipline the financial institutions he was propping up.

His justification rings somewhat hollower in the financial sector than in other sectors, such as health. With the increasingly hermetic clientelism of the financial sector, some of the indirect beneficiaries were not broader depositors, but merely other banks. Jonathan Katz describes how "[t]he real beneficiaries of the government's [financial crisis] actions were AIG creditors and counterparties to open AIG positions," first among whom was Goldman Sachs.[467] Katz says:

> [O]ne must recognize that much of the total cost of the AIG intervention could have been avoided, or reduced, if government officials had acted prudently (in negotiating the original terms of the AIG loan and in monitoring AIG bonuses), had [they] insisted on shared sacrifice

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463. MOSS, *supra* note 24, at 116–19 (citing Gregory Moore, *Solutions to the Moral Hazard Problem Arising from the Lender-of-Last-Resort Facility*, 13 J. ECON. SURVS. 443–76 (1999)).

464. Djelic & Bothello, *supra* note 22, at 595 (emphasis added).

465. MOSS, *supra* note 24, at 118.

466. *It's Geithner vs. Warren in Battle of the Bailout*, NPR (May 25, 2014, 5:29 AM), https://www.npr.org/2014/05/25/315276441/its-geithner-vs-warren-in-battle-of-the-bailout.

467. Katz, *supra* note 405, at 1578.

> from CDS counterparties in its negotiations, and had [they] not used AIG as a disguised funding conduit to other institutions.[468]

He continues, "There is a widespread perception that the decision to bail out AIG without demanding concessions was designed to save its counterparties, such as Goldman Sachs."[469]

Some might contend that these implicit guarantees of government bailout in times of crisis differ from the explicit guarantees laid out in reinsurance policies. But any differentiation in kind would depend on how widely and strongly held the expectation was that government would step in. Some data suggest that this belief was so pervasive in banking that the implicit promise was nearly as good as explicit.[470] "The government's insistence that large banks would not be allowed to fail worked only too well. Large banks were able to borrow money at rates 0.78[%] percentage points more cheaply than smaller banks," and they enjoyed lower rates even before the 2008 recession as well.[471] The beneficiaries of government banking reinsurance were in no small part these banks who could borrow at lower rates.[472] This suggests parallels with health reinsurance, where the primary health insurers are spared a significant degree of capitalization and additional risk loading. The key question is whether banks were passing those benefits onto depositors or instead pocketing the gains. Health insurers, by contrast, are required to pass on savings in the form of lower premiums or rebates because of the medical loss ratio limits established by the ACA.[473]

Though banking institutions enjoyed ad hoc bailouts and implicit guarantees, much of the money was channeled through pre-established automatic stabilizers.[474] Some have argued that these non-TARP (Troubled Assets Relief Program) bailouts were more important than the ad hoc bailout that was TARP itself.[475] For example, FDIC and FHA mortgage

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468. *Id.* at 1590.

469. *Id.* at 1593 (citing SIMON JOHNSON & JAMES KWAK, 13 BANKERS: THE WALL STREET TAKEOVER AND THE NEXT FINANCIAL MELTDOWN (2011) and ANDREW ROSS SORKIN, TOO BIG TO FAIL: THE INSIDE STORY OF HOW WALL STREET AND WASHINGTON FOUGHT TO SAVE THE FINANCIAL SYSTEM —AND THEMSELVES 532–33 (2010)). See Katz, *supra* note 405, at 1594, for the account that Goldman then received more money from the AIG special purpose vehicle (SPV) than it received from TARP, and for the crowning detail that shortly after Goldman received that SPV money, it repaid its TARP loan, thereby escaping the TARP conditions on executive compensation.

470. *See* FIN. CRISIS INQUIRY COMM'N, PRELIMINARY STAFF REPORT, GOVERNMENTAL RESCUES OF "TOO-BIG-TO-FAIL" FINANCIAL INSTITUTIONS 28 (2010).

471. *Id.* at 3, 12–13; JOHNSON & KWAK, *supra* note 469, at 180–81.

472. FIN. CRISIS INQUIRY COMM'N, *supra* note 470, at 3.

473. Public Health Service Act § 2718(b), 42 U.S.C. § 300gg–18(b); *see supra* notes 530–31 and accompanying text.

474. *See* Remarks by Lael Brianard, Bd. Governors Fed. Rsrv. Sys., Monetary Policy Forum (Feb. 21, 2020).

475. Katz, *supra* note 405, at 1569 (contending that "the money trail reveals that the funds expended by TARP were in fact merely one component of a much larger governmental intervention . . . ."); *see also id.* at 1584–85 (observing that "[w]hen compared to other government loan guarantee programs and secondary market interventions, it was a small piece of a very large pie . . . . [O]verall federal support for the national financial system [was] $3.7 trillion in actual expenditures and guarantees. Most of the amount was assumed or spent without direct congressional action.").

insurance both performed their intended roles while institutions like Ginnie Mae mopped up some of the spiraling mortgage debt and the Department of Education purchased student loans.[476]

The United States has entrenched the expectation that federal government will furnish material aid to secure an elaborate network of institutions against systemic money risk that would far exceed any individual bank's capacity to manage. This safety net was defended not only in the name of the individual depositor but even more broadly on behalf of any individual participant in the U.S. market economy.

2. Terrorism Reinsurance

In the wake of 9/11, the insurance market for terrorism coverage collapsed.[477] Congress responded by passing the Terrorism Risk Insurance Act of 2002 (TRIA), promising government reinsurance in case of a certified terrorist attack.[478] This reinsurance is available to insurance lines such as commercial property, business interruption, workers' compensation, and general liability, though not life or health.[479] It was originally slated to last three years but has since been extended with the most recent reauthorization effective through 2027.[480]

The purpose was, consistent with its reinsurance role, to spur private provision of a service through hefty government assumption of the catastrophic costs. The parameters of coverage are more complex and have changed over time, generally in the direction of "increas[ing] insurers' share of the losses and thus decreas[ing] explicit federal fiscal exposure."[481] Accordingly, the U.S. Treasury now pays 80% of "insured losses" above the insurer's individual attachment point, which is currently set at 20% of that insurer's direct-earned premiums from the prior calendar year.[482] Also, by way of limitation, an event only becomes eligible for certification as a qualifying terrorist event if aggregate property/casualty losses exceed $5 million in "insurance losses."[483] Moreover, government reinsurance does not trigger unless aggregate "insured losses" reach $200 million for the year 2020 and thereafter.[484] Roughly speaking, "insured losses" refer to the losses that the primary insurer will reimburse to the

476. *Id.* at 1585–87.

477. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-348, TERRORISM RISK INSURANCE: PROGRAM CHANGES HAVE REDUCED FEDERAL FISCAL EXPOSURE (2020) [hereinafter TERRORISM RISK INSURANCE].

478. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107–297, 116 Stat. 2322 (2002).

479. *Id.*

480. Terrorism Risk Insurance Extension Act of 2005, Pub. L. No. 109–144, 119 Stat. 2660 (2005); *see* Terrorism Risk Insurance Program Reauthorization Act of 2007, Pub L. No. 110–60, 121 Stat. 1839 (2007); *see also* Clay Hunt Suicide Prevention for American Veterans Act, Pub. L. No. 114–2, 129 Stat. 30 (2015); *see also* Further Consolidated Appropriations Act 2020, Pub. L. No. 116–94 § 502, 133 Stat. 3026 (2019).

481. TERRORISM RISK INSURANCE, *supra* note 477, at 11.

482. 31 C.F.R. § 50.4(p), (q).

483. *Id.* § 50.4(b)(2)(ii).

484. *Id.* § 50.4(v)(6).

insured, while "insurance losses" include the losses retained by the insured business as well, such as the amount below the deductible or other cost-sharing.[485] Most of the provisions in TRIA are pegged to "insured losses," except for the certification threshold.[486]

At $100 billion in aggregate insured losses, a ceiling caps the reinsurance available.[487] This ceiling is somewhat unusual insofar as it protects both government and primary insurers against further obligations. Not only do government reinsurance obligations cease beyond the cap, so do insurers' obligations to the underlying insured businesses.[488] The remaining incidence of loss reverts to those businesses suffering the terrorism damage in the first place.[489]

As with many state insurance guaranty funds, industry contributes to the collective financing of reinsurance. Here, the payment is not collected as a prepayment but as a post hoc "recoupment."[490] It consists of a premium surcharge, capped at 3%, that insurers collect from the insureds to remit to the government.[491] All issuers of commercial policies owe recoupment, even on policies without terrorism risk coverage.[492] However, they only pay when the specific recoupment threshold is met, and only until total insurers' payments compensate fully for the federal loss with some cushion for federal government risk-bearing and incidentals.[493] The threshold for when mandatory recoupment kicks in, rather than taxpayer financing, represents our public judgment as to how much of the terrorism loss the insurance industry should bear through TRIA deductible, cost-sharing, or otherwise.[494] A portion of the recoupment is "mandatory" and collected over a prescribed duration to make the U.S. Treasury whole with the additional cushion mentioned above.[495] Under certain circumstances, the Treasury may add a "discretionary" amount to that recoupment.[496]

To give a rough sense of the proportion of losses absorbed by the government under TRIA, the Treasury ran a hypothetical scenario for a 2018 terrorist event in San Francisco.[497] They estimated nearly $40 billion in overall losses out of which the government would foot $4.4 billion in explicit reinsurance, while insurers would pay $17 billion in claims to policyholders.[498]

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485. TERRORISM RISK INSURANCE, *supra* note 477, at 6–7.
486. *Id.* at 7.
487. *Id.* at 6–7.
488. *Id.*
489. *Id.* at 7 n.16 (stating however that "insurers remain liable for amounts up to their deductible, even if the $100 billion cap is reached.").
490. *Id.* at 7–10.
491. *Id.* at 8.
492. *Id.*
493. *Id.* at 9 & n.20.
494. *Id.* at 9.
495. *Id.* at 8–9.
496. *Id.* at 9–10.
497. *Id.*
498. *Id.* at 13–14.

The U.S. Government Accountability Office (GAO) has been tasked with periodically reviewing potential taxpayer exposure under TRIA and reporting to the Senate Banking Subcommittee on Financial Institutions and Consumer Protection.[499] GAO has repeatedly expressed concern over what they call the government's "implicit fiscal exposure" beyond the explicit terms of TRIA.[500] Industry has, after all, expressed confidence that Congress would step in ad hoc to mitigate "recoupment" should a large terrorist event occur.[501] GAO publicly worries that federal action in past disasters has created an "expectation that the government would provide financial assistance to businesses for uninsured or underinsured losses . . . regardless of whether a loss-sharing program existed."[502] For instance, terrorism insurance ordinarily excludes terrorist attacks involving nuclear, biological, chemical, or radiological (NBCR) weapons.[503] Moreover, stand-alone insurance for NBCR events is either unavailable or prohibitively expensive.[504] These losses are therefore uninsured, would never count toward an individual insurer's deductible, and consequently never trigger TRIA reinsurance.[505] However, it is commonly presumed that government would step in to relieve businesses in an NBCR event, perhaps through disaster relief channels, described *infra*, or as Congress did for the auto industry after the 2008 financial crisis.[506]

These examples acknowledge the reality suggested above: implicit reinsurance exists in many sectors. This observation underlines a major premise of my argument: the government's past actions with respect to catastrophic risk exposure in other contexts create a public expectation of affirmative government backing for analogous risks in the future. And medical coverage is one of the areas where Americans should press the claim.

3. Natural Disaster Reinsurance: Floods

With disasters more broadly, apart from those caused by terrorism, the federal response has involved both implicit as well as explicit reinsurance. One of the leading disaster law experts, Jim Chen, explains government disaster reinsurance in the following terms, which by now should ring familiar:

> Private insurance . . . represents the first and arguably most important layer of financial preparedness for disaster. . . . But many disasters pose special trouble, even for the largest, most financially secure insurers. . . . Modern portfolio theory sheds clarifying light on what is perhaps the most insidious factor undermining the financial integrity

499. *Id.* at 2.
500. *Id.* at 24 (citing prior report on fiscal exposure as well).
501. *Id.* at 20.
502. *Id.* at 22.
503. *Id.* at 22–23.
504. *Id.* at 23.
505. *Id.*
506. *Id.* at 22–24.

> of private insurance for catastrophic risk: private insurers are extremely loath to cover risks that are highly correlated to each other. . . . For this reason, insurers routinely exclude coverage for flood damage (or even water damage more generally), even in policies that purport to cover all risks.[507]

Here, I discuss flood disasters as an entry point to examining the federal role in disaster coverage and relief more generally. Indeed, flood damage is expressly reinsured by federal funds, following the precise logic Chen articulates.

In the aftermath of the Great Mississippi Flood of 1927, every flood insurer left the market.[508] Floods continued to be excluded from homeowners' or other policies throughout the 1950s, prompting calls for public intervention.[509] There was a general consensus that the studies to map and identify flood risk exceeded private capacity and required the Federal Army Corps of Engineers.[510] Thus, in 1968, Congress created the National Flood Insurance Program (NFIP).[511] NFIP used federal resources to spur flood coverage while simultaneously requiring communities who gained such coverage to institute zoning, building codes, and other hazard mitigation measures.[512] Part A of NFIP was structured as a public-private partnership with government reinsuring the private primary insurers, though gradually phasing out the government subsidy over time.[513] However, because participation of both insurers and insureds remained voluntary, many property owners and communities continued to opt out.[514]

Congress responded by passing the Flood Disaster Protection Act of 1973, which mandated the purchase of flood insurance for any property in a designated risk zone that received federal assistance or a federally backed mortgage.[515] On the supply side, many private insurers still elected not to participate, continuing to exclude floods from property and casualty policies, despite including tornado coverage.[516] Those insurers who did join the consortium of participating companies did not always cooperate

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507. Jim Chen, *Modern Disaster Theory: Evaluating Disaster Law as a Portfolio of Legal Rules*, 25 EMORY INT'L L. REV. 1121, 1133–34 (2011).

508. *See* Phyllis Cuttino, *How 20th-Century Events Shaped the National Flood Insurance Program*, PEW (June 7, 2016), https://www.pewtrusts.org/en/research-and-analysis/articles/2016/06/07/how-20th-century-events-shaped-the-national-flood-insurance-program.

509. Chen, *supra* note 507, at 1132–33, 1135–37.

510. REINSURING HEALTH, *supra* note 46, at 139 (citing Edward T. Pasterick, *The National Flood Insurance Program: A U.S. Approach to Flood Loss Reduction*, *in* FLOOD ISSUES IN CONTEMPORARY WATER MANAGEMENT (Jiri Marsalek, W. Ed Watt, Evzen Zeman, & Friedhelm Sieker eds., 2000)).

511. National Flood Insurance Act of 1968, Pub. L. No. 90–448, 82 Stat. 572 (codified as 42 U.S.C. §§ 4001–4131).

512. MOSS, *supra* note 24, at 263.

513. COMPTROLLER GEN., U.S. GEN. ACCT. OFF., CED-79-70, EXAMINATION OF THE FINANCIAL STATEMENTS OF THE NATIONAL FLOOD INSURANCE PROGRAM AS OF DECEMBER 31, 1977 2 (1979).

514. *Id.*

515. 42 U.S.C. § 4002 (1974); *see* MOSS, *supra* note 24, at 262–63.

516. *See* MOSS, *supra* note 24, at 262.

with government financial oversight.[517] NFIP contained a Part B, which authorized HUD (U.S. Department of Housing and Urban Development) to administer a "public fallback option" if the Part A industry partnership proved unworkable.[518] In 1977, the government, struggling to audit or negotiate new terms with industry partners, judged that the government would save money by direct provision.[519] HUD therefore activated Part B and assumed the insurance of flood risk directly by contracting with a private intermediary, much as traditional Medicare does, to administer the policies on the HUD's (and later FEMA's) behalf.[520] Since 1983, private insurers have increased their role in administering NFIP, "including selling and servicing policies and adjusting claims, but they largely have not been underwriting flood risk themselves."[521] Government actually holds the risk, and private entities "sell and service" the policies as fiscal intermediaries, keeping a whopping 32% of the premium.[522]

This degree of explicit financial backing has not eliminated the implicit government guarantee lurking in the flood context. As GAO noted in 2019:

> Congress demonstrated its willingness to fund the implicit exposure of policyholder claims that exceeded the amount NFIP was authorized to borrow from the Treasury. In October 2017, when NFIP was about to exhaust its borrowing authority, Congress passed a supplemental appropriation which the President signed into law, that cancelled $16 billion of NFIP debt to the Treasury.[523]

A recent legislative reversal signals the degree to which this implicit expectation of continued federal backstop is entrenched. Congress tried in 2012 to reduce its assistance for flood insurance through the Biggert–Waters Flood Insurance Reform Act of 2012,[524] but after outcry, Congress promptly restored premium relief again by passing the Homeowner Flood Insurance Affordability Act of 2014.[525]

Jim Chen, however, concludes that "[d]espite these shortcomings, the NFIP retains value as the one policy tool that has shown even modest

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517. *See* COMPTROLLER GEN., U.S. GEN. ACCT. OFF., CED-79-70, EXAMINATION OF THE FINANCIAL STATEMENTS OF THE NATIONAL FLOOD INSURANCE PROGRAM AS OF DECEMBER 31, 1977, 3–4 (1979).

518. *See id.* at 4; *see also* 42 U.S.C. §§ 4071–72.

519. COMPTROLLER GEN., U.S. GEN. ACCT. OFF., CED-79-70, EXAMINATION OF THE FINANCIAL STATEMENTS OF THE NATIONAL FLOOD INSURANCE PROGRAM AS OF DECEMBER 31, 1977, 4 (1979).

520. *Id.*

521. DIANE P. HORN & BAIRD WEBEL, CONG. RES. SERV., R45242, PRIVATE FLOOD INSURANCE AND THE NATIONAL FLOOD INSURANCE PROGRAM 6 (2020).

522. REINSURING HEALTH, *supra* note 46, at 139.

523. TERRORISM RISK INSURANCE, *supra* note 477, at 24.

524. Moving Ahead for Progress in the 21st Century Act 2012, Pub. L. No. 112–141, §§ 100201–49, 126 Stat. 405, 405–969 (2012).

525. Jennifer Wriggins, *Flood Money: The Challenge of U.S. Flood Insurance Reform in a Warming World*, 119 PENN. ST. L. REV. 361, 366 (2014).

historical success in 'guid[ing] development away from floodplains.'"[526] Reinsurance is roundabout and expensive, but nonetheless successful as regulatory leverage to effectuate cost- and risk-mitigating reforms. And as with the education example, the history of flood insurance shows that government action can transition from reinsurance to more direct public provision.

4. Natural Disaster Reinsurance: Beyond Floods

Apart from flood disasters, the federal government's role in responding to major disasters consists of the "provision of de facto reinsurance for the insurers that sell the policies in the first place."[527]

One example lies in the structure of the Robert T. Stafford Relief and Emergency Assistance Act (1988).[528] The Stafford Act, which succeeded the Disaster Relief Act first passed in 1950,[529] is a major pillar of disaster response.[530] Stafford Act relief is triggered upon Presidential declaration of a "major disaster."[531] If the President declares a "national emergency," additional categories of assistance become available even beyond those slated for "major disasters."[532]

Notably, the structure of Stafford Act assistance maps recognizably onto the features associated with reinsurance. "Stafford Act policies are structured to 'reinsure' rather than 'insure' insofar as the relief contemplates that states and localities will" serve as first responders.[533] The federal aid depends on a trigger and even then becomes available typically only after a Preliminary Damage Assessment (PDA) to evaluate whether the incident has reached a threshold of "unusual severity and magnitude."[534] This type of attachment point is set by guidance in the

526. Chen, *supra* note 507, at 1135–36 (citing Oliver A. Houck, *Rising Water: The National Flood Insurance Program and Louisiana*, 60 TUL. L. REV. 61, 160 (1985)).

527. REINSURING HEALTH, *supra* note 46, at 101.

528. 42 U.S.C. §§ 5121–207.

529. The Federal Disaster Relief Act of 1950, Pub. L. No. 81–875, 64 Stat. 1109, 1109 (1950).

530. *A Guide to Emergency Powers and Their Use*, BRENNAN CTR. FOR JUST. (June 9, 2022), https://www.brennancenter.org/our-work/research-reports/guide-emergency-powers-and-their-use (identifying four major framework statutes in our current legal landscape for federal disaster relief, including the Stafford Act, 42 U.S.C. §§ 5121–207, the National Emergencies Act, 50 USC §§ 1601–51, and the Public Health Service Act, 42 U.S.C. §§ 201–300, including 42 U.S.C. § 247d, as well as 22 U.S.C. § 2318(a)(1) for drawdown of resources from the Department of Defense).

531. Daniel Farber, *Presidential Power in a Pandemic*, CTR. FOR PROGRESSIVE REFORM (Mar. 18, 2020), http://progressivereform.org/cpr-blog/presidential-power-pandemic/ (explaining, "A major disaster authorizes the government to distribute supplies and emergency assistance, unemployment assistance, emergency grants to assist low-income migrant and seasonal farmworkers, food coupons and distribution, relocation assistance, community disaster loans, and emergency public transportation.").

532. *Id.*

533. Christina S. Ho, *With Liberty and Reinsurance for All: Demanding a Government Backstop in Health Care* 61–62 (Draft May 6, 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3840904

534. 44 C.F.R. § 206.33(b) (2022); *see generally* BRUCE R. LINDSAY & ELIZABETH M. WEBSTER, CONG. RES. SERV., R41981, CONGRESSIONAL PRIMER ON RESPONDING TO AND RECOVERING FROM MAJOR DISASTERS AND EMERGENCIES 7, 10 (2020).

"Preliminary Damage Assessment Guide."[535] The PDA threshold is determined in large part by whether the damage exceeds the states' capacity to respond without assistance from the federal government, an expression of the states' primary insurer role.[536] The factors considered in making that threshold determination include the amount of insurance coverage already in place and the state's total taxable resources, positioning the federal government as the insurer of last resort.[537]

The aid triggered includes not only Individual Assistance but also Public Assistance.[538] Public Assistance includes mitigating and preventive action that is projected to protect lives, property, public health, and safety.[539] That list by no means exhausts the capacity of the federal government for disaster assistance.[540] Indeed, the Brennan Center lists 136 federal statutes authorizing powers for emergency response.[541]

Congress's role in disaster relief dates as far back as the earliest days of the American republic with some of the first private bills enacted.[542] This federal role was so deeply entrenched that by 1887, precedent was routinely invoked "as a powerful argument both for and against the enactment of particular measures."[543] A capsule example of this reasoning was voiced by Texas Democratic Senator Richard Coke, sponsoring a relief bill for drought in his state:

> Coke . . . argued that although his wealthy state did not need the aid . . . it was entitled to receive the federal largess because '[t]here is not a session of Congress that money for the relief of people somewhere in the United States is not expended. We ask for no departure from any precedents established by the Government . . . we are not asking [for anything] except for that which has always been freely granted to others having no greater rights or equities than ourselves.[544]

5. Pension Benefit Guaranty Corporation

While we spoke earlier of ERISA and its effect on health coverage, ERISA is first and foremost a pension reinsurance act. A version of ERISA was first introduced in 1964 by Indiana Senator Vance Hartke as the

535. Individual Assistance Declarations Factors Guidance, 84 Fed. Reg. 10521 (Mar. 21, 2019); *see* FEMA, U.S. DEP'T OF HOMELAND SEC., FEMA PRELIMINARY DAMAGE ASSESSMENT GUIDE 18, 45–47 (2021) [hereinafter PDA Guide].

536. PDA Guide, *supra* note 535, at B-1, 9–10 tbl.1.

537. *See* Individual Assistance Declarations Factors Guidance, 84 Fed. Reg. 10521 (Mar. 21, 2019).

538. *Id.*; PDA Guide, *supra* note 535, at 15, 43.

539. *Id.* at B-1, D-3.

540. *See* Farber, *supra* note 531, at 1–3.

541. *Id.* at 2.

542. DAUBER, *supra* note 321, at 18; *see generally,* Shimomura, *supra* note 322.

543. DAUBER, *supra* note 321, at 27.

544. *Id.*

"Federal Reinsurance of Private Pensions Act,"[545] to authorize the Pension Benefit Guaranty Corporation (PBGC). The idea of the PBGC arose out of union advocacy in the face of employer defaults on pension obligations.[546] Unions had negotiated for pensions through private bargaining.[547] Yet, promises proved hard to enforce given employer underfunding and plant closures.[548] Pensions serve as insurance against the risks of income loss due to age.[549] Yet, unions and workers continued to seek further forms of security to back this insurance, especially against the risk that the employer's financing would fall short of the plan's obligations.[550] As the United Auto Workers (UAW) actuary lamented in 1958, "'Vested rights . . . were hailed as a great achievement when they were won. . . . But . . . [t]hey must be made to stick, even in the event of a plan termination.'"[551] UAW proposed "establishing something like the Federal Deposit Insurance Corporation to backstop private pension plans."[552] Notably, UAW chose government reinsurance rather than trying to collectively bargain for more employer protection against pension default risk, which might have resulted in lower wages for active employees. And like other reinsurance efforts, PBGC was intended to induce private primary insurers, the employers in this case, to continue "offering voluntary retirement plans in the first place."[553] This goal appears in the PBGC authorizing language[554] and is baked into ERISA jurisprudence.[555]

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545. *See* James A. Wooten, *"The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 686, 735 (2001). Wooten later says, "When Senator Jacob Javits introduced comprehensive pension-reform legislation in 1967, his bill contained a termination-insurance proposal that drew many of its provisions from a later version of Hartke's bill." *Id.* at 736. *See* Phyllis C. Borzi, *A National Retirement Income Policy: Problems and Policy Options*, 19 U. MICH. J.L. REFORM 5, 6–7 (1985).

546. *See* Wooten, *supra* note 545, at 685–86.

547. *Id.* at 686. Though Social Security existed, "public retirement benefits were thought to be inadequate" especially by higher wage workers, which led to supplementation through privately bargained pensions. *Id.*

548. *See id.* at 704 ("The tax laws allowed an employer to fund past-service liability created by a plan amendment over the same term—about twelve years—that applied to the initial liability when a plan was created. UAW contracts commonly called for a firm to amortize the liability on a thirty-year schedule from the date of the benefit increase.").

549. *Id.* at 684–85.

550. *Id.* at 726.

551. *Id.* at 717–18 (quoting Memorandum from Max Bloch to James Brindle 4 (June 17, 1958) and United Auto Workers Social Security Department Collection, Unprocessed Materials, Accession Date Mar. 23, 1978, Box 4 of 7, Staff Collective Bargaining Folder, Archives of Labor and Urban Affairs, Wayne State University).

552. *Id.* at 720.

553. Secunda & Maher, *supra* note 289, at 737.

554. 29 U.S.C. § 1302(a) (stating, "The purposes of this subchapter, which are to be carried out by the corporation, are (1) to encourage the continuation and maintenance of voluntary private pension plans for the benefit of their participants . . . .").

555. *See, e.g.*, Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987) (declaring in the context of ERISA's civil enforcement scheme, that the statute "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans.").

PBGC's design bore certain reinsurance features, by now familiar to us, such as the cap on benefits.[556] Employers pay into the fund at premium rates set by congressional formula.[557] In addition to benefits paid by PBGC on behalf of a terminated plan, the companies formerly responsible for the pension obligations must make payments to pensioners according to the applicable recovery ratio, much like a cost-share.[558] The benefit structure also features what is functionally an attachment point, whereupon PBGC pays out the benefits promised.[559] This point is based on determinations made in the terminations process. [560] In that process, PBGC must declare the presence of certain conditions, including whether the plan can pay benefits currently due, to trigger PBGC responsibility.[561]

## CONCLUSION

### *A. Why Not?*

The question that lingers after surveying the immense government infrastructure for collective risk absorption is, why not reinsure health care risk? Why should the state "de-risk" banking conditions and not "de-risk" the human condition by assuring the institutional resources for rescue measures? The single loss we care about most is excluded from this curated riskscape. In the era of the "derisking state," as Daniela Gabor has dubbed it, this differential underinvestment in health is emphatically not a given, but a matter of collective choice.[562]

Why was TRIA, also originally considered a "transitional" program extended in 2005, then in 2007 to 2014, and now through 2027?[563] Meanwhile, the transitional reinsurance program for the ACA, designed to last for three years, expired at a time when the unexpected elimination of the individual mandate heightened our need for government stabilization tools.[564] Sarah Quinn has written that the "shift of risks from elites to

556. Wooten, *supra* note 545, at 725; 29 U.S.C. § 1322(b)(3) (imposing an aggregate limit on benefits); *Maximum Monthly Guarantee Tables*, PBGC, https://www.pbgc.gov/wr/benefits/guaranteed-benefits/maximum-guarantee (last visited Oct. 30, 2022) (listing the maximum monthly guarantees set by formula tied to a Social Security index; the 2021 maximum for a sixty-five-year-old retiree is $6,034.09 per month, for instance)

557. 29 U.S.C. § 1306.

558. 29 U.S.C. § 1322(c).

559. 29 U.S.C. §§ 1341, 1341(a), 1342.

560. 29 U.S.C. §§ 1341, 1341(a), 1342.

561. *Pension Plan Termination Fact Sheet*, PBGC, https://www.pbgc.gov/about/fact-sheets/page/termination (last visited Oct. 30, 2022).

562. *See* Daniela Gabor, *Critical Macro-Finance: A Theoretical Lens*, 6 FIN. & SOC'Y 45, 51 (2020) ("[T]he most notable post-Lehman institutional change is the rise of central banks as market-makers of last resort (MMLR) for a set of collateral securities . . . . While initially restricted to large central banks, the COVID-19 pandemic has seen central banks of emerging countries . . . adopt it too."); *see also* QUINN, *supra* note 11, at 203 (urging that we look for the social contract in these hidden choices, reminding us that "[u]nderstandings of the limits and possibilities of what people owe to each other and can expect from the state are written into the designs of financial instruments.").

563. *Terrorism Risk Insurance Program*, U.S. DEP'T TREASURY, https://home.treasury.gov/policy-issues/financial-markets-financial-institutions-and-fiscal-service/federal-insurance-office/terrorism-risk-insurance-program (last visited Oct. 30, 2022).

564. *See supra* text accompanying notes 77–83.

nonelites has been widely noted as one of the hallmarks of financialization and neoliberalism."[565] Reinsurance for health might start, however modestly, a program of rebalancing.

Some argue that the case for reinsurance is less compelling in circumstances of predictable, stochastically independent loss, rather than catastrophic, systemically correlated loss.[566] But can anyone in the year 2022 deny that high-cost, economically crippling health events are systemically correlated? This correlation exists not just in times of pandemic. Countless studies demonstrate that inflationary, often wasteful conditions of national health expenditure are not mere happenstance—they are constituted by government policy.[567] High-cost health care covaries to the extent that Medicare's deferential payment policies have led and continue to lead to the inflation of price, volume, and the technological character of end-of-life care.[568] It covaries because everyone faces increased medical cost risk from the pharmaceutical industry's profiteering off specialty drugs, a situation enabled by government patent, approval, and exclusivity standards.[569] It covaries because our choice to fragment health finance and regulation through means like ERISA-preemption disables payers from effectively negotiating costs.[570] Everyone experiences these increased risks of high medical costs collectively, rather than as individual events.

In the sectors analyzed above, we recognize many themes native to the health sector as well. In the health domain, we similarly continue to struggle over whether certain risks can be "redlined" out of health coverage; we have also chosen in the ACA not to provide direct government services but to channel the power of private insurers; and we have endeavored without success as yet to institute a "public option" as a fallback. We can also draw lessons from the missteps and experiences accumulated in these other domains.

### *B. Issues and Lessons: Is Reinsurance a Bailout?*

"Bailouts," like "handouts," are in bad odor, a political mood Senator Marco Rubio tried to leverage when he pegged the ACA risk corridors as an insurance industry bailout to slash Obamacare appropriations.[571] But,

565. QUINN, *supra* note 11, at 206.

566. *See, e.g.*, J. David Cummins, Georges Dionne, Robert Gagné, & Abdelhakim Nouira, *The Costs and Benefits of Reinsurance*, 46 GENEVA PAPERS ON RISK & INS.—ISSUES & PRAC. 177, 180 (2021).

567. *See* QUADAGNO, *supra* note 188, at 56.

568. *See id.*

569. *See* FELDMAN, *supra* note 65, at 71–79; *see also* Amy Kapczynski & Aaron S. Kesselheim, *'Government Patent Use': A Legal Approach To Reducing Drug Spending*, 35 HEALTH AFFS. 791, 791 (2016).

570. *See generally* EINER ELHAUGE, THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer Elhauge ed. 2010).

571. *See* Elise Viebeck, *Insurers Fire Back Over ObamaCare Changes*, HILL (Dec. 10, 2014, 12:24 PM), https://thehill.com/policy/healthcare/226628-insurers-fire-back-over-risk-corridors-change. The bid was ultimately unsuccessful as the Supreme Court eventually ordered funding of the

my point is that as long as the prevailing form of state relief comes in the form of bailouts, to deny commensurate aid to suffering individuals and families at their time of greatest need is indefensible. We should "Bail out Humans," as the hashtag that emerged during the coronavirus pandemic demands.[572] It is also in this spirit that Katarina Pistor declared, "To treat the economic fallout of coronavirus, governments should directly assume the debt of high-risk households."[573] Instead, we assumed the debt of airlines.[574] Why should we be so quick to stand in assurance of certain institutions with no strings attached, when the connection between that aid and the relief of human suffering has been so tenuous? Yet when it comes to health risk, when human catastrophe befalls a specific individual, we have failed to furnish the government's guarantee. The argument that we are bailing out too many risks should not counsel against bailing out human health but instead demands urgent justification for why we have been bailing out these risks rather than health. If anything, such objection should prompt us to redirect resources from these other sectors to one of greater priority. At the very least, I see no principled objection to extending guarantees in the health sector first, based on urgency, then turning to reduce spending in other areas.

### *C. Issues and Lessons: Inefficiency in Targeting*

Others mentioned the relative inefficiency or ill-targeting of health financing under reinsurance as compared to other government aid, at least in reducing the number of uninsured in our communities. Some reported that equivalent funds spent on direct subsidies in the Kerry plan would have covered many more Americans for the same federal spending compared to what reinsurance could have achieved.[575] The current crop of state reinsurance waivers appears to have reduced premiums and stabilized private insurer participation, but some query whether they translate into a strong coverage effect.[576]

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risk corridor obligations. *See* Me. Cmty. Health Op's. v. United States, 140 S. Ct. 1308, 1331 (2020). For a comparison of reinsurance to bailouts of financial institutions rather than helping beneficiaries such as homeowners in the last recession (or Obamacare enrollees in the instant case), see *Government-Sponsored*, *supra* note 23, at 474.

572. In spring of 2020, amid the outbreak of coronavirus, billionaire Bill Pulte catalyzed an arguably astroturf hashtag, #bailouthumans. *See #BailOutHumans: Billionaire Bill Pulte Sparks Social Media Movement to Give Money to Strangers in Need*, CBS N.Y. (Apr. 22, 2020, 8:30 PM), https://newyork.cbslocal.com/2020/04/22/bail-out-humans-coronavirus-twitter-money/. I think the hashtag captures an egalitarian sentiment nevertheless and repurpose it here.

573. Katharina Pistor, *Why Debt Relief Should be the Answer to this Coronavirus Crash*, GUARDIAN (Mar. 18, 2020, 11:02 AM), http://www.theguardian.com/commentisfree/2020/mar/18/debt-relief-coronavirus-crash.

574. Michael Laris & Lori Aratani, *Taxpayers Spent Billions Bailing Out Airlines. Did the Industry Hold up Its End of the Deal?*, WASH. POST (Dec. 14, 2021, 6:00 AM), https://www.washingtonpost.com/transportation/2021/12/14/airline-bailout-covid-flights/.

575. *See Government-Sponsored*, *supra* note 23, at 474 (noting that at the time, the estimated cost of reducing the uninsured by financing reinsurance on the back end was $10,000 per previously uninsured person).

576. Giovannelli et al., *supra* note 125.

Depending on the status quo details against which reinsurance operates, there can be other distributive anomalies. For instance, the § 1332 ACA state reinsurance waivers described above exist in an ACA context when tax credits stream only to individuals above 100% of poverty who have no real offer of employer health insurance.[577] Furthermore, those tax credits, which protect recipients from spending more than a set fraction of their income on health insurance, already shield enrollees themselves from volatility in benchmark premiums.[578] Perversely, because the size of the tax credit is capped by the premium of the second lowest cost silver plan, a reinsurance plan that reduces premiums, including the premiums for the benchmark plan, could actually reduce the purchasing power of the ACA-subsidized slice of the population.[579] Reinsurance under that tax credit configuration thus primarily reduces premiums for those ineligible for significant tax credits.[580] The effects of reinsurance thus arguably favor the relatively affluent, even as premium tax credits, by aiming at the most price-sensitive, in theory tilt toward the healthy.[581]

While it is difficult to make an apples-to-apples marginal comparison, the current subsidies themselves may not be a more efficient means of increasing coverage compared to other options like Medicaid expansion.[582] In 2020, for instance, the federal government spent nearly a thousand dollars more per subsidized enrollee in the ACA exchanges than it did for each Medicaid/CHIP enrollee.[583] Meanwhile, we devote far more in federal tax subsidies for job-based coverage, which largely benefit higher-income Americans, than we do on ACA subsidies for lower- to middle-income Americans through the marketplaces.[584]

Others have correctly observed that the targeting of any of these policies cannot be analyzed without consideration of the progressivity of the taxes or other means used to finance these policies.[585] Here, I suggest that

577. 26 U.S.C. § 36B(c)(1)–(2)(B).

578. *See supra* text accompanying footnotes 118–126.

579. *Id.*

580. Norris, *supra* note 151.

581. *See* Geruso & Layton, *supra* note 76, at 30–31. However, in practice, some have claimed that the risk profile of those who enroll in the ACA exchanges render them a federally subsidized "high-risk pool" in function. Laura Joszt, *Former HHS Secretary Price Identifies a Path to Moving Forward in Healthcare Reform*, AJMC (Mar. 2, 2018), https://www.ajmc.com/view/former-hhs-secretary-price-identifies-a-path-to-moving-forward-in-healthcare-reform.

582. This is illustrated by recent debates regarding Arkansas' Medicaid expansion. The state has found that subsidizing Medicaid recipients to purchase a "private option" costs significantly more than extending traditional Medicaid. David Ramsey, *After Biden Nixes Work Requirements, Arkansas Explores New Path Forward for Medicaid Expansion*, ARK. NONPROFIT NEWS NETWORK (Feb. 17, 2021), https://arknews.org/index.php/2021/02/17/after-biden-nixes-work-requirements-arkansas-explores-new-path-forward-for-medicaid-expansion/.

583. CONG. BUDGET OFF., 56571, FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER 65: 2020 TO 2030 16–17 (2020).

584. *Id.* at 17.

585. Persad, *supra* note 10, at 1169 (showing that the equity or inequity of reinsurance depends on background design of the financing). Under the ACA, the fees that paid for reinsurance were collected from claims administrators for self-insured employers, too. *Three Types of Reinsurance*, *supra* note 29, at 1169. "Thus insurers that cover large groups [relatively more affluent] will help subsidize reinsurance for high-cost individual subscribers." *Id.* at 1171.

some of the financing could come in part from rebalancing away from the reinsurance of banking and special purpose vehicles for corporations. And the proposals that draw from this reinsurance rationale are not limited to the ACA exchanges. For instance, Medicaid, as arguably the deepest reservoir of the reinsurance impulse in our health care system, should be federalized and strengthened.[586] Employer-sponsored coverage should be coaxed away from risk fragmentation and toward greater standardization in exchange for reinsurance, as President Eisenhower proposed.

Another response to the inefficiency and targeting critique hearkens back to the argumentative thrust of this Article. The potential for "inefficiency" is not unique to reinsurance within the health sector. Inefficiency was alleged when Lyndon B. Johnson first issued Fannie Mae participation certifications with a guarantee of payment of principal and interest.[587] Yet government guarantees on mortgage-backed securities have continued to this day. Why selectively spurn reinsurance only in the domain of health? Why must health coverage meet a higher standard of cost-efficiency than mortgages or banking risk? What if the appropriate comparator is not a hypothetical world where direct state financing for health predominates, but the present-day landscape involving indirect subsidization of everything else, generating a risk slope that drains resources away from health? The demand for better targeting is used differentially as a tool for de-prioritizing certain material demands, as the debate over the targeting of the $2,000 coronavirus relief checks so painfully illustrates.[588]

### *D. Issues and Lessons: Upside Recoupment and Conditioning the Offer of Reinsurance*

The Kerry proposal promised government reinsurance on the condition that employers provide coverage to their employees.[589] President Eisenhower's plan offered reinsurance to insurers in exchange for the extension of coverage to those with poor health status.[590] Recently, Sherry Glied and Katherine Swartz proposed conditional reinsurance to address COVID-19.[591] They suggest that reinsurance be given to state Medicaid plans if states agree to cover all COVID-19 costs for the uninsured, and that reinsurance for COVID-19-related health care be made available to private plans only on condition that they waive cost-sharing.[592]

586. Christina S. Ho, *Bail Out Humans*, BILL HEALTH (May 19, 2021), https://blog.petrieflom.law.harvard.edu/2021/05/19/bail-out-humans/.

587. QUINN, *supra* note 11, at 188–89.

588. Jeff Stein, *White House Open to Narrowing Who Qualifies for Stimulus Checks but Keeping Payments at $1,400 Per Person*, WASH. POST (Feb. 2, 2021, 5:25 PM), https://www.washingtonpost.com/us-policy/2021/02/02/biden-stimulus-checks/.

589. *See supra* text accompanying notes 308–17.

590. *See supra* text accompanying notes 187–99.

591. Sherry Glied & Katherine Swartz, *Using Federal Reinsurance to Address the Health Care Financial Consequences of COVID-19*, HEALTH AFFS. (Apr. 1, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200401.505998/full/.

592. *Id.*

Reinsurance can serve as leverage for system-wide, salutary reform and has routinely performed that function in other sectors.

FHA insurance was by design available only for thirty-year, low down payment mortgages for the purpose of seeding new industry standards.[593] The Federal Reserve System imposes prudential regulation on the institutions that enjoy its backing, thus using its leverage to mitigate risk in the financial system.[594] The post-Depression Glass–Steagall Act safeguarded all bank deposits under the FDIC while simultaneously requiring the separation of commercial and investment banking to "prevent[] banks from using government-insured deposits to engage in high-risk business."[595] More recently, the 2014 Farm Bill conditioned premium subsidies on compliance with conservation of wetlands and highly erodible land.[596]

Thus, the provision of health reinsurance should be tied to requirements that reduce the systemic risks and exposures that plague our health system. Indeed, part of the appeal of reinsurance lies in its ability to align the incidence of high medical costs with the state, which is also the entity most capable of controlling systemic medical-cost conditions. Our failure to impose pharmaceutical cost control as a condition of reinsurance in the profligate Medicare Part D design proves a cautionary tale.[597] The result is "that in 2016 3.2 million beneficiaries reached the Part D catastrophic phase [and] [t]he costs for reinsurance have almost quadrupled to $37.4 billion in 2016 from $9.4 billion in 2008."[598] Government backing for prescription drug spending should have carried government price controls.[599] This logic is recognized in some of the recent state reinsurance proposals, such as Colorado's, which originally limited the government reinsurance paid to a Medicare reference price.[600] However, Colorado and other states

593. *See* QUINN, *supra* note 11, at 142, 170–76; *see also* Segal, *supra* note 374.

594. *See* Gorton & Metrick, *supra* note 455, at 46, 56–60.

595. Katz, *supra* note 405, at 1597–98.

596. Roger Claassen, *2014 Farm Act Continues Most Previous Trends in Conservation*, USDA (May 5, 2014), https://www.ers.usda.gov/amber-waves/2014/may/2014-farm-act-continues-most-previous-trends-in-conservation/#:~:text=Highlights%3A,programs%20from%2023%20to%2013.

597. MEDPAC, *supra* note 264, at 167. These runaway costs are not inevitable with reinsurance. The American Academy of Actuaries have proposed policy designs that would blunt the inflationary effects of reinsurance, including well-designed ceilings on reinsurance, and use of hierarchical condition categories (HCCs) to dampen moral hazard effects. *See* Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. No. 136, 41,935 (July 15, 2011); *see also* Letter from Mita Lodh & Robert Bachler, Risk Sharing Work Grp., Am. Acad. of Actuaries, to Dr. Melinda Buntin, Director, Off. of Econ. Analysis & Modeling (Sept. 22, 2010), https://www.actuary.org/sites/default/files/pdf/health/Reinsurance%20Options%209%2022%202010.pdf.

598. Cohen, *supra* note 261; 76 Fed. Reg. No. 136, 41935 (July 15, 2011).

599. We have only begun to move toward this in halting ways in the recently passed Inflation Reduction Act. The Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 11001, 136 Stat. 1818, 1878, (2022) (requiring price negotiation for some top-selling drugs in Medicare, and some protection against high drug cost inflation).

600. *See* Goodland, *supra* note 175; Charles Gaba, *Colorado: Reinsurance Waiver Would Reduce Premiums 23% . . . Using Medicare-based Reimbursement??*, ACA SIGNUPS.NET (Mar. 25, 2019, 12:38 PM), https://acasignups.net/19/03/25/colorado-reinsurance-waiver-would-reduce-premiums-23using-medicare-based-reimbursement (stating that reinsured claims would be paid at no more than

have flinched from cost-control conditions in the face of political pushback.[601] Once the government is a fiscal stakeholder in high-cost medical cases, it is well-positioned to address cost drivers. Why, indeed, should we grant monopolies or license government patents[602] to the pharmaceutical industry only for the industry to turn around and charge high rates that the taxpayer must reabsorb?[603]

Any proposal should also build in strict conditions for the upside financial gains of government reinsurance to be captured for the public. Any reinsurance design should ensure that "subscribers receive the full benefit of the subsidy rather than it going to cover corporate overhead and profits."[604] For instance, a medical loss ratio like that already legislated in the ACA triggers rebates to individual or small group consumers whenever the ratio of claims payments to earned premium revenue falls short of 80%.[605] This provision ensures that the premiums and state subsidies are used primarily for enrollees, and therefore limits the amount that insurers can reap in profits or lavish on administrative costs to no more than 20%.[606] Any additional amounts that are not spent on medical claims must be rebated to the subscribers.[607]

A similar mechanism to assure public benefit would be a risk corridor provision where the premiums and subsidies that exceed claims above a certain threshold are recaptured by the government. Crop insurance, as we saw earlier, contains just such an upside risk corridor.[608] This condition would be necessary to protect against reinsurance programs becoming yet another vehicle for socializing the risks and privatizing the profits, as President Obama lamented of the federal student loan guarantee program.[609]

### *E. Issues and Lessons: Bringing Health System Fragments Under the Reinsurance Umbrella*

Reinsurance could constitute a common substrate across our fragmented health system, bringing employer-sponsored insurance, Medicaid, and the ACA exchanges into closer integration. As I suggested, we already provide employer-sponsored health plans with a type of implicit limited liability protection that is a close cousin to reinsurance.[610] We should take what is now quasi-reinsurance for the risks of benefit denial and rationalize

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150% of Medicare while noting that some believe that it is hard to identify when reinsured claims begin and when the spending counts as below the reinsurance threshold).

601. *See supra* text accompanying note 176.

602. *Government-Sponsored*, supra note 23, at 476.

603. Kapczynski & Kesselheim, *supra* note 569, at 791–97.

604. *Government-Sponsored*, *supra* note 23, at 476.

605. 42 U.S.C. § 300gg-18(b) (setting medical loss ratio as no less than 85% in the large group market, and no less than 80% in the small group and individual markets, with any smaller percentage triggering the duty to rebate a portion of premiums to the enrollees).

606. *Id.*

607. *Id*. § 300gg-18(b)(1)(B).

608. *See supra* text accompanying note 356.

609. President Barack Obama, *supra* note 446.

610. *See supra* text accompanying notes 296–305.

it into an offer of express reinsurance redirected toward the actual risk of concern—high medical expenses. Federal reinsurance might be offered instead of ERISA preemption of state claims and would be conditioned upon reforms like regulatory parity between insured and self-insured plans, the provision of essential health benefits, and participation in risk adjustment. Even under the expired ACA reinsurance provision, third-party administrators for self-insured, employer-sponsored plans paid the "belly-button tax" that financed the reinsurance pool; one tiny step toward using reinsurance to knit the fragments of our health system into some relationship of common mutuality.[611]

There are many ways of embodying and perfecting the reinsurance principle in the health sector, as I have tried to show. These represent but initial steps whose significance could snowball. John Jacobi has argued that reinsurance, by establishing a foothold for broadly pooled health risk, could place us on the path to more comprehensive reform.[612] After all—and here I steal a quip from economist Henry Aaron—what would we call government reinsurance with an attachment point of zero? We would call it single-payer.[613]

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611. *See* HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,152.

612. Jacobi, *supra* note 3, at 381, 395–96 (quoting Alan Weil, *Increments Toward What?*, 20 HEALTH AFFS. 68, 81 (2001) (proposing, "we can judge incremental reform proposals not only on the basis of who they cover today, but whether they move us in the right direction for the future.")).

613. *Government-Sponsored*, *supra* note 23, at 478 (citing Randall R. Bovbjerg, *Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?*, 29 INQUIRY 158, 168 (1992)) ("[N]oted health economist Henry Aaron once proposed a government reinsurance program as a way to transition to a single-payer system, explaining that 'if the [stop-loss] limit were lowered, directly or by erosion due to inflation, the scope of private coverage would shrink, ultimately to the point of disappearing.'").