THE COMING HEALTH INSURANCE TRANSITION

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For decades, the dominant form of private health insurance in the United States—by far—has been employment-based group health insurance. Somewhere in the range of 175 million employees and their families receive health care coverage through a system in which employers serve as financiers, procurers, administrators, and fiduciaries of the health insurance promise. An overwhelming percentage of those health insurance arrangements are governed by ERISA, with little room for state law.

That is going to change.

This Article explains—for the first time anywhere—why and how. Because of the tremendous and as-yet unrecognized power of an obscure-sounding funding arrangement called the Individual Coverage Health Reimbursement Arrangement (ICHRA), a massive insurance transition—away from ERISA-governed group insurance and toward individual insurance—is likely to occur. It's already underway. The end result, whether sooner or later, will be a meaningfully transformed insurance landscape policymakers will not have the freedom to ignore. It will happen much like how retirement accounts replaced pensions in the retirement context.

The second claim this Article makes is normative. The transition from pensions to retirement accounts made society worse off. Yet this benefit transition—from ERISA insurance to individual insurance—is one that could make society better

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off, if sensibly regulated. A reasonable transition to individual insurance will likely have salutary effects on the exchanges and their offerings; on employees; on employers; and on regulators.

INTRODUCTION

For decades, the dominant form of private health insurance in the United States—by far—has been employment-based group health insurance. Somewhere in the range of 175 million employees and their families receive health care coverage through a system in which employers serve as financiers, procurers, administrators, and fiduciaries of the health insurance promise.[1] An overwhelming percentage of those health

[1] *See* KATHERINE KEISLER-STARKEY & LISA N. BUNCH, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2023 2 (2024) (178.2 million people were covered by employment-based insurance during 2023).

insurance arrangements are governed by ERISA,[2] with little room for state law.

That is going to change.

This Article explains—for the first time anywhere—why and how. Because of the tremendous and as-yet unrecognized power of an obscure-sounding funding arrangement called the Individual Coverage Health Reimbursement Arrangement (ICHRA),[3] a *massive* insurance transition away from ERISA-governed group insurance ("ERISA Insurance") toward individual insurance is likely to occur. It is already underway.[4] The end result, whether sooner or later, will be a meaningfully transformed insurance landscape policymakers will not have the freedom to ignore. A new era is upon us.

To be sure, traditional employment-based insurance (and the fashion in which ERISA governs it) has been assailed by critics for years. But ERISA Insurance has become so embedded in the American cultural and political landscape that no direct regulatory effort to erode, dislodge, or prohibit it has ever succeeded (or even come close). The ICHRA is going to succeed where other efforts have failed because it is not a top-down regulation. It doesn't force anybody to do anything. It simply empowers employers to relieve themselves of the very real burden of offering ERISA Insurance, while also ensuring employees will not be left uninsured and unprotected. And—exactly like employers did when they had the choice to go from offering more burdensome pensions to less burdensome retirement accounts—employers will increasingly opt for burden reduction.

The second claim this Article makes is normative. The transition from pensions to retirement accounts made society worse off. Yet this benefit transition—from ERISA Insurance to individual insurance—is one that *could* make society *better* off,

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2 Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93–406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.). A small percentage of employment-based insurance is exempt from ERISA, such as plans maintained by government entities and churches. 29 U.S.C. § 1003(b).

3 *See generally* Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28888 (June 20, 2019) (implementing final rules governing ICHRAs) (codified at 26 C.F.R. pts. 1, 54; 29 C.F.R. pts. 2510, 2590; 45 C.F.R. pts. 144, 146, 147, 155).

4 ICHRA adoption is rising rapidly among employers of all sizes, and particularly large employers. *See* HRA Council, Growth Trends: ICHRA & QSEHRA 2 (2024), https://www.hracouncil.org/resources/Pictures/2024%20Data%20Report/2024_HRAC_DataReport_Final_Web.pdf [https://perma.cc/NH9Q-N64N] (describing general growth since 2020 and noting that ICHRAs grew 84% among large employers in 2023–24).

if sensibly regulated. A reasonable transition to individual insurance will likely have salutary effects on the exchanges and their offerings; on employees; on employers; and on regulators. Compared to the predictive claim (that a sizable transition will likely happen), the normative claim (that such a transition could be good) is more tentative, and thus far closer to the beginning of a conversation than the end. But it is the first salvo in a normative discussion that *must* be had—and by observers across the political spectrum—given the insurance transition that is primed to occur. Ignoring the effect ICHRAs are going to have on today's insurance landscape is to abdicate the normative inquiry that must occur when people transition away from ERISA Insurance. That abdication will serve nobody.

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Part I explains the reality of private health insurance in the United States, prior to the enactment of the Affordable Care Act in 2010.[5] There were essentially two different private insurance regimes: the employment-based insurance regime (in which ERISA was dominant), and the individual insurance regime (in which state law was dominant). Part I explains the key differences between those two regimes, including why ERISA Insurance became by far the most common form of private health insurance in the United States.

Part II examines the ACA's effect on that dual regime world, and focuses on two things the ACA (as originally enacted) did. First, using a variety of regulatory interventions, the ACA reformed the individual insurance market, which was previously inaccessible and unaffordable. Second, it took measures to preserve the employment-based regime. Through the expedient of requiring large businesses to offer group health insurance (commonly known as the "employer mandate")[6]—along with maintaining the existing bar against the use of pre-tax dollars for individual insurance—the ACA made any transition from ERISA Insurance to individual insurance very costly for a large section of the population.

Part III explains how recent regulatory changes have altered things significantly. Shortly before the pandemic hit, the ICHRA received regulatory approval. ICHRAs permit employers to satisfy the employer mandate by offering employees a certain amount of pre-tax dollars that can be used to reimburse

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5 The Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010) (codified as amended at Health Care and Education Reconciliation Act, Pub. L. No. 111–152, 124 Stat. 1029 (2010)).

6 26 U.S.C. § 4980H.

the purchase of individual health insurance. By doing so, employers can largely free themselves from the regulatory and liability burdens of ERISA and from the nontrivial organizational responsibility to procure and administer health insurance as a benefit. Nor will employees be left in the cold; with ICHRA monies, they can purchase reasonable insurance on the exchanges. Giving employers this option—offloading regulatory and managerial burdens while still providing their employees with a desirable benefit—is going to result in far more employers taking it than is currently appreciated.

As Parts III.B. and III.C explain, theory and history support this conclusion. Consider retirement benefits. Originally—for many decades, in fact—the dominant form of retirement benefit was a pension, which is a lifelong annuity for retirees that the employer funds and pays. Yet pensions are highly burdensome to finance and perform, and when changes in the law made it easier for firms to instead offer (less-burdensome) retirement accounts, e.g., 401(k) accounts, they did so. For a number of reasons, that transition did not happen overnight, but over time, it surely did. A similar transition is unfolding here.

Part IV advances a normative claim—with caveats—that this insurance transition could be, from a societal perspective, welfare-enhancing. To make the strongest version of that argument, I imagine a slightly modified ICHRA, namely one that will virtually always result in those transitioning away from ERISA Insurance ultimately acquiring individual policies on the ACA exchanges (which I refer to as "Exchange Insurance"). I argue that, in such a case, the end result would be a massive influx of healthier and wealthier people onto the ACA's exchanges, which could yield considerable theoretical and practical benefits: better background law; better insurance products; more attentive and responsive regulators; unburdened employers; protected employees; and more state involvement.

I
A Tale of Two Insurance Regimes

Health insurance in the United States is infamously complicated.[7] Let's begin with the gist. Putting aside public insurance (of which Medicare and Medicaid are the most famous types), for our purposes, there are two chief "types" of private

[7] For generalist readers fearful of punishing engagement with the mind-numbing particulars of despairingly technical areas of the law like ERISA, ACA, and insurance law, rest assured that this Article, by design, avoids such deep dives except where absolutely necessary. *See infra* note 106. Mostly.

health insurance in the United States: employment-based group insurance and individual insurance. Employment-based group insurance is what it sounds like—group insurance one receives as an "employee benefit" in connection with the compensation deal with one's employer. Individual insurance is an individual policy that one buys on one's own—it's simply an insurance policy that anyone, whether they work for Employer A or not, could have purchased from the insurance company.

The set of laws that governs those two types of insurance has long been and remains very different. Put simply, employment-based and individual insurance do not "live" in the same legal regime. There are many reasons for that, a comprehensive summary of which is not necessary here. All that is needed here is to understand some key differences between the two regimes. That is the aim of Part I.

A. ERISA Insurance (Pre-ACA)

Most private health insurance in the United States is employment-based, and most employment-based insurance is governed by ERISA.[8] (As indicated above, I will call such insurance "ERISA Insurance.") The salient features of ERISA Insurance are explained below.

1. *The Anti-Federalism of ERISA Preemption*

Preemption refers to the displacement of state law that conflicts with or interferes with federal law. Among all federal laws ever enacted, ERISA's preemptive reach is among the most vast. There are three reasons for that. First, ERISA's express preemption provisions are extremely broad. Second, its implicit preemptive reach is also broad. Third, the statute has been interpreted such that the one area where states did retain regulatory power—insurance regulation—is easily sidestepped by employers (as explained below). The upshot is that ERISA, practically speaking, largely blocks states from being involved in regulating the health insurance deal.

Express preemption. ERISA's express preemption provisions are the "relate to" provision, the "savings clause," and

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[8] *See, e.g.*, *Health Insurance Coverage of Population Ages 0-64*, KFF, https://www.kff.org/other/state-indicator/health-insurance-coverage-population-0-64/ [https://perma.cc/JH26-AK5V] (showing predominance of employer-provided group coverage); https://www.dol.gov/general/topic/health-plans/erisa [https://perma.cc/5V9N-THFN] (explaining that ERISA governs most private health plans).

the "deemer clause."[9] The specifics of ERISA's preemption provisions have been covered elsewhere; only an abbreviated version is necessary here.

The "relate to" clause preempts any state law that relates to employee benefit plans.[10] That is an incredibly broad preemptive grant: The Supreme Court has explained that a state law "relate[s] to" employee benefit plans if it, among other possibilities, "has a connection with" employee benefit plans, including laws that can be said to somehow "govern . . . a matter of central plan administration" or otherwise "interfere with nationally uniform plan administration."[11] As one can see, that preempts an incredibly wide swath of state laws, including, for example, state "mandated benefit" laws requiring that health plans cover certain conditions, but also laws that merely require plans to *report* information about health care expenditures.[12]

State laws swept up by ERISA's broad "relate to" language can nonetheless avoid preemption if the law is "saved" by ERISA's savings clause, which in pertinent part says that states can regulate insurance matters.[13] Thus states can, and long have, regulated the policies that insurers could sell in their state—*including* policies that an employer might purchase from an insurer to satisfy its health insurance promise to employees.[14]

That saved regulatory power, however, is constrained by employer choice. Employers can fund their health care benefit promise through either purchasing an insurance policy (which states can regulate) or by "self-funding" the promise by paying for it without using an insurance policy. A plan that self-funds its health promise cannot be regulated by the states because of the deemer clause, which provides that no state may "deem" a benefit plan to be an insurer subject to saved state insurance laws.[15] The odd result is that, under ERISA, employers have the freedom to *choose* to be regulated under either state law (by using an insurance company policy) or federal law

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9 *See, e.g.*, Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 396 n.27, 417–18 (2020) (describing preemption mechanics).

10 29 U.S.C. § 1144(a).

11 *See* Brendan S. Maher, *Pro-Choice Plans*, 91 GEO. WASH. L. REV. 446, 456 (2023) (describing ERISA preemption in health care context).

12 *See id.* at 457, 470–71 (describing ERISA preemption in health care context).

13 29 U.S.C. § 1144(b)(2)(A).

14 FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990).

15 29 U.S.C. § 1144(b)(2)(B).

(by self-funding).[16] It is thus not surprising that approximately 65% of beneficiaries receive benefits through self-funded arrangements.[17]

For those unfamiliar with ERISA's intricacies, that result is surprising. Not only does ERISA preempt state regulatory authority, it also permits employers to evade the one area of law—insurance—reserved to the states.

Implicit preemption. The state-depowering story is acuter still. In addition to express preemption, ERISA also implicitly preempts state prerogative. Implicit preemption is where, even if ERISA's express preemptive provisions do *not* apply, those state laws that conflict with ERISA's "objects" or its provisions are set aside.[18] Both the Supreme Court and scholars have struggled to define the content or boundaries of ERISA's implicit preemption in a way that inspires confidence. One thing the Court has made clear, however, is that ERISA implicitly preempts virtually all state law rules pertaining to remedy, including rules of liability, damages, claims procedures, standard of review, and so on.[19] It does not matter if state law is more protective or less protective than ERISA. If the rule falls within ERISA's preemptive scope, it is preempted.

A substantive vacuum. ERISA's preemptive force would be less troubling were it paired with robust substantive rules concerning the scope and content of the health insurance promise. But (until the ACA was passed), the opposite was true. ERISA provided essentially no substantive regulation of the health insurance promise *at all.*[20] The entirety of the health insurance promise was left to negotiation between employers and employees. Other than by regulating insurance policies sold to employers by in-state insurers—a state power which employers could and did sidestep using the self-insurance expedient—states were

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16 *See, e.g.*, Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y, L. & ETHICS 89, 90 (2005) (describing the "self-insured" loophole under ERISA).

17 GARY CLAXTON ET AL., KFF, EMPLOYER HEALTH BENEFITS 2023 ANNUAL SURVEY 11 (2023), https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf [https://perma.cc/TLH3-6S2D] (reporting coverage via category).

18 *See* Boggs v. Boggs, 520 U.S. 833, 841 (1997) (state law impliedly preempted); *see also* Thomas W. Merrill, *Preemption and Institutional Choice*, 102 NW. U. L. REV. 727, 739–40 (2008) (explaining implied preemption).

19 *See infra* Part I.A.2.

20 *See* Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 491–508 (1998) (explaining ERISA's lack of substantive regulation of health benefits and noting the very minor exceptions Congress later added).

powerless to fill the substantive void at the center of ERISA with health insurance regulation of their own.[21]

2. *ERISA as Tort Reform*

Although hailed originally as a statute designed to protect workers and their beneficiaries,[22] the federal judiciary's interpretation of the statute has largely run counter to that expectation. Scholars have for decades criticized ERISA as being remedy-constraining in ways that match almost perfectly a wish list for tort reformers.[23] Some of those constraints are described below.

Standard of review. When an employer (or any insurer) promises employees health insurance, that promise is embodied in a writing. Under ERISA, that writing is called the "plan."[24] But the plan is not magical. It is a document that contains legally enforceable terms, and someone must interpret those terms. Health promises generally hinge on providing care that is "medically necessary," a term that can be difficult to apply in practice.[25] Even impartial arbiters might disagree about whether a particular treatment is medically necessary to address a given patient's condition. As a result, the value of the health care promise to the beneficiary—and the corresponding cost of making the promise to the employer—rises or falls

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21 PETER J. WIEDENBECK & BRENDAN S. MAHER, ERISA PRINCIPLES 438–42 (2024). Note also that state law of remedy is implicitly preempted by ERISA. Because ERISA's savings clause does not save state laws from implicit preemption, that means states—regardless of whether a plan was self-insured or not—were powerless to beef up ERISA's remedies in a way that would protect beneficiaries.

22 29 U.S.C. § 1001(b) (Congressional purpose in enacting ERISA); *see also* Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 358–60 (1994) (describing ERISA's central purpose as protecting beneficiaries).

23 *See, e.g.*, George L. Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 618–19 (1994) (criticizing ERISA's remedial regime); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 151–52 (2009) (same); Andrew Stumpff, *Darkness at Noon: Judicial Interpretation May Have Made Things Worse for Benefit Plan Participants under ERISA than Had the Statute Never Been Enacted*, 23 ST. THOMAS L. REV. 221, 232–36 (2011) (same); Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 661–62, 695 n.225 (2014) [hereinafter *Litigation Reform*] (describing ERISA's anti-plaintiff constraints as so significant that the term "litigation reform" was a better term to describe them than "tort reform").

24 29 U.S.C. § 1102(a) (written plan requirement).

25 *See, e.g.*, Amy B. Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. REV. 423, 425–27 (2022) (describing challenges of applying "medical necessity" rule).

depending on how often plausibly ambiguous cases will go in the employee's favor.

The baseline rule in insurance law is one of *contra proferentem*, where ambiguities in the promise are construed against the drafter.[26] ERISA's text, however, makes no mention of what standard of review should be used when a beneficiary claims benefits and the employer denies them, either with respect to the health insurance promise or indeed any benefit promise any employer may make.[27] Judge-made law was needed to determine the applicable standard of review.

In *Firestone v. Bruch*, the Supreme Court held that, while ERISA's default standard of review was *de novo*, should the plan documents grant plan administrators "discretion[]" to interpret the plan, courts must defer to the administrator's judgment.[28] Absent an "abuse of discretion" by the administrator (which is very hard to show), courts must uphold the administrator's benefit determination.[29]

The *Firestone* deference rule was swiftly condemned by scholarly observers (and has been since).[30] The reason is simple. The employer (and thus the payer of claims) both *writes* the plan and either employs or pays those administering the plan.[31] It is a minor matter for employers to amend plans to award plan administrators discretion to interpret its terms, and they routinely have. That destroyed the ability of the judiciary to either put a thumb on the scale for beneficiaries (like the traditional rule of *contra proferentem*) or even adopt neutral interpretations of the plan's language in benefit disputes.[32] Moreover, because claims administrators are virtually always subject to some form of financial control by the employer, they thus labor under an undeniable incentive to please their patron by denying care.[33] Both insurance contexts generally and conflicted-decisionmaker contexts specifically traditionally justify

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26 *Id.* at 433–34.

27 Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989).

28 *Id.* at 115.

29 *Id.* at 111.

30 *See, e.g.*, John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 208–09 (offering stinging criticism of *Firestone* immediately after the decision); *see also* Secunda, *supra* note 23, at 147; Stumpff, *supra* note 23, at 230–32.

31 *See* Daniel R. Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1126 (1988).

32 Langbein, *supra* note 30, at 213.

33 John Bronsteen, Brendan S. Maher & Peter K. Stris, *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297,

more judicial scrutiny, rather than less. *Firestone* deference leads to the opposite.

Subsequent decisions made *Firestone* deference even more pernicious. In *Metro Life* v. *Glenn*, the Supreme Court held that the existence of a conflict was not enough for a reviewing court to use a *de novo* standard; deferential review was still necessary.[34] In *Conkright v. Frommert*, the Court held that even a previous abuse of discretion by an administrator was not enough to discard *Firestone* deference; only (vanishingly rare) "bad faith" could do that.[35] Thus the standard of review regime faced by ERISA beneficiaries is one in which (1) a likely conflicted administrator is entitled to advance a policy interpretation that (2) a court must defer to, absent an abuse of discretion, *even if* (3) the administrator's original attempt to interpret the plan was abusive.

Damage limitation. The federal courts, likewise, read into ERISA significant restrictions on the damages recoverable when a benefit is wrongfully denied. Punitive damages are prohibited but *so are all consequential damages* beyond the value of the care denied.[36]

No one questions that a wrongful refusal to pay for care can lead to damages consisting of (1) the cost of the denied care itself and (2) foreseeable damages resulting from that care not being provided. Yet the Supreme Court has nonetheless interpreted ERISA to permit *only* the recovery of the cost of the denied benefit, rather than foreseeable damages (of either the emotional or physical variety).[37] The result is that ERISA beneficiaries wrongfully denied care who suffer serious injury—including death—as a result of that denial are barred under ERISA from recovering anything resembling full damages, let alone damages meaningful enough to appropriately deter malicious actors.

Claim limitation. ERISA specifically provides that claimants may bring a number of claims directly under the statute.[38] The

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2308–09 (2008) (discussing problem of conflicted administrators through agency cost lens).

34 Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 121 (2008).

35 Conkright v. Frommert, 559 U.S. 506, 513–14 (2010).

36 *See* Brendan S. Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 WIS. L. REV. 657, 669–75 (describing ERISA's damages regime).

37 Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985).

38 29 U.S.C. § 1132.

two most relevant for health benefit denials are set forth in 29 U.S.C. 1132(a)(1)(B) and 1132(a)(3).

Section 1132(a)(1)(B) causes of action are the ones most commonly brought for claims denials, i.e., when a beneficiary accuses an administrator of denying benefits in breach of the governing policy. This claim is not only burdened by ERISA's other limitations—in terms of *Firestone* deference and restricted damages—but it has been read by the courts quite narrowly. The rough result is that ERISA beneficiaries have only the functional equivalent of a contract claim when faced with a benefit denial, with no potential recourse to causes of action like insurance bad faith or tortious breach.

And while it is true that there is a "catchall" remedy provision in ERISA—namely section 1132(a)(3),[39] which authorizes beneficiaries to sue for "appropriate equitable relief" for violations of ERISA or the plan—that provision has also been narrowly interpreted by the Court, in two ways. First, that provision generally does not apply (and (a)(3) claims cannot be brought), when an (a)(1)(B) claim could be brought.[40] Second, the Court has interpreted (a)(3) to permit *only* the awarding of equitable relief that was "typically available in equity" in the equity courts during the premerger days of the divided bench.[41] That *vastly* limits the use of (a)(3) generally, and the precise scope of that limit has been intensely litigated for decades. The upshot, however, is that the federal courts' cramped interpretation of (a)(3) has seriously limited the work it can do with respect to remediating or policing claims denials.

Contractual obstacles. The Court has also made clear that the terms of the ERISA plan—which, again, are largely written by the employer or those subject to the employer's influence—can be altered in ways that make beneficiaries worse off compared to background law. Plans can require completing an internal "appeal" of claims before a beneficiary may file a claim in federal court, and they can shorten statutes of limitation, for example.[42] Plans can also award the employer more aggressive subrogation rights vis-à-vis any funds that an injured beneficiary has recovered from a third-party tortfeasor.[43] These rights

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39 29 U.S.C. § 1132(a)(3).

40 Varity Corp. v. Howe, 516 U.S. 489, 516 (1996) (limiting the applicability of the (a)(3) remedy). *See also* Maher, *Litigation Reform, supra* note 23, at 659 n.48.

41 Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993).

42 Heimeshoff v. Hartford Life & Accident Ins. Co., 571 U.S. 99, 105 (2013).

43 Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 368 (2006).

can and do include awarding the plan "first dollar recovery" rights, where monies a beneficiary recovers from a tortfeasor for *nonmedical* damages—such as lost wages—are owed to the plan for its payments for *medical* bills, without any deduction for the attorneys' fees the plaintiff paid in getting that money from the third-party tortfeasor.[44]

One may very well find some or all of the above limitations conducive to efficiency or otherwise appealing. Conversely, one may find them almost comically unjust. The point is that one need grasp this very real feature of ERISA Insurance—i.e., its remedial constraints—in order to think about whether alternatives are better.

3. *Employer as Parent*

ERISA by design heavily involves the employer in the provision of several socially important goods—most notably health insurance, retirement income, and disability wage replacement.[45] Relying on employers in that way has positives and negatives. Whether doing so is a desirable regulatory approach generally has been a subject of intense debate among scholars across decades and contexts.[46]

In the health insurance context, a brief version of the general argument for the positives of employer involvement goes as follows. First, the purchase of insurance is an unpleasant, complex task involving the trade of money in hand in return for the reduction of a contingent, future risk.[47] Performing that task optimally requires time, effort, and knowledge, and even then, is a process almost uniquely designed to exploit a raft of cognitive biases that afflict human decision-making. The employer can devote specialized personnel to that task, who on balance are likely to do a far superior job acquiring insurance (or creating a menu of choices) for employees than

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44 U.S. Airways, Inc. v. McCutchen, 569 U.S. 88, 98 (2013).

45 This is true beyond the fact that the employer, as plan sponsor, and many of the employer's employees (who administer the plan) will be fiduciaries under ERISA. 29 U.S.C. § 1102(a). In ERISA world, whether strictly acting as fiduciaries or not, employers have tremendous influence on the construction and performance of the benefit promise—for good or ill.

46 *See generally* Brendan S. Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257 (2016) [hereinafter *Regulating*] (discussing role of employer with regard to the provision of any type of benefit).

47 *See, e.g.*, Jonathan Gruber, *Covering the Insured in the United States*, 46 J. ECON. LIT. 571, 576–77 (2008); Peter Diamond, *Organizing the Health Insurance Market*, 60 ECONOMETRICA 1233, 1236–37 (1992) (discussing the factors needed to assess the risks and rewards of health insurance properly).

they would on their own in the open market.[48] Second, as opposed to a government regulator, an employer might have a relationship with its employees such that it knows what the employees collectively want in a policy; employer paternalism, in other words, might be more bespoke than government paternalism.

The argument against the virtues of employer as parent is (at least) two-fold. First, many employers may not be sufficiently sophisticated to serve as effective parents, given who the counterparties—insurance companies—are. On this account, expecting employers to serve as benevolent guardians meaningfully overstates their actual capabilities.[49] Second, an employer might prioritize its own goals over the goals of its employees, whether in the form of financial savings (by buying cheap policies) or in the form of refusing to offer insurance that covers things the employer strategically or morally objects to (such as reproductive care).[50]

The question—are employers good parents or not?—is not one we need resolve in this Part I. The point is that ERISA puts employers in a position with the expectation they will serve a paternalistic role. Confidence or doubt in their ability to do so will affect how one views the merit of ERISA Insurance compared to alternatives.

4. *Group and Tax Advantages (Pre-ACA)*

ERISA Insurance is group insurance. That matters, because group insurance has some important economic advantages over individual insurance. A simplified explanation will suffice.

Writing economically sensible insurance requires that the insurance company believe that the collected premiums (plus investment returns) exceed the expected payout to the

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48 Indeed, insurance acquisition is so unpleasant that there is good reason to fear individuals left alone won't acquire it at all. Even absent the benefit of employer selection and negotiation, merely tying the insurance purchase to wage reduction—in the form of an implicit decrease in pay if he does not buy insurance (namely the lost employer contribution, which is generally not rebated to the employee)—increases the odds that the employee will buy insurance at all. ICHRAs accomplish that even more directly. *See infra* Part III.

49 *See* Maher, *Regulating*, *supra* note 46, at 1294–96.

50 *See id.* at 1302 (describing *Burwell v. Hobby Lobby*, 573 U.S. 682 (2014) as being an example of precisely this). To be sure, those dangers can be countermanded by regulation. But the point is that, conceptually speaking, relying on the employer as parent has drawbacks. *Cf.* Valarie K. Blake & Elizabeth Y. McClusky, *Employer-Sponsored Reproduction*, 124 COLUM. L. REV. 273, 317–37 (2024) (offering nuanced account of employer views about reproductive care).

insureds.[51] Insurance companies determine the expected payout for a given insured based on a risk-assessing process called "underwriting."[52]

While insurers are quite sophisticated in their ability to assess the risk of potential insureds through the underwriting process, it is considerably easier to accurately underwrite a group rather than an individual.[53] As the group gets larger, the closer the group approaches the community risk, that is, the average risk for any member of the community in a given geographic region (which is a risk number for which insurance companies have great confidence that it is accurate).[54]

One particular underwriting risk that is far less for groups is the risk of adverse selection. Adverse selection, roughly speaking, describes the chance that the person seeking insurance represents a higher risk than the insurance company is accurately able to assess.[55] Group insurance naturally combats adverse selection because the insurance unit is the group, and the group has been created for reasons unrelated to the decision to seek insurance; in the employment setting, the group has been created by virtue of the employees' choice to work for a particular firm.[56] Individual insurance, in contrast, is significantly affected by underwriting and adverse selection problems, such that, prior to the ACA, the individual market was extraordinarily costly and inaccessible to many people.[57]

Indeed, the organic virtues of group insurance likely explain in part why employment-based insurance has long enjoyed the tax advantage conferred on it by Congress—which, in functional terms, is that employment-based insurance is

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51 *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 960 (1963).

52 *See* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 32 (2001) (explaining the role of the underwriting process).

53 *Cf.* Mark A. Hall, *The Geography of Health Insurance Regulation*, HEALTH AFFS., March/April 2000, at 174 (explaining that the characteristics of large-group markets allow them to function with little to no underwriting).

54 *See* John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88 TEMP. L. REV. 411, 437–38 (2016).

55 *See* George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488, 492–94 (1970) (explaining adverse selection in the insurance context). The existence of asymmetric information prevents the insurer from knowing everything about an insured's real risk profile and thus makes them susceptible to adverse selection. *See infra* Part I.B.

56 *See* Hyman & Hall, *supra* note 52, at 32.

57 *See* Cogan, *supra* note 54, at 440–41. *See also infra* Part I.B. (explaining problems with pre-ACA individual market).

permitted to be purchased with pre-tax dollars.[58] Part of that tax advantage, certainly, is attributable to historical circumstance and path dependence.[59] But equally certain is that, from a policymaker's perspective, health insurance is a crucially important good that one would want many people to have access to.[60] Making the provision of employment-based insurance tax-advantaged creates strong labor market pressure on employers to offer it, because (1) that form of compensation is both more valuable to employees than an equivalent amount of wage and (2) it allows employees to escape the problematic individual market.[61]

B. Individual Insurance (Pre-ACA)

The time spent above identifying the key features of ERISA Insurance has a nice payoff: the key features of individual insurance are essentially the converse. We can accordingly summarize the individual insurance regime in a more abbreviated fashion.

Federalism. With respect to ERISA Insurance, the federal government is dominant. The statute's preemptive reach and the self-insurance loophole largely disemboweled state power to regulate employment-based health arrangements. With regard to individual insurance, however, the opposite is true: the states are dominant.[62]

This matters apart from liking or disliking the specific substantive regulation a set of state regulators may have chosen. Empowering state regulation (whatever the content of regulation

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58 26 U.S.C. § 106; *see also* Stephen Utz, *The Affordable Care Act and Tax Policy*, 44 CONN. L. REV. 1213, 1233 (2012) (considering tax treatment of individual insurance).

59 *See* Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 BYU L. REV. 1229, 1231–41 (1995) (explaining the practical and theoretical rationales for this disparate tax treatment).

60 *See* Maher, *Regulating*, *supra* note 46, at 1275–76; *cf.* Thomas R. McLean & Edward P. Richards, *Health Care's Thirty Years War: The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 285 (2004) (explaining the broad benefits of medical insurance on society).

61 It also increases health insurance access in a way that sidesteps the long-standing political resistance to single-payer systems. That may be another reason for the tax preference. *Cf.* Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117, 1121–22 (2010) (discussing the political debates on public-option health care).

62 In this Part I.B. I am describing individual insurance in the pre-ACA period. Post-ACA, the federal government assumed an important "floor-setting" role. *See infra* Part II.A.

is in a given state) can have important systemic virtues that federalism scholars have long identified—such as experimentation, preference, voice, and exit.[63] Experimentation is the idea that States can serve as policy laboratories to figure out what works. Preference is the idea that a State A's residents have different preferences than State B's residents, and therefore might prefer different legal treatment of similar problems. Voice is the idea that state governments are more responsive to their constituents than the comparatively faraway federal government. Exit is the idea that reposing power in the states (rather than the federal government) is preferable because people who dislike State A's approach can move to State B. State power, in other words, can be justifiable (or objectionable) entirely apart from whether one state is making the specific substantive legal choices that match an observer's preference.[64]

Indeed—and again without necessary reference to the content of state regulation—the historic American practice had been that insurance *specifically* was a traditional area of state dominion.[65] While the Constitutional underpinnings of that tradition have been overturned,[66] Congressional solicitude for state priority in insurance regulation was embodied in a specific statute, the McCarran-Ferguson Act.[67] Whereas ERISA has been interpreted in a way hostile to both federalism and the nation's regulatory traditions, the regulation of individual insurance is faithful to both.

State as Parent. Regarding the actual content of state regulation, states have not been *laissez faire* with respect to insurance. They have, generally speaking, been far more interventionist. States have a long history of directly playing a paternalistic role regarding the issuing, offering, and sale of insurance—from rate regulation to mandated coverage terms to solvency requirements.[68] Insurance has long been identified

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63 *See, e.g.*, Heather K. Gerken, *Federalism All the Way Down*, 124 HARV. L. REV. 4, 11–14 (2010) (describing the various systemic virtues of federalism).

64 *Id.*

65 Jonathan R. Macey & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation*, 68 N.Y.U. L. REV. 13, 14–15 (1993) (describing the McCarran-Ferguson Act as an affirmative declaration that insurance regulation is the domain of state regulation).

66 United States v. Se. Underwriters Ass'n, 322 U.S. 533, 553 (1944) (holding that insurance is not exempt from regulation by Congress under the Commerce Clause).

67 15 U.S.C. §§ 1011–15.

68 *See, e.g.*, Daniel Schwarcz & Steven L. Schwarcz, *Regulating Systemic Risk in Insurance*, 81 U. CHI. L. REV. 1569, 1579–80 (2014).

as a classic contract of adhesion,[69] and states have aggressively regulated it in a way to protect and shield beneficiaries from anything resembling an uninhibited, open-market transaction. Such state intervention was deemed necessary to prevent abuse of the overmatched consumer/insured.[70]

Empowering Plaintiffs. One notable element of state regulation has been the degree to which state insurance law is pro-beneficiary in terms of the remedies, damages, standard of review, and immutable default rules that define the beneficiary's ability to seek relief.[71] In other words, not only is the state acting as a parent with respect to substantive terms of the insurance deal, it has further empowered disappointed beneficiaries to seek relief in ways that stand in stark contrast to ERISA's tort-reform approach.

Not Group Insurance, Not Tax Advantaged. Finally, the economic realities of individual insurance meaningfully distinguish it from group insurance (such as ERISA Insurance). Individual insurance is on balance less affordable and accessible than group insurance. In systemic terms, the individual insurance market is far more susceptible to market failures that can undermine or even destroy its utility as a socially valuable means to finance health care for a large number of people.[72]

The key reasons for that are adverse selection and asymmetric information. Those jargony terms respectively mean nothing more than, in plain English, that (1) people more likely to become sick will be more likely to seek insurance, and (2) the insurer's ability to ascertain the higher risk of those people is limited, because their ability to underwrite in individual cases is imperfect.[73]

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69 Edwin W. Patterson, *The Delivery of a Life-Insurance Policy*, 33 HARV. L. REV. 198, 222 (1919) (describing insurance as a contract of adhesion); *see also* Friedrich Kessler, *Contracts of Adhesion—Some Thoughts about Freedom of Contract*, 43 COLUM. L. REV. 629, 632 n.11 (1943) (noting "contract of adhesion" was first used in Patterson's article).

70 *See* Schwarcz & Schwarcz, *supra* note 68, at 1579–80.

71 *See* Maher, *Litigation Reform*, *supra* note 23, at 662–64 (describing state remedial law). Undoubtedly, states vary in the content of their insurance remedies; some are less plaintiff-friendly than others. But none is so restrictive as ERISA.

72 *See* Gruber, *supra* note 47, at 573–74 (contrasting the acute risks of individual insurance pools with those in employer insurance pools).

73 *Id.* at 574–77 (describing shortcomings in the individual insurance market); *see also* Michael Geruso & Timothy J. Layton, *Selection in Health Insurance Markets and Its Policy Remedies*, J. ECON. PERSPS., Feb. 2017, at 23, 25 (explaining that "adverse selection arises because consumers have private information that is not accessible to the insurance provider . . . ").

Insurers make money by accurately assessing and pricing risk. If they cannot do that, they will either charge too low a premium to make money on the issued contracts, or too high a premium to attract sufficient buyers. The former will drive insurers out of business. The latter will mean that far too few insurance policies are sold, and that is problematic for policymakers concerned about health care delivery. Modern health care is too costly to obtain, absent access to some form of insurance. Insurance being available to too few people thus risks too little health care being provided.

Precisely that is what happened to the individual market in the United States prior to the ACA.[74] To protect against adverse selection, insurance companies used a variety of approaches that vastly reduced who could obtain or afford individual insurance. One simple expedient was for insurance companies to protect themselves by engaging in extensive, time-consuming underwriting. That practice had two negative effects. First, it reduced the uptake of insurance generally, because insureds dislike the underwriting process. Second, it meant even willing insureds were priced out of the market, because many individuals were assessed a risk-adjusted premium far beyond their ability to pay.

Another prophylactic measure insurers took was to generally charge higher prices for individual insurance than underwriting strictly indicated to protect against the likelihood that their underwriting missed important risk factors for individuals generally.[75] Those protective price hikes—which may very well be economically defensible from the insurance company's perspective—both put insurance out of reach for those of modest means and drove healthy people out of the market (because actually healthy people are by definition less interested in paying high premiums for policies they are unlikely to use).[76] A final protective measure against adverse selection was the widespread use of pre-existing exclusions, which is the idea that those with certain chronic (and common) conditions either

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74 *See* Gruber, *supra* note 47, at 576–80; *see also* Maher, *Regulating*, *supra* note 46, at 1272–73.

75 *Cf.* Hyman & Hall, *supra* note 52, at 31–32 (discussing how fears of adverse selection cause insurers to raise their premiums).

76 *See, e.g.*, George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1541 (1987) (explaining the cycle of high premiums pushing out low-risk individuals which in turn raises premiums); *see also* Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. HEALTH POL., POL'Y & L. 71, 86–89 (2000) (discussing how protective premiums likely drove healthy individuals from the New York market, resulting in a "high-risk pool").

could not purchase insurance or could not use the purchased insurance for coverage of that condition, rendering the insurance mostly useless for providing needed care.[77]

The result was that the individual market for health insurance in the United States was both unaffordable and inaccessible to large numbers of people. Whether because of the known infirmities with individual insurance or otherwise, the purchase of individual insurance did not enjoy the same preferential tax treatment as did the purchase of employment-based insurance. Unlike ERISA Insurance, individual insurance can generally only be purchased with post-tax dollars.[78]

II
THE ACA

The ACA is a statute of staggering complexity and length.[79] Happily, we need only train our attention on one of the legislation's aims: reforming and restructuring the individual health insurance market.

A. Reforming Individual Insurance

The ACA's reform goals with respect to the individual market were multifaceted. It aimed to make individual insurance accessible, affordable, and substantively appealing, as well as to make the insurance purchase process streamlined and intelligible to the average person.

Accessible and Affordable. Part of ACA reform strategy famously involved the use of three regulatory requirements: community rating, guaranteed issue, and the individual mandate. Community rating is the idea that insurers, with limited exceptions, can only sell policies based on the average

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77 *See* Jessica L. Roberts, "*Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 U. ILL. L. REV. 1159, 1166 (2012) (discussing pre-existing condition exclusions).

78 26 U.S.C. § 213; *see* Utz, *supra* note 58, at 1232–34 (explaining tax treatment).

79 Moreover, the substance of the ACA's insurance reforms varies depending on the type of insurance one is considering, and the statutory language embodying those reforms is complex and inartful, in part because of the circumstances of its enactment. *Cf.* King v. Burwell, 576 U.S. 473, 491–92 (2015) ("The Affordable Care Act contains more than a few examples of inartful drafting . . . . [and] does not reflect the type of care and deliberation that one might expect of such significant legislation."). Much is praiseworthy about the ACA. Its draftsmanship is not one of them.

community risk within a geographic area.[80] Guaranteed issue is the requirement that insurers must sell policies to all willing buyers.[81] And the individual mandate (conceptually speaking) is the requirement that all individuals must purchase insurance.[82]

If everyone in the community is required to buy insurance at the community rate, and insurers must sell insurance at the community rate to anyone who asks, in conceptual terms that resembles selling group insurance to the whole community and collecting from each individual the same community-risk premium.[83] That, of course, is analogous to what happens in employment-based insurance: the insurer insures the entire group, and every individual in the employed group, whatever their individual risk, pays the same premium. Underwriting in a community-risk paradigm is unnecessary, and adverse selection is prevented because everyone needs to buy insurance. For those of modest means, the ACA also added a sliding scale subsidy to make this newly accessible insurance affordable, because even community-rated insurance can be quite costly.[84]

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80 42 U.S.C. § 300gg(a)(1)(A) (listing the permitted rating factors); *id.* § 300gg-3(a) (prohibiting discrimination based on preexisting conditions).

81 42 U.S.C. § 300gg-1.

82 *Cf.* I.R.C. § 5000A (2012) (original individual mandate provision). In 2017, Congress zeroed out the individual mandate. I.R.C. § 5000A(c)(3)(A) (2018); *see also* California v. Texas, 141 S. Ct. 2104, 2123–24 (Alito, J., dissenting) (tracing the history of the mandate). Thus, the current penalty for not buying insurance is zero dollars.

83 The ACA also used reinsurance mechanisms to ensure that insurers, regardless of the actual risk associated with the specific persons that in actuality purchased their policies, were only on the hook for the community risk associated with that pool of persons. *See generally* 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/affordable-care-act/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/ [https://perma.cc/4C5R-WUZH] (discussing how the ACA uses risk adjustment, reinsurance, and risk corridors to promote market stability); *see* Mark A. Hall, *The Three Types of Reinsurance Created by Federal Health Reform*, 29 HEALTH AFFS. 1168 (2010) (explaining reinsurance and risk reallocation mechanisms). In other words, if insurers happened to get a slice of the community that was far riskier than the community at large, the government would compensate the insurers. This is admittedly an oversimplification, but it will suffice here.

84 *See* Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1947–48, 1953 (2013) (explaining how the subsidies work for unaffordable employer coverage). During the Biden Administration, those subsidies were expanded to cover people higher up the income scale, but that expansion expired in 2025. American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182 (2021) (temporarily expanding premium tax credits for tax years 2021–2022); Inflation Reduction Act of 2022, Pub. L. No.

Certainly, the ACA's scheme—both in its implementation details and its broad conceptual approach—had detractors, and infamously resulted in feverish litigation, including, repeatedly, at the Supreme Court.[85] And ultimately Congress (as opposed to the Supreme Court) did away with the individual

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117-169, § 12001, 136 Stat. 1818, 1907 (2022) (extending the enhanced premium tax credits through 2025).

The expiration of the enhanced premium tax credits was unwise and hurt the exchanges. Those enhanced subsidies had expanded subsidy eligibility and helped lead to record exchange enrollment of roughly 24 million; their expiration has increased net premiums for most enrollees, and the Congressional Budget Office projected a loss of approximately 2.2 million insured individuals in 2026 as a result. CONG. BUDGET OFFICE, *The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums*, 3 (Dec. 5, 2024), https://www.cbo.gov/publication/59230; *see also* Justin Lo et al., *ACA Marketplace Premium Payments Would More Than Double on Average Next Year if Enhanced Premium Tax Credits Expire*, KAISER FAM. FOUND. (Sep. 30, 2025), https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/ [https://perma.cc/2XKN-TCMQ] (estimating that net premiums would increase). This matters because the people most likely to drop coverage when premiums rise are healthier individuals, who are precisely the enrollees whose presence on the exchanges is most valuable for risk pool stability and product quality. *See infra* Part IV. Candor requires acknowledging that the exchanges are thus somewhat worse than they were when this Article was first drafted.

That said, the subsidy expiration is not fatal. First, the original ACA subsidies remain in force; community rating and guaranteed issue protections are intact; and the exchange enrollment decline nonetheless represents a reversion toward earlier enrollment levels rather than a collapse of the market. The exchanges will survive, and thus continue to serve as an option for employers wishing to shed ERISA obligations, although likely one some may be more cautious about embracing. *See infra* Parts III and IV.E. Second, the ICHRA transition itself is the partial *antidote* to the problem the enhanced subsidy expiration creates. The workers who would flow onto the exchanges via ICHRAs are the type of healthier, wealthier enrollees whose absence is most damaging to the exchange risk pool. *See infra* Part IV. In that respect the termination of the enhanced subsidies makes the ICHRA influx more valuable to the exchanges, not less. It also makes the normative need for thoughtful exchange and ICHRA regulation more pressing, not weaker. *See infra* Part IV. Lastly, the political prospects for some future form of enhanced subsidies are meaningful. Approximately 77% of ACA exchange enrollees in 2025 resided in states won by President Trump, and exchange subsidies disproportionately favor them—meaning the political cost of subsidy cutbacks falls heavily on Republican constituents. Emma Wager, *More Than 3 in 4 ACA Marketplace Enrollees Live in States Won by President Trump in 2024*, KAISER FAM. FOUND.: QUICK TAKES (Oct. 3, 2025), https://www.kff.org/quick-take/more-than-3-in-4-aca-marketplace-enrollees-live-in-states-won-by-president-trump-in-2024/ [https://perma.cc/4FRS-CJ6G]. It seems reasonable to expect that some version of the enhanced subsidies will return, whether under a future Democratic administration or under a Republican Congress less constrained by the current political moment. *See also infra* note 87.

85 Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471, 1472 (2020) ("The ACA is the most challenged statute in American history.").

mandate.[86] But the key takeaway is that the ACA reforms, whatever their infirmities and imperfections, were intended to and in fact did make the individual market far more accessible and stable than prior to the ACA.[87] One cannot be denied

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86 *California*, 141 S. Ct. at 2123 (Alito, J., dissenting) (explaining that Congress zeroed out the mandate).

87 Another word on recent developments: A final rule issued by CMS in June 2025, as well as various provisions in the One Big Beautiful Bill Act (in July 2025), together made exchange enrollment and maintenance of coverage more difficult and administratively burdensome in a number of respects, e.g., shortening enrollment windows, eliminating certain special enrollment periods, removing repayment caps that had protected low-income enrollees, and implementing various program integrity measures. *See* Patient Protection and Affordable Care Act; Patient Protection and Affordable Care Act Marketplace Integrity and Affordability, 90 Fed. Reg. 27074 (June 25, 2025) (to be codified at 45 C.F.R. 147, 155, 156) (stayed in part by City of Columbus v. Kennedy, 796 F. Supp. 3d 123) (D. Md. 2025); One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (2025); Am. Medical Ass'n, *Summary of Select ACA Marketplace Eligibility, Enrollment, and Affordability* (2025), https://www.ama-assn.org/system/files/aca-enrollment-changes-summary.pdf [https://perma.cc/RUH6-HRKK] (summarizing exchange changes). Critics (including me) believe these changes are markedly undesirable and will weaken the exchange ecosystem; various projections have attributed depressed exchange enrollment to either or both of these measures. *See, e.g.*, Cong. Budget Office, *Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act*, at 4–5 (June 4, 2025), https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf [https://perma.cc/3VPV-LEPE]; Jared Ortaliza et al., *How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?*, KFF (Aug. 11, 2025), https://www.kff.org/policy-watch/how-will-the-2025-budget-reconciliation-affect-the-aca-medicaid-and-the-uninsured-rate/ [https://perma.cc/G5TV-V53E].

Yet, as with the enhanced subsidy expiration, these disappointing developments do not alter the fundamental legal architecture of the employer mandate, ICHRA eligibility, or the pre-tax treatment of ICHRA funds that drives the subject transition. The reality is an employer's incentive to shed the administrative burdens, litigation exposure, and cost volatility of ERISA-governed group coverage does not evaporate simply because the exchanges to which workers are redirected are smaller and weaker than they might otherwise be; if that were true, many more employers would still offer pensions. *See infra* Part III. There is little chance that employer forbearance will be sufficient to save people in full from sub-optimally regulated exchanges. Moreover, in political economy terms, employers interested in shedding ERISA obligations but unhappy (because of concern for workers) with the exchanges have a sincere incentive to lobby for exchange quality. One expects that for this reason and others, future administrations and Congresses will be more favorably inclined toward exchange vitality, and act accordingly. Put simply, robust exchanges benefit several different constituencies, and regulatory behavior is, hiccups aside, ultimately likely to follow that reality. For that reason, the transition argument from ERISA towards individual insurance does not in the long term depend on any particular administration's regulatory choices (assuming those choices stop short of destroying the exchanges entirely). What it depends on are the underlying economic forces that make the ICHRA transition plausibly attractive to employers and tolerable to employees. Those forces currently remain intact. Wise regulation can accelerate that transition and result in better outcomes for all. *See infra* Part IV. Poor regulation,

individual insurance today merely because of pre-existing conditions, nor priced out of the market by being charged an exorbitant rate. That is a major change from the pre-ACA days. Public polling with respect to the idea that everybody can buy insurance at the community rate, regardless of their health status, has understandably scored very high approval ratings, across the political spectrum.[88]

Paternalistic Deal Regulation. In contrast to ERISA's hands-off approach to regulating the content of insurance deals it governs, the ACA directly spoke to what an insurance policy must contain. Most notably it required that individual insurance contain ten categories of "essential health benefits"—which, jargon aside, simply means that sold policies must cover medical care that falls within ten broad categories of coverage, the practical scope of which is functionally defined by the HHS Secretary and state authorities.[89] It also, among other things, added substantive financial requirements for individual policies, such as caps on out-of-pocket expenditures by insureds and medical loss ratio requirements for insurers (which require that insurers spend a minimum amount of money, compared to their collected premiums, on care).[90]

In other words, the ACA imposed policy quality requirements that served a paternalistic function of ensuring that individual policies sold met some decent minimum of substantive quality that might arguably approximate what an average reasonable insured might want. Although the ACA preempted the ability of states to do *less* than the ACA's requirements, it largely preserved the ability of states to require more, that is, to

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however, is unlikely to stop it; it will just result in more people getting worse deals along the way.

88 Ashley Kirzinger et al., *5 Charts About Public Opinion on the Affordable Care Act*, KFF (Oct. 3, 2025), https://www.kff.org/affordable-care-act/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act/ [https://perma.cc/9GDB-BC2V] (finding that the prohibitions on pre-existing condition exclusions remain the most popular ACA provisions).

89 *See* Jessica Mantel, *Setting National Coverage Standards for Health Plans under Healthcare Reform*, 58 UCLA L. REV. 221, 229–31 (2010) (discussing the considerations HHS must follow when drafting essential health benefits); *see also infra* notes 159 (discussing EHB process), 181 (noting inapplicability of EHB to large employers).

90 42 U.S.C. § 18022(c) (placing limitations on cost-sharing); *id.* § 300gg-18 (instituting the medical loss ratio). Individual policies sold on the exchanges also need to be certified as qualified health plans. 42 U.S.C. § 18021(a) (defining qualified health plans); *id.* § 18031(d)(2)(B)(i) (exchanges can only sell qualified health plans); *id.* § 18041(a) (providing regulatory authority to set qualified health plan standards).

be more protective and paternalistic with respect to individual policy requirements.[91]

Intelligible Choice. Finally, the ACA expressly aimed to ameliorate the cognitive difficulties associated with purchasing and choosing insurance. For ERISA Insurance, the employee benefits from the expertise and organizational frame the employer offers; the employer either does all the work in picking the insurance or does most of the work, leaving to the employee only a constrained set of choices with regard to the health insurance decision.[92] Open market, unguided insurance purchases are far more difficult, and a fertile ground for cognitive biases to impede an optimal purchase by the individual insured.[93] To combat this, the ACA created an intelligible choice architecture for the insurance purchase: the exchanges.

The exchanges functioned to make the insurance purchase streamlined and digestible—such as through the clear labeling of policy options, the creation of metallic tiers of financial coverage, the use of plain English, and the availability of Navigator personnel to aid in the purchase process—in order that individuals would be more likely to understand their options and choose wisely.[94] For those concerned about the likelihood that individuals purchasing insurance would be too overwhelmed, distracted, or confused to make a sensible insurance decision, the cognitive behavioral benefit of the exchanges was no small boon—providing a benefit similar in kind to the cognitive benefit commonly argued to accrue to those who get employment-based insurance.

B. Deterring Insurance Transition

While reforming the individual market in the ways the ACA did was beneficial, it created a second-order political problem.[95] When the individual market was unaffordable and inaccessible,

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91 *See* 42 U.S.C. § 18041(d) (preemption provision). In the case of essential health benefits, however, a state that wishes to require more must pay some additional cost. 42 U.S.C. §§ 18031 (d)(3)(B)(i)–(ii).

92 *See* Maher, *Regulating*, *supra* note 46, at 1288 (ERISA conscripts employers as "private bureaucrats" in order to implement employee benefits, including insurance).

93 *Id.* at 1278 (explaining how the complicated nature of insurance hinders individual's ability to purchase health insurance on the open market).

94 *See, e.g.*, 42 U.S.C. § 18031(c)(1) (requiring certain criteria that increases transparency for individuals); *id.* § 18031(e)(3)(B) (requiring the "use of plain language"); *id.* § 18031(i) (requiring exchanges to establish a navigator).

95 *Cf.* Maher, *Regulating*, *supra* note 46, at 1272–74 (observing that political influence preserved employment-based health insurance).

for many employees, the only realistic option for health insurance was through the workplace. The consequence was that the labor market exerted strong pressure on large employers to provide employment-based insurance—because for many employees the absence of employment-based insurance would mean no insurance at all. Shoring up the individual market, however, would lessen that pressure—employers would feel free to stop offering coverage, knowing that their employees could obtain legitimate health insurance on the exchanges.

For the coalition of reformers that supported the ACA, widespread dropping of employment-based insurance was feared to be potentially destabilizing and politically costly. Employment-based insurance was popular and also benefited from the widespread misimpression that employment-based insurance was a free gift from the employer.[96] A change to that system would naturally roil voters—both because it would represent an actual change and because it would be misinterpreted as taking away "free" or heavily discounted insurance that the employer offered as a gift. The latter is not true; for over a century, economists have known that health insurance is paid for by foregone wages.[97] But in political terms, embarking on significant reform that was already under heavy attack that could be said to potentially undermine the existing employment-based system was too tall a political ask.

As a result, the ACA deliberately made it difficult for people to transition from ERISA Insurance to individual insurance, and in two particular ways. First, it adopted the so-called employer mandate, where large businesses were obligated to offer health insurance or face considerable penalties.[98] Unlike the individual mandate, the employer mandate has nothing to do with adverse selection or asymmetric information. The chief purpose of the employer mandate was to ensure that large firms would not stop offering health insurance and simply direct their employees to take advantage of the newly created exchanges. Second, although the ACA extended subsidies to a small slice

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96 *See id.* at 1308 (describing confusion over who shoulders the cost of employer-based benefits).

97 *See* Albert DeRoode, *Pensions as Wages*, 3 AM. ECON. REV. 287, 287 (1913) ("A pension system . . . is really paid by the employee, not perhaps in money, but in the foregoing of an increase in wages which he might obtain except for the establishment of a pension system."); *see also* Sherwin Rosen, *The Theory of Equalizing Differences*, *in* 1 HANDBOOK OF LABOR ECONS. 641, 641–42 (Orley C. Ashenfelter & Richard Layard eds., 1986) (explaining the tradeoff between wages and benefits).

98 I.R.C. §§ 4980H(a), 4980H(c)(2)(A).

of low-income purchasers of individual insurance,[99] it (1) did not do so if an employer offered affordable health insurance,[100] and (2) did not otherwise permit purchasers of individual insurance to use pre-tax dollars to buy individual insurance.

III
The Coming Health Insurance Transition

As originally enacted, the ACA could fairly be described as seeking to perpetuate and protect ERISA Insurance. Although some of the ACA's regulations affected the content of all health insurance issued (including policies otherwise governed by ERISA),[101] the legislation took care to ensure that its reforms to the individual market would not result in a flow of individuals out of the ERISA-dominated, employment-based world and into the reformed individual market the ACA built. As the 2010s came to a close, however, that began to change. Congressional and agency choices greenlit the possibility, first narrowly and then more broadly, of a reasonably smooth glidepath away from ERISA Insurance. That change and its likely impact—namely, an insurance landscape increasingly weighted toward individual health insurance, at ERISA's expense—are considered in this Part III.

A. Empowering Insurance Transition

As emphasized above, because of the threat to the employment-based system that the ACA's reforms of the individual market posed, federal law—by imposing an employer mandate and by refusing to allow individual insurance to be purchased with pre-tax dollars—explicitly impeded any meaningful transition to individual insurance.[102] Altering either of those impediments would make an insurance transition more likely, not because that would *require* the purchase of individual insurance, but because it would unleash natural forces that would

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99 *See generally id.* § 36B(c)(1)(A) ("[A] taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved."). Subsequent expansions to the subsidy that allowed it to reach people with higher incomes occurred during the Biden administration, but those did not survive the current Trump administration and Republican Congress. *See supra* note 84.

100 I.R.C. § 36B(c)(2)(C).

101 *See* ERISA Principles, *supra* note 21, at 448 nn.110–11 (explaining the complicated interaction between the ACA's battery of insurance reforms and ERISA).

102 *See supra* Part II.B.

make it more likely that involved parties would choose to transition to individual insurance.

Shortly before the pandemic hit, precisely that happened.[103] Late in the first Trump Administration, the relevant implementing agencies issued final regulations for a benefit vehicle called an Individual Coverage Health Reimbursement Arrangement—the ICHRA.[104] An ICHRA is a reimbursement benefit; a company (of any size) may promise an employee that the company will reimburse (up to a certain amount) monies spent acquiring qualifying health insurance (whether sold on the exchanges or otherwise).[105] The precise details of ICHRAs are not simple, but thankfully, we need not map them out with exacting precision here. We need only acknowledge (for now) that ICHRAs have three crucial features.[106]

The first is that the creation of an ICHRA with a reimbursement promise above a certain amount is considered to satisfy the employer mandate.[107] Prior to ICHRAs, the agencies

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103 It goes without saying that the pandemic slowed the speed with which employers would have otherwise adopted ICHRAs. The world was effectively on pause.

104 *See generally* Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28888 (June 20, 2019); *see also* CONG. RSCH. SERV., HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs): OVERVIEW AND RELATED HISTORY, at 7–10 (2022) (describing the various features of ICHRAs).

105 26 C.F.R. § 54.9802-4(c)(1)(ii) (2025). A forerunner to the ICHRA was the QSEHRA, which offered small employers—and small employers only—the option of creating a similar (but with some difference) reimbursement account. 26 U.S.C. § 9831(d).

106 The regulations implementing ICHRAs are *extremely* technical and involve multiple agencies. One could go into a great deal of more technical specificity about the ICHRA's various regulatory features, several of which could be improved. That level of detail, while appropriate for a (separate) technical paper analyzing the ICHRA as a particular instantiation of a health insurance reimbursement account (rather than its potential systemwide effects), is here unnecessary and likely unhelpful. One may consider the broad conceptual issues presented in Part IV without getting that deep into the weeds. Where appropriate, I nonetheless note (in non-technical language) a few ways in which the ICHRAs as currently constituted might be made additionally protective of employees.

107 *See* CONG. RSCH. SERV., *supra* note 104, at 8 (explaining minimum ICHRA funding requirement). Currently the required funding is tied to the cost of the lowest-cost silver self-only policy on the relevant exchange. The way the affordability calculation roughly works is that, given the employee's income, if he has to pay more than a small, specified percentage of his income to buy the lowest silver self-only policy, then the ICHRA is not affordable and the mandate is not satisfied. *Id.* While the current requirements implicitly incorporate the employee's age (because the policy cost on the relevant exchange is age-banded), they do not take into account family status. Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28946. Employers are free to, and many do, increase ICHRA monies to account for family status.

charged with implementing ERISA and the ACA had made clear that standalone reimbursement accounts did *not* satisfy the employer mandate.[108]

Second, ICHRA money is pre-tax.[109] Thus, unlike an open-market purchase of individual insurance, buying an individual policy through an ICHRA means one gets to spend pre-tax dollars on health insurance. That bears repeating: while individual insurance that one might wish to purchase without an ICHRA can generally only be done with post-tax dollars, if the employer sets up an ICHRA, the employer is effectively transferring the ability to purchase insurance pre-tax to the employee.

The third important feature of an ICHRA is one, regrettably, that will require some additional ERISA-specific explanation. ERISA's various regulatory requirements turn on whether or not an employer is offering what ERISA calls a benefit "plan."[110] Those requirements, as I will discuss below, are a meaningful burden upon employers—a burden that ERISA drafters felt was justified to ensure that when benefit promises were made, they would be kept and discharged along the way with prudence and loyalty. Were the creation of an ICHRA *not* a plan, then doing so would entirely free employers from ERISA's weighty obligations and the very real liabilities it imposes.

ICHRAs *are* benefit plans—both according to the implementing agencies and under a fair reading of past precedents regarding what it means to create a benefit plan (as opposed to non-benefit compensation or one-off benefit payments—neither

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26 C.F.R. § 54.9802-4(c)(3)(iii)(A) (2025). One protective regulatory tweak would be to require family status be considered. *See infra* Part IV.D. A similar "family glitch" affordability issue regarding traditional group coverage was addressed by an executive order by President Biden, and then apparently rescinded by President Trump (and it is currently not clear what new position the implementing agencies are planning to advance). *See* Ivana Greco, *The Affordable Care Act's 'Family Glitch' Strikes Back*, INST. FOR FAM. STUD. (Jan. 27, 2025), https://ifstudies.org/blog/the-affordable-care-acts-family-glitch-strikes-back [https://perma.cc/KR6E-7UGU].

108 Utz, *supra* note 58, at 1234 (observing the federal government had routinely rejected efforts to use any version of defined contribution health accounts to funnel an employee pre-tax money to spend on premiums outside of group coverage).

109 Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28888, 28890 (June 20, 2019) (explaining tax status); *see also* CONG. RSCH. SERV., *supra* note 104, at 1 (same).

110 29 U.S.C. § 1101(a); *see also* Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 92 (1983) (discussing ERISA's regulation of plans).

of which trigger ERISA).[111] Importantly, however, an ICHRA is a plan *only* with respect to the reimbursement scheme.

Put slightly differently, an ICHRA triggers ERISA obligations only with respect to the employer offering and paying the *reimbursement* itself. For example, an employer must disclose the terms of the ICHRA to its employees in plain English, and it must abide by ERISA in connection with the manner in which it reimburses legitimate ICHRA expenditures the employee has made.[112] But the ICHRA as a burden-triggering benefit plan has a very important ERISA border: the actual insurance policy that an employee purchases with the funds reimbursed by the ICHRA is *not* subject to ERISA.[113] In other words, to slightly oversimplify, employers are really only on the hook, in ERISA terms, for properly administering the reimbursement account; they are *not* on the hook for administering the health insurance promise. With regard to the health insurance promise that arises from the policy the employee has purchased with the ICHRA reimbursed funds, it is the insurance company that is legally on the hook, and its obligations and liabilities are governed by ACA and state law, *not* ERISA.[114]

Thus, as complicated as ERISA, the ACA, and the ICHRA can be both individually and collectively, the digestible upshot is that ICHRAs mean something very powerful in big picture terms. With ICHRAs, *all* employers have an option to—aside from writing reimbursement checks and doing modest disclosure and monitoring regarding the ICHRA expenditures—otherwise offload the health insurance promise to state-regulated insurance companies, while still providing their employees with a genuine, pre-tax health insurance benefit. Insurance regime transition, in short, is now in the hands of employers.

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111 *See* 29 U.S.C. § 1002(1) (definition of welfare plan); 26 C.F.R. § 54.9815-2711(d)(1) (2025) (providing that HRAs are plans); Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg 28888, 28951–52 (explaining how ICHRAs are subject to notice requirements); *see also* Donovan v. Dillingham, 668 F.2d 1196, 1198–99 (11th Cir. 1982) (spelling out what it means for there to be a plan); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 14 (1987) (holding that one-time payments aren't plans).

112 *See* sources cited *supra* note 111. Employers also have to reasonably substantiate that a beneficiary seeking reimbursement has acquired individual coverage. 26 C.F.R. § 54.9802-4(c)(5) (2025).

113 29 C.F.R § 2510.3-1(i) (2025) (assuming certain conditions are met, the individual insurance policy that is reimbursed with ICHRA monies is not an ERISA plan).

114 *See supra* Part I.B.

B. Insurance Transition Impediments

Given the analysis set forth above, two questions present themselves: (1) what is the likelihood of a sizable transition away from ERISA Insurance, and (2) were it to occur, would that transition—to individual insurance—be, on balance, desirable or undesirable? The first question is considered in Parts III.B. and III.C., and the second in Part IV.

Regarding the likelihood of a move away from ERISA Insurance to individual insurance, a skeptical reader may correctly point out that it is not the law alone that drives business decisions (such as the decision to provide compensation in the form of health benefits). Things other than law greatly affect what firms will do. That is undoubtedly true, and to extend full credit to the skeptic, it is worth considering generally what factors might prevent a mass transition away from ERISA Insurance to individual insurance. After all, there are multiple reasons why ERISA Insurance has long been dominant in the United States, and ICHRAs alone do not moot all of those rationales.

To assess this argument, two things make sense. The first is to articulate and weigh a set of rationales that might describe the staying power of ERISA Insurance *other than* the existence of the employer mandate and the tax advantage that accrues to such insurance (both of which the ICHRA functionally moots). The second is to go beyond theoretical argument and look at history. We can do so in the form of a benefit case study, namely, to see what happened in the retirement benefit context when the relevant law changed and permitted employers to transition from offering pensions (the traditional and decades-long default form of retirement benefits) to offering retirement accounts (of which the 401k is the most famous). Although not a perfect analogy, the parallels are very strong, and those inclined to make predictions about the likelihood of a health insurance transition would be wise to consider that example.

Inertia. Consider first the easiest theoretical argument in favor of ERISA Insurance: inertia. Virtually everyone has a favorite example of changes that benefit the decisionmaker but nonetheless failed to occur because of the human tendency to leave well enough alone. Consider my favorite example: professional football.

Professional football is an incredibly competitive sport, in which even the smallest margins can be the difference between wild success and bitter failure. Nonetheless, for many years it

was widely believed that "going for it" on fourth and short was, outside of a *very* limited set of circumstances, a strategically unsound decision.[115] Today that calculus has changed dramatically.[116] While football coaches remain fairly conservative, the prevailing (and statistically accurate) wisdom today is that going for it on fourth and short is justified far more often than was acknowledged in the past, and so teams do it more.[117] Ironically, today going for it on fourth down is less advantageous than it was in the past, not because it is wrong to go for it, but because the *other* coach today is more likely to *also* go for it when he is faced with a fourth-down situation, thus depriving today's coach of the benefit of having a competitor following a suboptimal strategy.

The problem with the inertia argument is that inertia tends to operate mostly to *slow* the adopting of changes rather than forestall them entirely. While inertia often does retard the pace of change, if it is the sole force inhibiting change, that is, if it is unaccompanied by some other factor operating to prevent change, it is unlikely to stop change entirely.

The wise and good-hearted employer. Consider a second argument, one we might refer to as the "wise and good-hearted employer" argument. This argument draws upon the employer's sophistication in making insurance choices and its solicitude for its workers. Employers, and particularly large employers, are not only considerably more sophisticated (when it comes to purchasing insurance) than most of their individual employees,

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115 In football, a team loses possession of the ball if the team does not advance ten yards after four attempts (which are referred to as "downs"). "Fourth and short" refers to those circumstances where the team has fallen short of advancing ten yards by a small distance. In fourth and short situations, going for it means the team is foregoing its chance to punt on fourth down. The strategic advantage of punting is that, although doing so concedes the ball to the opponent, punts travel such long distances that the receiving opponent will be very far away from the goal line (and thus face taller odds to score itself). Going for it has the potential advantage of maintaining possession and obtaining a new set of downs, but risks turning over the ball to an opponent much closer to your own goal line. *Cf.* Derrick R. Yam & Michael J. Lopez, *What Was Lost? A Causal Estimate of Fourth Down Behavior in the National Football League*, 5 J. SPORTS ANALYTICS 153, 155 (2019) (analyzing historical NFL data). I am old enough to recall quite vividly when going for it on fourth and short was incredibly rare and greeted with dramatic pearl-clutching by beefy commentators.

116 *See* NYT 4th Down Bot, *4th Down: When to Go for It and Why*, N.Y. TIMES: UPSHOT (Sep. 4, 2014), https://www.nytimes.com/2014/09/05/upshot/4th-down-when-to-go-for-it-and-why.html [https://perma.cc/FN9L-7UTZ].

117 *Why Are More Football Teams Going For It on Fourth Down? Behavioral Economics Has the Answer*, IRRATIONAL LABS (Apr. 20, 2022), https://irrationallabs.com/blog/football-teams-behavioral-economics/ [https://perma.cc/HDP5-LYCM].

they might be genuinely committed to deploying that expertise in a way that gets their employees a better insurance deal than an employee would be able to strike on their own.[118] An employer might be able to secure a better insurance deal for its employees any number of ways, whether by merely ferreting out and rejecting bad deals, by using purchasing power to make better-than-market deals, by understanding employee preferences sufficiently to negotiate more appealing deals with insurers, or by offering bespoke insurance arrangements to its employees that are self-funded out of the employer's own coffers.[119] (Many large employers, after all, self-fund the insurance promise.) Whatever the manner in which an employer delivers additional value to its employees, the wise and good-hearted employer argument counsels against an overnight transition to the individual market by seizing upon the belief that employers offering employment-based insurance are both delivering additional value to employees (beyond merely writing a check) and are committed to continuing to do so.[120]

The problems with this argument are apparent. First, the existence of robust exchanges will likely persuade some, if not most, employers that employees can obtain suitably good insurance on their own, by using ICHRA money (and on the convenient exchanges). When the employer's refusal to provide insurance leaves employees to the dangers of the pre-ACA individual market or deprives them of a tax advantage, the wise and good-hearted employer argument is quite powerful—indeed, prior to the ACA, the provision of health insurance by any employer was optional, and yet many employers offered it. In the old days, effectively *any* insurance the employer

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118 *See supra* Part I.A; *see also* Hyman & Hall, *supra* note 52, at 30 (arguing that, with respect to health insurance decisions, employers have superior personnel resources).

119 Brendan S. Maher, *The Private Option*, 2020 MICH. ST. L. REV. 1043, 1084 (2020).

120 While those unfamiliar with the delivery of benefits in the United States might find this argument ultimately unpersuasive, in the view of this longtime observer (and one who has repeatedly represented employees in benefit disputes) it deserves serious consideration. It not only accurately describes the sincere emotional commitment of many benefit decisionmakers, it also accurately captures the reality that at least some employers genuinely do honestly attempt to leverage their sophisticated benefits personnel to actually deliver better deals for their employees than employees would secure on their own, perhaps even on the exchanges. *See supra* Part IV; *cf.* Amy B. Monahan & Barak D. Richman, *Hiding in Plain Sight: ERISA's Cure for the $1.4 Trillion Health Benefits Market*, 42 YALE J. ON REGUL. 234, 257 (2024) (urging that fiduciary duties be interpreted to require employers to strike insurance deals of certain quality, which implicitly assumes some level of employer ability to do so).

provided would make the employees better off; a lot more employers would rightly believe they were delivering value. Today, however, fewer employers will feel confident they are actually delivering better value.

Second, even assuming there is some meaningful segment of employers who are delivering better insurance to their employees than the employee would otherwise obtain—which does not seem impossible—the relevant question is whether this practice will withstand the powerful economic forces justifying employer abdication of this role. Does the extra insurance value the employer is giving the employees through the use of expert human resources personnel or deployment of the company's purchasing power justify the company taking on the extra administrative, regulatory, and liability burdens associated with offering health insurance directly to the employees (as compared to writing an ICHRA check)?

In some cases, as explained in Part IV, it might—because doing so might, for example, be the sign of an elite business that delivers something unusual to highly sought-after employees.[121] Some businesses, after all, pay more than others, and using company wherewithal to secure better health insurance for employees is no different. But in *many* cases, the employer-as-insurance-angel sentiment—however genuinely felt by current members of the employer's business—seems likely to be overcome by countervailing forces. It is unlikely to happen immediately, true. Over time, however, whether through retirement of the old guard or otherwise, the cost-benefit calculus will cause even benevolent employers to make the choice to simply write checks and free themselves of the very real burden of being involved in health insurance.[122] Compared to a traditional ERISA plan, an ICHRA approach quite literally means an employer who *does* less will get *sued* less. That is a very powerful incentive.

Labor pressure. A related but distinct objection is that, regardless of an employer's internal commitment to providing quality health insurance to its employees, *employees* might demand that employers provide health insurance more desirable than what is offered (or perceived to be offered) in the individual market.[123]

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121 *See infra* Part IV.

122 *See infra* Part III.C.

123 Unions, for example, have long sought generous health care coverage. *See, e.g.*, Kathryn L. Moore, *The Future of Employment-Based Health Insurance After*

Widespread fear among employees—particularly skilled or managerial employees—that individual insurance policies are not as appealing as ERISA Insurance along certain dimensions (such as the breadth of physician networks) will certainly impede insurance transition in cases where the employer fears the departure of (or inability to recruit) talented labor.[124] Like with the wise and good-hearted employer objection, however, this rationale might lose out to more acute financial pressures upon the employer, namely the desire to offload the not insubstantial burden of complying with ERISA in connection with the health insurance promise.[125] It also might simply result in the employee making the offered ICHRA more generous in dollar terms, rather than continuing to offer ERISA Insurance.

Labor counterpressure will also lose power to the degree to which employees are happy with what they can obtain on the individual market. One imagines that this transition-impeding force—like the wise and good-hearted employer—is most likely to slow the transition, rather than stop it. To the extent labor pressure preserves some amount of ERISA Insurance, it seems likely to do so only for a small slice of firms in which labor pressure is particularly acute and motivated by a genuine reason to believe the employer can truly deliver better-than-market insurance value.

Regulatory uncertainty. Another force counseling against insurance transition is regulatory uncertainty. Life involving standard ERISA plans is largely settled, regulatorily speaking, and regulatory volatility is something firms generally seek to avoid. And, although it took several decades, employers offering ERISA Insurance know what they're getting. Replacing a standard ERISA plan with an ICHRA approach is much more unsettled, for several reasons. It is not clear, even to experts, precisely what problems will arise in connection with ICHRA administration. Nor is there great confidence about what life on the exchanges will look like under the current presidential administration and Congress. Indeed, the early days of the second Trump administration have cast doubt on regulatory stability with respect to *anything*. It is entirely reasonable to be

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the Patient Protection and Affordable Care Act, 89 NEB. L. REV. 885, 891 (2011) (describing unions' aggressive pursuit of health benefits in the post-war years).

124 *But see infra* note 171 (offering evidence that certain things insureds may prefer in insurance do not correlate with better care or lower costs).

125 *Cf.* Peter J. Wiedenbeck, *ERISA's Curious Coverage*, 76 WASH. U. L.Q. 311, 336–39 (1998) (describing the intense regulation ERISA applies to employer-provided health insurance).

cautious about embracing the ICHRA approach, whatever its potential advantages, given such uncertainty.[126]

Again, however, this counterargument seems to counsel in favor of slow change, not never change. The more companies take the plunge—and iron out the regulatory wrinkles associated with using ICHRAs—the less regulatorily uncertain the transition will be for others, and the more attractive the ERISA offload will be.

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However valuable theoretical arguments might be, real-world examples always bring additional explanatory power. In the benefit context, we have a *very* good example of how employers responded to legal incentives that permitted them to move from a form of benefit that was more burdensome to them to one that was less so. When ERISA was first enacted in 1974, the dominant retirement benefit was a pension (and had been for close to a century).[127] Today, the dominant retirement benefit is a retirement account, such as a 401(k).[128]

Are there lessons from that benefit transition? There are, as I consider in more detail below. I will not hide the takeaway:

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126 This Article was written in January 2025 and goes to press in the spring of 2026. During that period, there have been a number of developments—most notably the end of the enhanced ACA subsidies, the passage of the One Big Beautiful Bill Act, CMS rulemaking regarding exchange enrollment and eligibility, and various late night presidential pronouncements about the future of health care financing—that health care observers have followed with concern. *See supra* notes 84, 87. I am certainly in that concerned group, although practical constraints will not allow me to spell out all the details here. Instead, I will say this: while there are certainly conceivable regulatory changes that could destroy the exchanges as a viable option, I do not think the latest Trumpian health care perturbations so qualify. As wrongheaded as they have been, my honest view at press time is that they will likely slow but not stop the transition to individual insurance—largely because the employer incentives driving that transition are simply too powerful. *See* this Part III and *see infra* Part IV.E. Many of these developments do, however, have the real potential to make the exchanges worse (both overall and for various individuals) with little to show for it. Some of these I acknowledge in passing in this Article, but I believe this also supports my normative position: individual insurance could work well and make *both* employers and employees happy, but only if regulators behave sensibly and wisely. *See infra* Part IV. While the current administration has given me little confidence that it will do so, no administration governs forever, and the merits of the ICHRA transition should be evaluated against a reasonable regulatory baseline, not against the shortcomings of any particular incumbent.

127 Patrick W. Seburn, *Evolution of Employer-Provided Defined Benefit Pensions*, 114 MONTHLY LAB. REV. 16, 16 (Dec. 1991) (tracing history of defined benefit pensions and their growth into the 1980s).

128 PATRICK PURCELL & JENNIFER STAMAN, CONG. RSCH. SERV., RL34443, SUMMARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 5 (2009) (showing that 401(k) plans are the most common defined contribution plans offered by employers).

Even though a very similar set of anti-transition arguments were made during the relevant period—i.e., employer benevolence, employee desire, and regulatory uncertainty—the ultimate result was the admittedly slow but near-total victory of burden-reduction forces: employers moved en masse from offering the more burdensome pensions to the less burdensome 401(k)s (or similar vehicles).

C. A Benefit Transition Case Study: Pensions to 401(k)s

Some background is necessary to appreciate what happened in the retirement context and why it is instructive.

ERISA was enacted in 1974, and its chief purpose was to regulate the provision of retirement benefits.[129] ERISA's origin story is well-known and often told. Prior to its passage, several high-profile companies were unable to live up to their pension promises, leaving workers despairing.[130] Congress studied the matter and then reacted by passing ERISA, which was intended to ensure that, to the extent a retirement benefit promise was made, it would be performed.[131]

At the time of ERISA's enactment, Congress was primarily concerned with protecting pensions, which were the long-dominant form of retirement benefit.[132] A pension is simply an annuity that an employee receives upon retirement and is customarily based on the product of his average pay, his years of tenure, and some small percentage.[133] The aim of a pension is to replace a significant portion of the employee's wage for the entirety of his retirement years, such that the employee can confidently retire from his job without fear of penury in old age.

Congress was interested in regulating pensions in part because, in the event the company fails to perform its pension promise, elderly workers have few alternative options; their working years are over. Because pension promises reflect a

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129 *See generally* JAMES A. WOOTEN, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY (2004).

130 *See, e.g.*, 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, 683–84 (2001) (discussing the Studebaker-Packard Corporation's pension default).

131 *See* JOHN H. LANGBEIN, SUSAN J. STABILE & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 77–87 (4th ed. 2006) (describing the legislative history of ERISA).

132 *See* Michael S. Gordon, *Why Was ERISA Enacted?*, *in* S. SPEC. COMM. ON AGING, 98TH CONG., THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: THE FIRST DECADE 1, 2–5, 15–18 (Comm. Print 1984).

133 *See* John H. Langbein, *ERISA's Role in the Demise of Defined Benefit Pension Plans in the United States*, 31 ELDER L.J. 1, 5 (2023).

future commitment to pay monies to retirees, Congress's regulatory scheme in ERISA imposed a battery of requirements: namely that, *inter alia*, firms promising pensions fund a portion of that promise contemporaneously; that pension monies be contained in a trust and could not be used by the company for non-pension purposes; that parties involved in the funding and performance of the pension promise must observe strict fiduciary duties of prudence and loyalty; and that companies promising pensions pay a premium to the Pension Benefit Guaranty Corporation, a government agency set up to guarantee (up to a certain amount) the pension promise in the event of company failure.[134]

These requirements, while undoubtedly successful in making pension promises more likely to be performed, were also undoubtedly burdensome on employers.[135] Moreover, employers are not required to offer pensions; they are free to offer no retirement benefit at all.[136] The calculus of Congress at the time of ERISA's enactment, however, was that the regulatory burden ERISA created in association with offering a pension was worth it; any potential reduction in how frequently companies would offer pensions was thought to be outweighed by the fact that those pension promises that were offered would be more reliable. While ERISA's drafters were certainly aware that too much of a regulatory burden could reduce the frequency with which pensions were offered, they were confident—in part because of a strong belief in employer commitment and labor power—that the additional regulatory burden ERISA created was unlikely to meaningfully reduce the frequency with which pensions were offered.

In the years subsequent to ERISA's passage, a number of legal changes made it plausible for employers to offer a retirement benefit different than a traditional pension, in particular something called a "defined contribution" retirement benefit, of which the most famous variant is the 401(k).[137] A brief

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134 ERISA PRINCIPLES, *supra* note 21, at 225–312 (discussing in great detail ERISA's wide range of "content controls" for pension plans).

135 *See, e.g.*, Langbein, *supra* note 133, at 44–48 (discussing the most burdensome provisions of ERISA on plan sponsors). Whatever the merit of pension regulation—and it is considerable—there is no question ERISA's pension regulations are very burdensome.

136 *See* Lockheed Corp. v. Spink, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefits plans.").

137 Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451, 471–72 (2004) (explaining how ERISA promoted the growth of the defined contribution plan).

digressive word about ERISA parlance. A traditional pension is what's known as a "defined benefit" plan, which means that the benefit is defined as equaling an *output*—namely the monthly pension payment—that is payable to the employee.[138] In contrast, a "defined contribution" plan is defined as equaling an *input*—namely the amount of money the employer and/or employee contributes to a tax-protected investment account—for the employee's ultimate use in retirement.[139]

Putting aside the question of employer willingness, whether defined benefit or defined contribution accounts are objectively better for employees has been debated ad nauseam for several decades.[140] The balance of scholarly opinion is that defined benefit pensions are better for the vast majority of workers, for a myriad of reasons.[141] The simplest version of the defined benefit case is that individual workers on balance are considerably worse financial stewards and risk managers than firms, and defined benefit plans relieve them of those responsibilities while defined contribution plans impose those responsibilities upon them.[142] The result is that the widespread adoption of defined contribution retirement accounts that occurred in the

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138 29 U.S.C. § 1002(35).

139 29 U.S.C. § 1002(34).

140 *See, e.g.*, Donald C. Snyder, *Defined Benefit or Defined Contribution Plans: Which Way are Private Pensions Headed?*, SOC. SEC. BULL., Sep. 1986, at 14, 14; David Millon, *Worker Ownership Through 401(k) Retirement Plans: Enron's Cautionary Tale*, 76 ST. JOHN'S L. REV. 835, 843–53 (2002) (arguing in favor of employee-controlled retirement plans); Regina T. Jefferson, *Rethinking the Risk of Defined Contribution Plans*, 4 FLA. TAX. REV. 607, 612 (2000) (stating that defined contribution plans are more likely than defined benefit plans to fall short of compensation goals in the event of mismanagement); Colleen E. Medill, *The Individual Responsibility Model of Retirement Plans Today: Conforming ERISA Policy to Reality*, 49 EMORY L.J. 1, 9–10 (2000) (quoting Deborah M. Weiss, *Paternalistic Pension Policy: Psychological Evidence and Economic Theory*, 58 U. CHI. L. REV. 1275, 1276–77 (1991)) (contrasting the "paternalistic" defined benefit plan with the "participant-directed" defined compensation plan).

141 *See, e.g.*, ALICIA H. MUNNELL & ANNIKA SUNDEN, COMING UP SHORT: THE CHALLENGE OF 401(K) PLANS 56 (2004) (noting that around 26% of eligible employees do not participate in defined-contribution plans); Amy B. Monahan, *Addressing the Problem of Impatients, Impulsives and Other Imperfect Actors in 401(k) Plans*, 23 VA. TAX REV. 471, 486 (2004) (noting that the average investment rate in 2001 was half of the "ideal" investment rate); Millon, *supra* note 140, at 841 (discussing the disastrous impact of Enron employees' failure to diversify their investments).

142 *See* Paul M. Secunda & Brendan S. Maher, *Pension De-Risking*, 93 WASH. U. L. REV. 733, 734–40, 751 (2016) (examining how the fall of pensions and rise of retirement accounts has left many workers unprepared for retirement); *see also* Debra A. Davis, *Do-It-Yourself Retirement: Allowing Employees to Direct the Investment of Their Retirement Savings*, 8 U. PA. J. LAB. & EMP. L. 353, 365 (2006) (noting that retirement experts believe most participants to be poorly prepared to make investment decisions).

last forty years has left a generation of Americans far less prepared for retirement than those generations who had access to defined benefit pensions.[143]

Whatever one thinks of the objective merit of the transition from pensions to retirement accounts, however, there is little question that a crucial motivation for the transition was employers seeking regulatory burden reduction.[144] There was and is no question—none at all—that the regulatory burden associated with maintaining a pension promise is *far more* than the regulatory burden associated with maintaining a retirement account promise. When making a pension promise, an employer has to fund the promise, pay a premium to the PBGC, manage the assets prudently, and then actually perform the promise by paying out annuities to beneficiaries.[145] When making a 401(k) promise, the employer's chief obligations are to cut a check to the employee's retirement account, ensure the beneficiaries have a reasonable menu of investment options, and steward the account honestly. Poor performance of the account is not the employer's problem.[146]

Interestingly, the defined benefit to defined contribution transition did not happen overnight. Although the key regulatory predicates for the transition were all in place by the early 1980s, it took many years before the retirement landscape of the United States changed.[147] Part of that, likely, was for a

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143 *See* Samuel Estreicher & Laurence Gold, *The Shift from Defined Benefit Plans to Defined Contribution Plans*, 11 LEWIS & CLARK L. REV. 331, 334–35 (2007) (arguing that "a pension plan design that shifts the decision-making responsibility on plan financial matters" to beneficiaries is severely flawed).

144 *See* Langbein, *supra* note 133, at 44–48 (discussing the burdens ERISA imposed on defined benefit plans).

145 *See* ERISA PRINCIPLES, *supra* note 21, at 225–312 (detailing pension obligations).

146 *See* Susan J. Stabile, *Is it Time to Admit the Failure of an Employer-Based Pension System?*, 11 LEWIS & CLARK L. REV. 305, 312 (2007); *see also* Angela Boothe Noel, *The Future of Cash Balance Plans: Inherently Illegal or a Viable Pension Option?*, 56 ALA. L. REV. 899, 901 (citing Susan J. Stabile, *Paternalism Isn't Always a Dirty Word: Can the Law Better Protect Defined Contribution Plan Participants?*, 5 EMPLOYEE RTS. & EMP. POL'Y J. 491 (2001)) (comparing how poor investments impact defined benefit plans and defined compensation plans).

147 *See* Stabile, *supra* note 146, at 307–08; *see also* EMP. BENEFIT RSCH. INST., EBRI DATABOOK ON EMPLOYEE BENEFITS 4 (2011), https://users.cla.umn.edu/~erm/data/sr472/Data/MicroData/EBRI/DataBook/DB.Chapter%2001.pdf [https://perma.cc/JVP2-ED6E] (private worker participation in DB plans was 62% in 1975 and 7% in 2009); U.S. DEP'T OF LAB., EMP. BENEFITS SEC. ADMIN., PRIVATE PENSION PLAN BULLETIN HISTORICAL TABLES AND GRAPHS 1975–2022, at 14 graph E10g (2024), https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/pension-plan-historical-tables.pdf [https://perma.cc/6342-QUZ5] (showing total pension plan assets by the type of plan for 1975–2022).

reason analogous to the theory offered in Thomas Kuhn's *The Structure of Scientific Revolutions*. Even in the hard sciences, personal and cultural commitments to older ways of seeing the world tend to last despite contrary evidence. The reason that Copernican astronomy replaced Ptolemaic astronomy was not chiefly because of the force of evidence in Copernicus' favor; it was because the Ptolemaic adherents died out.[148] Something similar happened in the pension space. For decades, benefit professionals at large companies believed pensions were "good business" for both the firm and its workers.[149] Those professionals were skeptical of 401(k) accounts and their ilk.[150] But eventually those professionals retired or departed and were replaced by executives who lacked a similar commitment to pensions, and thought more coldly about what was best for the company's bottom line.[151] While decision makers were not indifferent to labor's preferences, ultimately the transition happened, albeit slowly.

A similar dynamic is present with respect to employment-based group insurance versus individual insurance. There is an employer and employee attachment to employment-based insurance that is partly cultural—for decades the sign of a good job has been one that offers quality health insurance. But as the regulatory realities make it such that an

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148 *See* THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS 155–58 (4th ed., 2012) (describing the adoption of new scientific theories as a process of converting scientists until the supporters of the new theory outnumber the supporters of the old); *cf.* Richard A. Posner, *The State of Legal Scholarship Today: A Comment on Schlag*, 97 GEO. L.J. 845, 847, 851 (2009) (explaining the ebbs and flows of legal theory in Kuhnian terms).

149 *Cf.* Ronald E. Roel, *Challenge: Training Workers to Stay on the Job*, NEWSDAY, Jan. 23, 1989, at 8, https://plus.lexis.com/api/permalink/5e1696e1-58e1-4f55-84fe-649a79004d26/?context=1530671 [https://perma.cc/Y26C-LFKK] ("Most major companies already use traditional benefits - pensions and medical insurance plans - to keep employees . . . .").

150 *See* Albert B. Crenshaw, *Limping Toward Retirement on Three Very Shaky Legs*, WASH. POST, July 30, 1995, https://www.washingtonpost.com/archive/business/1995/07/30/limping-toward-retirement-on-three-very-shaky-legs/4719964d-c2a9-4248-9924-2c9ac27145a4/[https://perma.cc/V2GV-HU6Z] (reporting that "the nation's private pension system" has been undergoing "worrisome changes").

151 *Cf.* Atul Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* 4 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2021) (showing private equity firms takeover of nursing homes worsened health outcomes); Elizabeth Lewis, *A Bad Man's Guide to Private Equity and Pensions* 4 (Harvard Univ. Edmond & Lilly Safra Ctr. for Ethics, Working Paper No. 68, 2015), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2620320 [https://perma.cc/6PQL-PL2Z] (discussing how private equity uses the bankruptcy process to shed pensions).

employer can avoid most of the regulatory burden associated with health insurance and merely fund an employee's ability to obtain reasonable insurance on exchanges or elsewhere, strong adherence to that employment norm will fade, and increasingly large numbers of firms will send their employees to the individual market.

IV
The Pro-Transition Case

Predictive analysis is one thing. Normative analysis is another. Assuming the correctness of this Article's prediction of insurance regime change—namely that a great many of those today holding ERISA Insurance will find themselves, sooner or later, in the individual insurance market—is that good or bad, on balance?

The true answer is one that has made clients frustrated with their lawyers since the days of Hammurabi:[152] "it depends." Part of that uncertainty is because different observers will have different first principles, rank values differently, and credit some pieces of empirical evidence more highly than others. That said, in this Part IV I will argue that, *unlike* the pension to retirement account transition, a widespread movement away from ERISA Insurance to (a particular type of) individual insurance is reasonably likely to be a *positive* societal development—if it occurs within a sensible regulatory framework. That, admittedly, is a very big if. But the world is as it is.

A. A Simplifying Assumption

Importantly, the ICHRA in its current formulation does *not* require that ICHRA money be spent on policies offered on exchanges; certain off-exchange policies also qualify.[153] The case

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152 *Cf.* Frank L. Fetzer, *The Code of Hammurabi—The Oldest Known Legal Code*, 35 Com. L.J. 726, 726 (1930) (describing Hammurabi as the source of the oldest known legal code).

153 *See* Cong. Rsch. Serv., R47041, *supra* note 104, at 24 n.81. In addition, in spite of my promise to avoid technical particulars, *see supra* note 7, I cannot resist mentioning one additional regulatory impediment to exchange insurance growth that is both technical and pre-dates ICHRAs. Employees who wish to purchase exchange coverage using pre-tax salary reductions through a cafeteria plan cannot do so, because pre-tax "cafeteria plan" dollars may only be used for premiums on non-exchange individual insurance (or group coverage). I.R.C. § 125(f)(3); *see also* I.R.S. Notice 2013-54, 2013-40 I.R.B. 287 (confirming that employer arrangements designed to fund exchange coverage through pre-tax cafeteria plan contributions are impermissible). This restriction, which predates the Trump administration, could needlessly but modestly disadvantage ICHRA-fueled *exchange*

below depends in part on employees being transitioned away from ERISA Insurance into a regime that enjoys the entirety of the ACA's regulatory protections (both in terms of substantive regulation and the cognitive streamlining associated with making a purchase on an exchange).[154] Accordingly, for the sake of analytical convenience, I shall imagine a slightly modified version of the ICHRA: one that *only* permits its monies to be used for the purchase of on-exchange individual policies ("Exchange Insurance") and otherwise lacks features likely to keep people away from the exchanges. The current version of the ICHRA does *not* satisfy those conditions.[155]

Why assume a version of the ICHRA that does not exist? The answer is that thinking about the pending insurance transition in a binary way—namely, that people will either have ERISA Insurance or use ICHRAs to obtain Exchange Insurance—both clarifies the contrasting regimes and reflects an argumentative hierarchy of merit. Put slightly differently, in my view the strongest case that transitioning away from ERISA Insurance is welfare-enhancing is when the replacement is Exchange Insurance. Features of an ICHRA that would increase the likelihood of a significant percentage of the population moving from ERISA Insurance to off-exchange individual insurance (or no insurance at all) would weaken (although not fatally) the overall argument that a transition away from ERISA Insurance is a good thing. Thus, if observers cannot be persuaded that Exchange Insurance "wins" against ERISA Insurance, there is little point in arguing that something *worse* than Exchange Insurance would fare better. Conversely, if a fair-minded observer can be convinced that Exchange Insurance is

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enrollment, because employees who want to buy more expensive insurance policies than their ICHRA monies cover could only use tax-protected cafeteria plan monies to buy *off*-exchange individual insurance. It makes little sense to in any way privilege off-exchange purchases over exchange-purchases. A future Congress interested in promoting exchange viability and the ICHRA transition described in this Article should accordingly revisit I.R.C. § 125(f)(3).

154 The degree to which the ACA's full suite of regulatory protections flow to off-exchange policies varies depending on a number of circumstances. That is another reason why assuming the relevant comparator is Exchange Insurance is analytically simpler.

155 *See* CONG. RSCH. SERV., R47041, *supra* note 104, at 24 n.81. The current version of the ICHRA has several features I believe are suboptimal, some but not all of which I allude to, where appropriate, in this Article. *See supra* note 106 (explaining why a more technical and granular analysis of the current version of the ICHRA is better suited to a separate work). But I do not believe the ICHRA's current imperfections should prevent thinking, in broad strokes, about the general case of ERISA Insurance versus Exchange Insurance.

preferable to ERISA Insurance, *then* we can have a sensible debate about whether individual insurance is less desirable than Exchange Insurance might nonetheless still be preferable to ERISA Insurance.

So, if we assume that a significant percentage of roughly 170 million or so people currently enjoying ERISA Insurance will end up with (ICHRA-funded) Exchange Insurance, is that something to welcome or fear?

B. Thinking About Federalism and Fit

One positive consequence of transitioning away from a world dominated by ERISA Insurance to one dominated by Exchange Insurance is that it will help restore ERISA to something resembling its original intended form: a retirement statute with a modest practical role in regulating health benefits. From there, various positive results will flow.

ERISA's full name is the Employee Retirement Income Security Act of 1974, and its animating purpose, unsurprisingly, was to regulate retirement benefits. While it unquestionably was the 93rd Congress's intention that ERISA also regulate other benefits offered to workers—including health benefits—Congress did not have the faintest clue that employment-based health insurance would become so *practically* dominant (and thus render ERISA's regulation of it so immensely important).[156] Congress therefore did not originally write ERISA in a fashion anywhere close to what one would expect of a statute that soon became by far the most important statute in the United States with respect to the regulation of private health insurance.[157]

Because of the hot-button, controversy-attracting nature of health reform, subsequent efforts to directly regulate health insurance at the federal level failed, year after year, decade after decade. That parade of failures had the second-order effect of giving a woefully underwritten statute—in health insurance terms—an almost thirty-five-year life as the most fearsome null-set regulator in modern American history.[158] Until 2010,

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156 *See* Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century*, *in* EMPLOYEE BENEFITS LAW 1, 3 (Steven J. Sacher et al. eds., 2d ed. 2000) (explaining how Congress did not appreciate the health regulatory aspect of ERISA in 1974). Michael Gordon was a benefits lawyer and key legislative aide to Senator Jacob Javits, one of ERISA's principal sponsors.

157 *See supra* Part I.A.

158 *See supra* Part I.A; *cf.* Brown & McCuskey, *supra* note 9, at 393 (illustrating the consequences of ERISA's broad preemption power in the state single-payer context).

ERISA contained virtually no substantive regulation regarding the content of health insurance *at all*. And yet its voracious preemptive reach almost entirely blocked states from stepping into the breach.

It was only after more than three decades that the Affordable Care Act finally and directly regulated health insurance at the federal level—and in a way that was far more solicitous, both explicitly and implicitly, of state regulatory preference.[159] Yet by that time, ERISA—and the employment-based group insurance it, and it alone, governed—was so firmly established in the American legal and business firmament that the ACA's drafters took pains to limit the effect it could have to disrupt ERISA's dominance.[160]

In political terms, that decision was understandable.[161] Health care reform was and is so politically fraught and precarious that taking a broadside to something so firmly established as ERISA Insurance would have been to invite epic political failure.[162] Instead, the ACA merely laid the groundwork for an eventual move away from ERISA, but no more.

ICHRA is the more. A sensibly designed ICHRA is the way in which ERISA can be cut down to size—and not by legislative fiat, but by empowering employers to deliver to employees forfeitable, pre-tax dollars that must be spent on an exchange where (1) the insurance purchase process is intelligible and (2) the policies sold benefit from a federal ACA regulatory floor and complementary state law, all while (3) offloading ERISA liability employers have bitterly assailed for years.

Put somewhat differently, ICHRAs will allow health insurance promises (and the parties thereto) to live in a regulatory world—namely the ACA plus state law—that was and is

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159 To name two examples: (1) the ACA's preemption provision is drafted as a floor, such that it only preempts state law that "prevent[s] the application" of the ACA, 42 U.S.C. § 18041(d), and (2) the manner by which the essential health benefits are defined is a collaborative process between HHS and the individual states. *See, e.g.*, Alan Weil, *The Value of Federalism in Defining Essential Health Benefits*, 366 NEJM 679, 679–81 (2012) (describing collaborative federalism in reaching EHB definitions).

160 *See supra* Part II.B.

161 *See* Chad Terhune & Laura Meckler, *A Turning Point for Health Care*, WALL ST. J., Sep. 27, 2007, at Al (reporting Sen. Hillary Rodham Clinton's view that "people aren't ready to cross employers out of the equation"); *see also* Maher, *Regulating*, *supra* note 46, at 1317 (explaining that political calculations favored the continued existence of employer-based health insurance).

162 *Cf.* Ross Douthat, Opinion, *A Hidden Consensus on Health Care*, N.Y. TIMES, July 7, 2013, at SR12 (suggesting that political realities protect employment-based insurance).

specifically designed *for health insurance*. That reality is a key reason why transitioning away from ERISA to Exchange Insurance is attractive: because the regulatory regime will match the regulated subject. There are, of course, more specific reasons why Exchange Insurance is preferable to ERISA Insurance, and I discuss those below. But regulatory fit is the best place to start.

C. Thinking About Exchanges

A key advantage of the ICHRA is the effect it will have on the exchanges (it will make them more populous)[163] and the corresponding effect that population growth will have on insurance product quality and regulatory quality (it will improve both of them). The short version of the argument is that the exchanges are socially valuable, and the social value they generate increases the more people (and the more healthy people) use them.

Insurance Positives. Insurance is a business, not a charity. All else being equal, insuring more people and more healthy people is a more stable and more attractive business than insuring fewer and sicker people.[164] Community-rated policies that serve a sicker pool than the community will always be a losing deal for insurers, and their long-term viability will ultimately depend upon government support. In contrast, community-rated policies that serve a pool as healthy as (or healthier than) the community pool are long-term sustainable and, as the pool size increases, increasingly economically attractive to serve.

Consider the following thought experiment. Assume every employer in the United States collectively decided, tomorrow, that they would replace their ERISA Insurance with a well-funded ICHRA. That would mean roughly 175 million[165] people (less some small percentage who would fail to buy insurance and forfeit their ICHRA entitlement) would immediately populate the exchanges. Moreover, that new population would be

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163 Exchange enrollment in 2025 was roughly twenty-four million people. *Nearly 24 Million Consumers Have Selected Affordable Health Coverage in ACA Marketplace, with Time Left to Enroll*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 8, 2025), https://www.cms.gov/newsroom/press-releases/nearly-24-million-consumers-have-selected-affordable-health-coverage-aca-marketplace-time-left [https://perma.cc/FCU4-JTMX].

164 *See* Michael F. Cannon, *Health Insurance Regulation*, *in* CATO HANDBOOK FOR POLICYMAKERS 1, 2 (2022) (describing community rating).

165 KEISLER-STARKEY & BUNCH, *supra* note 1, at 2.

healthier and wealthier than the current exchange population, because working people with employment-based insurance are healthier and wealthier on average than people who obtain insurance through the exchanges.[166]

Being able to sell insurance to a larger, healthier, and wealthier pool would incent more insurers to participate and to offer (within the bounds of what the ACA permits) more varied and better insurance products, i.e., more insurance policies that exceed the ACA's minimum requirements, in any number of ways. Currently, for example, platinum policies—which offer the highest cost-coverage level for ACA policies—are only sold on a minority of exchanges, because there is so little demand for them; that would obviously change if 175 million additional (employed) people were on the exchanges.[167] Other common complaints about the quality of exchange coverage—such as offering narrow physician networks—are also likely to recede if not disappear were the exchanges to serve a vastly larger pool.[168] A pool of that size and quality would also promote more insurer innovation than would serving the current, vastly less economically attractive pool.

The thought experiment is useful not because employers will unanimously adopt ICHRAs overnight; they won't. The point is that increasing the size, health, and wealth of the population the exchanges serve will exert salutary pressure. Put differently, rising ICHRA adoptions will drive the exchanges to

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166 *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-106798, PRIVATE HEALTH PLANS: COMPARISON OF EMPLOYER-SPONSORED PLANS TO HEALTHCARE.GOV MARKETPLACE PLANS 19 (2024) (observing that "nongroup plan enrollees are generally sicker than large group plan enrollees"); NANETTE GOODMAN, LEAD CTR., THE IMPACT OF EMPLOYMENT ON THE HEALTH STATUS AND HEALTH CARE COSTS OF WORKING-AGE PEOPLE WITH DISABILITIES 2 (2015) (noting that a "large body of research has established that employed individuals are healthier than those who are not employed"); *cf.* Amy. B. Monahan, *The Regulatory Failure to Define Essential Health Benefits*, 44 AM. J.L. & MED. 529, 535 (2018) (explaining how the design of the ACA will attract less healthy individuals to exchange plans).

167 As of 2025, seventeen states offer a platinum plan with 118,099 individuals enrolled. *Marketplace Plan Selections by Metal Level*, KFF, https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-metal-level-2 [https://perma.cc/GTZ3-5WYJ] (last visited Feb. 7, 2026).

168 Recent federal regulation addressed the issue, providing new minimum network adequacy requirements for policies offered on the exchanges. *See* Rebecca Pifer Parduhn, *CMS Finalizes ACA Network Adequacy Rule*, HEALTHCARE DIVE (Apr. 3, 2024), https://www.healthcaredive.com/news/cms-final-aca-network-adequacyrule/712126/ [https://perma.cc/KQ33-VMEQ]. That is an example of a generally sensible approach for those troubled by insurance product shortcomings associated with the current exchanges: regulation can shore up the exchange offerings during the growth period. As the exchanges swell in size, some of that initial regulation may not be necessary.

overall work better—by attracting more participating insurers, by offering policies with larger networks or other features, by encouraging insurers to think about ways in which they can develop attractive new products for the important exchange market, and so on.[169]

Admittedly, natural market pressure may be too slow to improve the exchange offerings quickly enough to satisfy the preferences of the earliest waves of workers, who might be comparatively unhappy with what they can obtain on the exchanges versus their old ERISA Insurance coverage. A few responses.[170]

First, there are *other* reasons that society may prefer Exchange Insurance, which, taken together, could outweigh the loss of utility associated with early transitioners holding an Exchange Insurance policy that is less attractive in some way than their old ERISA Insurance. For example, as explained below, transitioned employees benefit because the remedies associated with policing Exchange Insurance will be better, and likely far better, than ERISA Insurance; the expected value of a policy, after all, includes the odds that the policy as written will be *performed*. Employers, in turn, benefit because they will be freed from the burden of being involved in insurance. The point is that policymakers considering the overall appeal of a transition to Exchange Insurance should consider all the benefits associated with that transition, not solely whether in every instance the new Exchange Insurance policy every transitioner receives will be as good as their past coverage.

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169 Those not hostile to the idea of well-functioning exchanges might worry that the ICHRA—a regulatory vehicle greenlit by the first Trump Administration—might be some sort of Trojan horse designed to undermine either the exchanges or health insurance generally. It is certainly possible to imagine an ICHRA with features that would do that (and some of the features of the current version of the ICHRA are indeed undesirable). That said, a good-faith version of the ICHRA—such as the one that I imagine here—should not be written off merely because it was a product of an administration many fair-minded observers otherwise oppose. *Cf. Heartbreaking: The Worst Person You Know Just Made a Great Point*, ClickHole (Feb. 5, 2018), https://clickhole.com/heartbreaking-the-worst-person-you-know-just-made-a-gr-1825121606/ [https://perma.cc/XCE4-3ZPM].

170 Of course, it may well be that some transitioned employees *prefer* what they can obtain on the exchanges compared to their old ERISA Insurance; their increased utility would need to be factored into the overall calculus. But even assuming arguendo that more people overall would be comparatively dissatisfied, that dissatisfaction is bounded. Because of the ACA's regulatory floor, it is hard to broadly credit the worry that the policies on the exchange will be acutely worse than the ERISA Insurance that transitioned employees formerly enjoyed. Plus, labor market dynamics suggest that early transitioners to the exchanges will be people who did not enjoy the most generous ERISA Insurance to start with.

Second, it may well be that some disappointment with exchange offerings is perceptual rather than actual, i.e., some features of policies commonly thought to be "better" do not actually deliver better health care outcomes or otherwise result in better objective results.[171] While psychological dissatisfaction with health insurance is certainly not irrelevant, it is less concerning than more concrete shortcomings.[172]

Third, targeted regulation shoring up certain perceived or actual shortcomings of Exchange Insurance policies—such as recent regulation intended to address the perception that some exchange policies offered unduly narrow provider networks—would be one plausible way to address transition growing pains.[173] Indeed, the subject of regulation is one I turn to next.

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171 Whether or not broader networks result in the delivery of superior care, for example, is an unsettled empirical question. *See, e.g.*, Olena Mazurenko, Heather L. Taylor & Nir Menachemi, *The Impact of Narrow and Tiered Networks on Costs, Access, Quality, and Patient Steering: A Systematic Review*, 79 MED. CARE RSCH. & REV. 607, 616 (2022) (finding, after a meta-study, that narrow networks and tiered networks do not appear to lead to worse care).

172 Another way to make this same point is to address a common misperception about the exchanges, which is that exchange policies are inherently "worse" than employment-based policies. To the extent that exchange policies are today less generous in terms of their cost coverage (with the average policy on the exchange being silver, *see* EDITH CHAN ET AL., THE INDIVIDUAL HEALTH INSURANCE MARKET IN 2023 9 (MCKINSEY & CO., 2023), https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/the%20individual%20health%20insurance%20market%20in%202023/the-individual-health-insurance-market-in-2023-f.pdf [https://perma.cc/B4AW-JLVB]) than are employment-based policies (which are on average more generous than that), that is not because of some inherent defect of the exchanges. It's because the population paying for employment-based policies (with their collective foregone wages) are more numerous, healthier, wealthier, and completely tax-advantaged, as compared to their current exchange counterparts, who are fewer, poorer, sicker, and only partially subsidized. Cost-sharing reimbursements (which are distinct from the premium subsidy) are also only available for silver plans. *See* D. KEITH BRANHAM ET AL., DEP'T HEALTH & HUM. SERVS. OFF. HEALTH POL'Y, HEALTH INSURANCE DEDUCTIBLES AMONG HEALTHCARE.GOV ENROLLEES, 2017–2021, at 7 (2022), https://aspe.hhs.gov/sites/default/files/documents/748153d 5bd3291edef1fb5c6aa1edc3a/aspe-marketplace-deductibles.pdf [https://perma.cc/5YQD-TA4S]. Accordingly, one would expect the current exchange offerings to be less generous than current employment-based offerings. That will change as the populations change.

173 Another targeted form of regulation could be to require (to satisfy the mandate) the ICHRA to be funded at a higher level than one tied to silver. That would make it more likely that transitioned employees would be able to find a similar level of insurance on the exchanges. While the current ICHRA rules permit ICHRAs to be funded above the minimum level, they do not require it. As a matter of practical fact, many employers funding ICHRAs will fund above the minimum, even absent regulation, because they are replacing an expensive plan, and a failure to fund a comparable ICHRA will invite employee complaints. Plus, of course, the employer is saving resources by eliminating its obligation to comply with the meaningful burdens associated with traditional ERISA insurance.

Regulation Positives. An influx of healthier, wealthier, and more people onto the exchanges will have another effect: it will make regulation of Exchange Insurance—whether via federal or state action—a subject more likely, in realpolitik terms, to get sustained attention. Larger, richer, healthier populations are simply more likely to attract and demand the attention and solicitude of regulators than a smaller group of more marginalized people. Hope as we might that we live in a world of enlightened regulators who attempt to maximize the welfare of whomever the affected population is, it is clearer than ever that that is most certainly not the case. Squeaky wheels get grease, but squeaky big wheels get even more.

ICHRAs also have a particular feature that is very valuable for those interested in promoting insurance purchase and ensuring the vitality of the exchanges. ICHRA monies are forfeitable unless used on health insurance; the money earmarked for reimbursement simply returns to the company—it does not go to the employee.[174] Thus, an employee with an ICHRA benefit faces a "soft" mandate to spend it on the exchanges or lose it.[175] The furious ACA litigation of the 2010s indicates that the mechanism by which people are incented to seek insurance matters very much, in political terms.[176] Hard mandates generate far more backlash than anything else. Less intrusive means to ensure the exchanges are sufficiently populated with healthy people to sustain their vitality should be employed where possible.

D. Thinking About Employees

A key virtue of ERISA Insurance is the significant administrative work the employer does in selecting quality insurance and in streamlining the insurance decision.[177] In some cases the employer makes one option available to the employees, and the employee either accepts or declines it. In others, the employer presents several options for the employee to choose, and the employee makes a constrained choice. That is *vastly* easier

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174 26 C.F.R. § 54.9802-4(c)(1)(ii) (2025) (forfeiture).

175 *Cf.* Liz Hamel, *The Public's Views on Vaccines, Mandates, and More*, KFF (Nov. 18, 2024), https://www.kff.org/quick-take/the-publics-views-on-vaccines-mandates-and-more/ [https://perma.cc/8CMP-U3TS] (reflecting on the negative effects of COVID vaccination mandates and future alternatives).

176 *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 538 (2012). *See also* JOSH BLACKMAN, UNPRECEDENTED 33 (2013) (assailing the individual mandate as a stark assault on liberty).

177 *See, e.g.*, Hyman & Hall, *supra* note 52, at 31.

than the non-employment-based alternative in the pre-ACA world. Purchasing individual insurance was time-consuming, confusing, and came with a significant risk of selecting a poor-quality policy.

When the alternative is purchasing Exchange Insurance, however, the choice architecture and quality floor the exchanges provide largely replace the paternalistic protection that formerly came from the employer. Choosing insurance is relatively easy, and there is little risk (because of the ACA's protective regulation) of picking a wildly unsuitable policy.

It is true that the exchanges—not now, and perhaps not ever—may not offer policies that are as good as the *very* best ERISA Insurance. It is not unreasonable to assume that there exist and will always exist some wealthy and sophisticated employers—such as Google, for example—that can think of some way in which the health insurance arrangement they offer is better for their employees than policies on the exchange—and not because the policies on the exchange are not of high quality, but because of the quality *and* bespoke nature of the elite employer offering.[178] But it is important this possibility appropriately be oriented among several practical realities.

First, the possibility of exceptional employer performance must be weighed against the converse—the possibility of poor employer performance, namely the chance that an employer offers ERISA Insurance that, whether in cost or care delivery terms, does *worse* than what an individual might acquire on the exchange with a suitably generous ICHRA fund. As Professors Monahan and Richman have recently pointed out, there is good reason to believe that *some* employers are doing a fairly *poor* job with respect to the ERISA Insurance they are offering.[179] Employees of those firms might welcome the opportunity to be let loose on the exchanges with ICHRA monies—and employers might be happy to oblige.

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178 *See* Maher, *supra* note 119, at 1084 (describing why and how employers might develop and offer elite insurance policies).

179 Monahan & Richman, *supra* note 120, at 28–29. Other researchers have indicted commercial group policies (which are often sold to employers) for overpaying for service relative to Exchange plans. *See Affordable Care Act Exchange Plans Negotiate Lower Hospital Prices Than Commercial Plans, According to New Schaeffer Center Analysis*, USC SCHAEFFER CTR. (Sep. 15, 2022), https://healthpolicy.usc.edu/article/affordable-care-act-exchange-plans-negotiate-lower-hospital-prices-than-commercial-plans-according-to-new-schaeffer-center-analysis/ [https://perma.cc/AF8P-GNKU] (comparing commercial and ACA plans negotiated pricing with hospitals).

Second, given the quality floor of Exchange Policies generally and the funding floor of ICHRA needed to satisfy the mandate, the existence of the ICHRA options sets up an interesting negotiation dynamic between employers and employees. As noted above, employers incapable of delivering additional insurance value beyond what Exchange Insurance offers can fund generous ICHRAs and be done with it—and employees should be happy with that. With respect to employers capable of delivering some special quantum of insurance value that is not available on exchanges, in that instance employees can collectively negotiate (whether formally through a union or informally through a leadership group of employees the employer consults with when making annual benefit decisions) to encourage the employer to pursue that course. This choice—between high-quality Exchange Insurance or elite-level ERISA Insurance—seems like the sort of thing that *should* be handled through market and labor dynamics (because neither option results in a socially worrisome outcome). It is not a reason to dislike Exchange Insurance per se.

Third, some employees may value the additional choices available on the Exchanges—not because the ERISA Insurance options they would have had are undesirable generally, but because some employees may find that among the broad range of Exchange Insurance policies offered, some match better with their personal preferences.

Fourth, while the degree to and frequency with which employers will be able to, through ERISA Insurance, deliver additional core insurance value is fairly debatable, the difference in the remedial regimes between ERISA Insurance and Exchange Insurance is not. The remedial options for those holding Exchange Insurance are *far* better than for those holding ERISA Insurance.[180] While the first order concerns of most insureds are the core terms of coverage, a close second is the degree to which the insured has the power to remediate coverage denials. It is difficult to think of a worse set of remedial options than what ERISA provides; any Exchange Insurance in any state would give one access to a stronger remedial scheme.

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180 *See supra* Part I and notes 23, 30, 36 (various scholars decrying the baffllingly weak remedial scheme ERISA imposes upon beneficiaries it was supposed to protect); *cf.* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1316 (2007) (criticizing the weakness of ERISA's remedial regime with respect to its inability to combat gross payer misconduct).

One last concern might be that, in the transition from ERISA Insurance to Exchange Insurance, employees will be short-changed with respect to ICHRA funding. In other words, a scenario where under the originally offered ERISA Insurance, the employee was functionally receiving health insurance that would have cost X dollars, while under the ICHRA, the employee will receive ICHRA monies only worth a reduced percentage of X. This is a different concern than one that exchange policies are substantively worse; it's a concern that in the transition from ERISA Insurance to Exchange Insurance, employees will be chiseled by the employer.

There are several responses to this concern. First, employers who wish to chisel—i.e., to reduce health insurance coverage—can do that *now*. Small employers aren't bound by a mandate, and large employers have considerable freedom to configure their plans in a way that satisfies the mandate but is less generous than previous plans.[181] Second, such chiseling is functionally equivalent to a wage cut, and it won't be difficult for employees to notice if an ICHRA that provides a concrete amount of money is less than they were functionally getting under the old ERISA plan and assert market pressure accordingly.[182] In many instances, in other words, chiseling using an ICHRA is going to be more fraught for the employer than chiseling through tinkering with the group plan. Third, regulatory tweaks to the ICHRA can protect against chiseling possibilities—from simply requiring a higher funding floor to more intricate adjustments that seek to tie initial ICHRA requirements to the functional value of what employees were receiving under the old ERISA plan.[183] Because the benefit to employers of

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181 Large employers, for example, do not have to offer essential health benefits. 42 U.S.C. § 300gg-6 (essential health benefits requirement applies only to individual and small group policies). While subsequent regulation has constrained the ability of employers to massively abuse this discretion by offering skinny plans, *see* 45 C.F.R. 156.145(a) (2025), they still possess significant freedom to configure their offerings in ways that can easily deliver less value.

182 *See* 26 U.S.C. § 6051(a) (requiring the employer contribution for, *inter alia*, a group plan to be listed on the W-2). In any event, an ICHRA transition is highly salient and will result in some portion of employees immediately calculating whether they are worse off.

183 Another indirect way to protect against this possibility would be to require that an ICHRA must apply to all employees, not just certain "classes" of employees, as the current rule permits. 26 C.F.R. § 54.9802-4(d) (2025). Savvy regulators long ago learned that one approach to generally prevent employer abuse in a benefit setting is to require that all employees have the same plan; in those circumstances the executive decision-makers (as employees themselves) are unlikely to adopt a plan that makes themselves worse off, and less influential employees benefit concomitantly. Allowing for (some) classes, as the current rule

offloading the burdens of ERISA Insurance is so significant, regulators will have considerable regulatory freedom with regard to ICHRAs.

E. Thinking About Employers

A concisely stated advantage of transitioning away from ERISA Insurance is precisely why it's going to happen: because it makes employers' lives *much* easier.

Offering ERISA Insurance is far more costly than simply the financial expenditure associated with funding the insurance promise: it involves meaningful organizational and administrative burdens, as well as highly acute regulatory and performance liability. The burdens and liabilities that employers bear as plan sponsors in connection with offering ERISA retirement and health plans are so significant that the Supreme Court has repeatedly noted, when handling ERISA disputes, that there is a large risk that interpreting ERISA too much in favor of beneficiaries—whom ERISA was quite literally written to protect—would lead employers to stop offering benefits altogether.[184] Health insurance promises can be particularly burdensome because they are highly volatile, in that even impartial arbiters will often disagree about whether a given policy governs a sought treatment. The result is incredibly frequent and costly litigation contesting the judgment of ERISA fiduciaries who have denied claims. Every employer in the country would welcome no longer facing that particular bundle of burden and liability.

Freeing employers from ERISA's panoply of burdens—other than writing a check and administering a reimbursement account, which is all ICHRAs require—permits firms to focus on their comparative advantage, which is pursuing their core businesses, not administering health insurance promises. Under basic principles of allocative efficiency (and common sense), that is a welfare-enhancing change. And note also that because ICHRAs are optional, any employer who concludes that offering

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does, leaves opportunity for employers to behave strategically in ways that are unlikely to redound to the benefit of the weakest employees. *See also supra* notes 106, 155 (identifying other suboptimal features of the current ICHRA but reserving extended discussion of them for a separate work in progress).

184 *E.g.*, Heimeshoff v. Hartford Life & Accident Ins. Co., 571 U.S. 99, 108 (2013); Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan, 555 U.S. 285, 302–03 (2009); Conkright v. Frommert, 559 U.S. 506, 517 (2010) (each affirming that one of ERISA's core concerns is to provide a predictable regulatory framework to promote employee benefit plans).

some version of ERISA Insurance is desirable for competitive or recruiting reasons still has the opportunity to do so.

F. Thinking About Experimentation

In Part IV.B, I noted generally how Exchange Insurance's regulatory scheme is a better fit for regulating health insurance and is more solicitous of state involvement. That is true generally, but one particular aspect deserves some brief further elaboration.

One oft-asserted virtue of federalism is experimentation.[185] Consistent with that, the ACA specifically authorizes its implementing federal agencies to grant innovation waivers to states who seek to pursue "innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA,"[186] even if such strategies facially conflict with certain ACA provisions. Such regulatory flexibility is attractive, as it could lead to superior outcomes that could be the model for other states, or for future federal regulation. It also might merely permit local variance that is more faithful to state-specific preferences while not otherwise undermining federal aims.

State innovation ability with respect to ERISA Insurance is far less. ERISA itself contains no waivers. The ACA's waiver provision cannot be used to directly waive traditional ERISA provisions[187] and faces political economy constraints with respect to its power to waive provisions of federal law that would affect ERISA plans. A powerful trade group for ERISA plans, for example, has repeatedly taken the position that ACA innovation waivers that are facially permissible must not be permitted when they would interfere with the operation of ERISA plans.[188]

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185 *See, e.g.*, Heather K. Gerken, *Federalism All the Way Down*, 124 HARV. L. REV. 4, 22 (2010).

186 *Section 1332: State Innovation Waivers*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last visited Feb. 22, 2025), https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers [https://perma.cc/5N67-RD5K] (quoting CMS' description of the ACA 1332 waiver).

187 As the implementing agencies put it: "The Departments' State Innovation Waiver authority . . . does not grant the Departments the authority to waive any provision of ERISA." State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, 53577 n.12 (Oct. 24, 2018).

188 *See, e.g.*, Letter from the ERISA Indus. Comm. to Ctrs. for Medicare & Medicaid Servs. (Sep. 22, 2017), https://www.eric.org/uploads/doc/resources/09-23-17%20OK%201332%20Waiver%20Application%20CMS%20Comment%20Letter%20Final.pdf [https://perma.cc/VA6F-PN9F] (arguing Oklahoma's proposed Section 1332 waiver is preempted by ERISA); *ERIC Submits*

Whatever the boundaries of the ACA's waiver innovation power, Exchange Insurance falls within its heartland. To the extent one prefers a world where state regulators have additional influence, a mass transition to Exchange Insurance increases that likelihood.

Conclusion

Pensions were the dominant form of retirement benefit in the United States for over a century. Yet, as has been widely chronicled, pensions were slowly replaced by retirement accounts. A key reason was burden reduction: employers that offered retirement accounts rather than pensions reduced their regulatory and liability burdens significantly.

This Article argues that something similar is going to happen—indeed, is already happening—in the health insurance context. More specifically, ERISA-governed group insurance policies have been the overwhelmingly dominant form of private health insurance in the United States for at least fifty years. But that is going to change. Recent changes in the law allow employers to send employees to government exchanges with pre-tax ICHRA dollars, all while freeing themselves from the staggering burdens and liabilities associated with providing ERISA-governed insurance. All employers have to do, instead, is write ICHRA checks (mostly). Put more starkly: employers who *do* less will be regulated less and sued less. So they increasingly will.

The good news is that this might be good. Unlike the transition from pensions to retirement accounts (which made society worse off), the transition from ERISA-governed group insurance to individual insurance purchased on the exchange might be socially beneficial. A key reason is that the protections associated with individual Exchange Insurance are better than ERISA Insurance, and sending more people to the exchanges will offer a wide variety of potential benefits to employers, employees, regulators, and states alike.

It is true that the strongest case in favor of a transition to individual insurance assumes a sensible regulatory posture with respect to ICHRAs and the exchanges, and, candidly, with respect to thoughtful regulation generally. Sadly, that

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Comments to CMS on 1332 Waivers, ERIC (Dec. 17, 2018), https://www.eric.org/eric-submits-comments-to-cms-on-1332-waivers/ [https://perma.cc/ZSF2-ULB5] (urging that states applying for a Section 1332 waiver should comply with ERISA).

assumption is in doubt given the unprecedented actions of the second Trump Administration. But Trumpian turmoil *cannot* be good reason to not think carefully about what the world might look like once stability returns. Quite the opposite. The scholarly enterprise requires clear thinking even among chaos, because a failure to do so only aids those who seek to profit from distraction and tumult. Ignoring ICHRAs won't prevent the transition from happening. It just means the results will likely be worse.