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## ERISA, Agency Costs, and the Future of Health Care in the United States

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## ERISA, Agency Costs, and the Future of Health Care in the United States

### Cover Page Footnote

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## ARTICLES

### ERISA, AGENCY COSTS, AND THE FUTURE OF HEALTH CARE IN THE UNITED STATES

*John Bronsteen,\* Brendan S. Maher\*\* & Peter K. Stris\*\*\**

*Because so many Americans receive health insurance through their employers, the Employee Retirement Income Security Act (ERISA) of 1974 plays a dominant role in the delivery of health care in the United States. The ERISA system enables employers and insurers to save money by providing inadequate health care to employees, thereby creating incentives for these agents to act contrary to the interests of their principals. Such agency costs play a significant role in the current health care crisis and require attention when considering reform. We evaluate the two major health care reform movements by exploring the extent to which each reduces agency costs. We find that agency cost analysis clarifies the benefits, limits, and uncertainties of each approach.*

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This Article develops ideas formed while litigating two recent Employee Retirement Income Security Act (ERISA) cases before the U.S. Supreme Court: *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006) (argued by Professor Stris on March 28, 2006) and *LaRue v. DeWolf, Boberg & Associates* (argued by Professor Stris on November 26, 2007). We are grateful to the many participants in sessions held by the Georgetown University Law Center Supreme Court Institute, the Alan Morrison Supreme Court Assistance Project, and the American Health Lawyers Association, whose insights guided our initial thinking and research. The development of these ideas benefited substantially from suggestions and references from colleagues associated with the AARP, the Pension Rights Center, and the U.S. Department of Labor. We owe special thanks to Professors Gail B. Agrawal, Bruce Ackerman, Roger M. Baron, Russell D. Covey, Judith F. Daar, Richard Epstein, Owen Fiss, Alison L. LaCroix, Shaun P. Martin, and Radha A. Pathak for their input and encouragement. Finally, we thank April Bonifatto, Molly O'Brien, and Karyn Washington for their invaluable research assistance.

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## INTRODUCTION

*The very reason that most "people seek health insurance is to have some medical security in a crisis." For the more than 50% of American workers who receive their health insurance through an ERISA-governed plan, however, such security is sorely lacking . . . .*<sup>1</sup>

On October 3, 2007, President George W. Bush issued only the fourth veto of his seven years in office, rejecting a bill to expand health coverage for children because it would "move [them] out of private health insurance."<sup>2</sup> Such private insurance comes from employers and is the

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1. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 64 (D. Mass. 1997).  
 2. Michelle West, *Bush Defends Veto of Congressional Children's Health Measure*, Bloomberg.com, Oct. 6, 2007, <http://www.bloomberg.com/apps/news?pid=20601087&sid=aJdihRvQcKiU&refer=worldwide>; see also Sheryl Gay Stolberg & Carl Hulse, *Bush Vetoes Child Health Bill Privately: Later Offers Compromise on Children's Plan*, N.Y. Times, Oct. 4, 2007, at A18; Associated Press, *Bush Vetoes Child Health Insurance Plan: President, Congress Battle over \$30*

cornerstone of health care in the United States. Support for this employer-based system is universal among leaders of both parties, whatever their stances on certain exceptions such as programs for children.

To be sure, there is widespread agreement that American health care is in need of reform. The leading presidential candidates all highlighted it in their campaigns,<sup>3</sup> and even popular culture has taken note via Michael Moore's recent film *Sicko*, the third-highest-grossing documentary on record.<sup>4</sup> But both major approaches to reform—the defined contribution movement associated primarily with President Bush and other Republicans, and the universal care movement associated primarily with Hillary Clinton and other Democrats—retain the basic structure of employer-sponsored care as their backbone.

This structure, wherein people receive health insurance through the company for which they work, is governed by the Employee Retirement Income Security Act (ERISA) of 1974.<sup>5</sup> ERISA is a labyrinthine statute, and scholarly attempts to address health care reform have, by necessity, delved into its intricacies. This Article confronts those intricacies, but its ultimate ambition is to extract from them an organizing theme that explains the problems with the status quo.

That theme is agency cost: the cost arising from a system that gives an agent the incentive to act contrary to the interests of its principal. Specifically, employers and insurers stand to gain by providing inadequate health care to their employees. In this Article, we rigorously examine our ERISA-governed health care system through the lens of agency cost and suggest that such an approach is the most promising theoretical framework.

Part I explains the preeminent role of ERISA in the regulation, and therefore delivery, of health care in the United States. Virtually all private health care is paid for by employer-provided benefit plans, which are governed by ERISA, and the preemptive sweep of the statute has nearly foreclosed health care regulation or reform other than at the federal level.

Part II is our central theoretical contribution. Drawing upon theories of agency that dominate the literature on economics and corporate law, we argue that there are fundamental agency cost problems that inhere in any ERISA-governed employee benefits plan, and that the precise nature of

*Billion Coverage Difference, MSNBC.com, Oct. 3, 2007, <http://www.msnbc.msn.com/id/21111931/>.*

3. Hillary for President, American Health Choices Plan, <http://www.hillaryclinton.com/feature/healthcareplan/?sc=8> (last visited Feb. 8, 2008); Join Rudy 2008, <http://www.joinrudy2008.com/commitment/indepth/8> (last visited Feb. 8, 2008); Mitt Romney, Health Care, [http://www.mittromney.com/Issue-Watch/Health\\_Care](http://www.mittromney.com/Issue-Watch/Health_Care) (last visited Feb. 8, 2008); Obama '08, Healthcare, <http://www.barackobama.com/issues/healthcare/> (last visited Feb. 8, 2008).

4. Box Office Mojo, Documentary Movies, <http://www.boxofficemojo.com/genres/chart/?id=documentary.htm> (last visited Feb. 8, 2008).

5. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.).

these ERISA agency cost problems (EACPs) is in current need of explication and clarification. Using examples from the ERISA-governed retirement plan context, we suggest and define two distinct types of EACPs—asset risk and benefit risk. In our view, this conceptual refinement supplies the theoretical tool needed to map agency analysis onto ERISA reality.

In Part III, we argue that a significant part of our current health care crisis is the result of unmitigated EACPs. Specifically, we maintain that the agency cost problems that inhere in every ERISA-governed health plan are particularly acute and largely misunderstood, that these agency cost problems are exacerbated by the specific—and largely accidental—manner in which ERISA has come to regulate health plans, and that the failure to address meaningfully these agency cost problems has resulted in fundamental problems of coverage and care.

In Part IV, we develop a taxonomy of health care reform proposals so that our construct may be used as an evaluative heuristic. It is axiomatic that agency risk will menace any system, like ERISA, that relies upon conflicted fiduciaries absent countervailing safeguards of appropriate strength. In our view, potential safeguards must be organized according to their objectives in order to assess their ability to satisfactorily address problems of agency cost. Our proposed taxonomy identifies three such objectives: to improve the negotiation, terms, or policing of health plans. Such grouping is a necessary prerequisite to the establishment of an empirical research agenda that can address the difficult questions whose answers must inform any considered attempt at systemic reform.

In concluding, we illustrate the power of our construct as an evaluative heuristic by examining the two dominant movements that purport to change fundamentally the financing and delivery of health care in this country. Using our conception of EACPs as a framing device forces both movements into sharper focus, exposing likely problems, revealing potential adjustments, and prompting necessary inquiries.

## I. ERISA'S INFLUENCE ON OUR HEALTH CARE SYSTEM

### A. *The Prevalence of Health Care as an Employee Benefit*

Most Americans are familiar with the concept of receiving health insurance through their places of work. But it is more than common; it is the overwhelmingly predominant way in which Americans who are neither senior citizens nor government employees pay for their health care. “Although the figures have fluctuated somewhat in the past decade, employment-based coverage seems to have stabilized at approximately 65% of the under-65 population, or roughly 177 million Americans.”<sup>6</sup>

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6. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 *Yale J. Health Pol'y L. & Ethics* 23, 26 (2001) (citing Robert J. Mills, U.S. Census Bureau, *Health Insurance Coverage: 2000* (2001), available at

It was not always this way. Before World War II, few people received health insurance through their employers.<sup>7</sup> Like in many other arenas, the war was an unintended catalyst for changes in domestic America. Because of wage controls, wartime employers could not compete for employees by offering more attractive wages.<sup>8</sup> In contrast, nonwage compensation (such as payment of health care expenses) was free from such restrictions and was increasingly used by employers to compete for employees.<sup>9</sup> After the war, in what was undoubtedly intended as progressivism, the government made such benefits tax free, with the enthusiastic support of employers and labor.<sup>10</sup> Neither employers nor employees had to pay taxes on the money employers contributed towards health care. This tax break, which appeared modest at the time of enactment, has increased exponentially in size and importance. Estimates for the size of the current tax preference range from \$100 billion to \$125 billion.<sup>11</sup>

The favorable tax treatment of employer-sponsored health care encourages employers to offer (and employees to accept) generous health packages—more generous than if the government were not picking up part of the bill. The tax break in essence subsidizes the purchase of health insurance through one's employer. In addition to the subsidization effect, obtaining health insurance through the workplace permits employees access to group plans, which, because of risk pooling, are available on more attractive terms than are individual policies. Having become accustomed to the tax and group advantages associated with employer plans, Americans have long been suspicious of health care reform proposals that do away with the employer-based model (even those that offer tax and group advantages of their own). Although there has been much scholarly

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<http://www.census.gov/prod/2001pubs/p60-215.pdf>; Stephen H. Long & M. Susan Marquis, *Stability and Variation in Employment-Based Health Insurance Coverage, 1993–1997*, 18 *Health Aff.*, Nov.–Dec. 1999, at 133).

7. See Clark C. Havighurst, *American Health Care and the Law*, in *The Privatization of Health Care Reform: Legal and Regulatory Perspectives* 1, 3–4 (M. Gregg Bloche ed., 2003); Robert B. Helms, *The Tax Treatment of Health Insurance: Early History and Evidence, 1940–1970*, in *Empowering Health Care Consumers Through Tax Reform* 1, 7–8 (Grace-Marie Arnett ed., 1999).

8. See Havighurst, *supra* note 7, at 3.

9. See *id.*; Paul L. Starr, *The Social Transformation of American Medicine* 311–12 (1982).

10. See Havighurst, *supra* note 7, at 3.

11. See, e.g., Nat'l Health Policy Forum, *Retooling Tax Subsidies for Health Coverage: Old Ideas, New Politics* 3 (1998), available at [http://www.nhpf.org/pdfs\\_ib/IB728\\_TaxSubsidies\\_11-12-98.pdf](http://www.nhpf.org/pdfs_ib/IB728_TaxSubsidies_11-12-98.pdf) (estimating \$108 billion in foregone revenues); John Sheils & Paul Hogan, *Cost of Tax-Exempt Health Benefits in 1998*, 18 *Health Aff.*, Mar.–Apr. 1999, at 176, 178 (estimating that the tax subsidy was \$124.8 billion in 1998); Leonard E. Burman et al., *Tax Incentives for Health Insurance* 1 (Urban-Brookings Tax Policy Ctr., Discussion Paper No. 12, 2003), available at [http://www.urban.org/UploadedPDF/310791\\_TPC\\_DP12.pdf](http://www.urban.org/UploadedPDF/310791_TPC_DP12.pdf) (estimating that \$100 billion of revenue is lost each year as a result of the tax preference for employer-sponsored health benefits).

criticism of the desirability of employment-based health insurance,<sup>12</sup> no serious reform proposal moving away from this approach has come close to realization.

### B. *The Primacy of ERISA in Regulating Employee Benefits*

ERISA was enacted to regulate employer-sponsored benefit plans, of which there are two kinds, “pension” and “welfare.”<sup>13</sup> The former includes both traditional pensions<sup>14</sup> as well as 401(k) plans.<sup>15</sup> The latter includes plans that provide health care and disability benefits.<sup>16</sup>

ERISA was born following a groundswell of scholarly and governmental concern over pension security and the real-world collapse of several high-profile pension plans (notably Studebaker), leaving thousands of retired employees broke and indignant.<sup>17</sup> There is little doubt that ERISA was drafted and passed with the primary aim of protecting employees’ pension

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12. See, e.g., Uwe E. Reinhardt, *Employer-Based Health Insurance: R.I.P.*, in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* 325, 348–50 (Stuart H. Altman et al. eds., 1998); Alain C. Enthoven, *Consumer-Centered vs. Job-Centered Health Insurance*, 57 *Harv. Bus. Rev.*, Jan.–Feb. 1979, at 141, 151–52; Victor R. Fuchs, *The Clinton Plan: A Researcher Examines Reform*, 13 *Health Aff.*, Spring 1994, at 102, 110–11; Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, *Health Aff. Web Exclusive*, May, 28, 2003, at W3-237, W3-237 to W3-238, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1>; cf. Susan J. Stabile, *Is It Time to Admit the Failure of an Employer-Based Pension System?*, 11 *Lewis & Clark L. Rev.* 305 (2007) (arguing that the failures of the employer-based retirement system cannot be rectified by incremental changes).

13. 29 U.S.C. § 1002(3) (2000) (“The term ‘employee benefit plan’ or ‘plan’ means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.”).

14. ERISA defines a “pension plan” to include “any plan, fund, or program . . . established or maintained by an employer” that “(i) provides retirement income” or “(ii) results in a deferral of income by employees.” *Id.* § 1002(2)(A). Traditionally, pension income was provided through what ERISA refers to as a “defined benefit” retirement plan. *Id.* § 1002(35). A defined benefit plan promises to pay a fixed retirement benefit, usually monthly, for the lives of the participant and his or her spouse. The amount of such a benefit is typically determined pursuant to a formula that takes into account the participant’s years of service and compensation. See *Employee Benefit Res. Inst.*, *Fundamentals of Employee Benefit Programs* 56 (5th ed. 1997).

15. A 401(k) plan is the most common type of what ERISA refers to as a “defined contribution” retirement plan. 29 U.S.C. § 1002(34); see also U.S. Dep’t of Labor, *Retirement Plans, Benefits & Savings: Types of Retirement Plans*, [www.dol.gov/dol/topic/retirement/typesofplans.htm](http://www.dol.gov/dol/topic/retirement/typesofplans.htm) (last visited Feb. 8, 2008) (explaining that “defined contribution plans include 401(k) plans, 403(b) plans, employee stock ownership plans, and profit-sharing plans”).

16. ERISA regulates not only pension plans but also welfare plans. See *supra* note 13 and accompanying text. An “employee welfare benefit plan” or “welfare plan” is defined by the statute to include “any plan, fund, or program . . . established or maintained by an employer” that provides “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.” 29 U.S.C. § 1002(1).

17. James A. Wooten, *The Employee Retirement Income Security Act of 1974: A Political History* 51–79 (2004). The second chapter of Professor Wooten’s intensive historical account is entitled “‘The Most Glorious Story of Failure in the Business’: The Studebaker-Packard Corporation and the Origins of ERISA.” *Id.* at 51.



benefits.<sup>18</sup> In contrast, welfare plans received such scant attention during ERISA's coalescence that some have described their inclusion as an "afterthought."<sup>19</sup> Few afterthoughts have had such momentous consequences. In the United States today, "most health care for the nonelderly is delivered through ERISA-covered employee benefit plans."<sup>20</sup> Moreover, state laws that "relate to" employee benefits plans—including state law remedies—are expressly preempted by the statute, which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."<sup>21</sup> To a degree that often astounds the uninitiated, states have an extraordinarily limited ability to regulate the provision and delivery of health care as financed by employer-sponsored plans.<sup>22</sup>

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18. *Id.* at 1 ("ERISA was Congress's attempt to devise a comprehensive regulatory program to protect millions of American workers who looked to private pension plans for financial support in their retirement years."). In the words of Congress, "[T]he growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial [and] the continued well-being and security of millions of employees and their dependents are directly affected by these plans." 29 U.S.C. § 1001(a).

19. Hyman & Hall, *supra* note 6, at 29 ("Health benefits were included in ERISA as an afterthought, with little consideration given to whether the same regulatory framework would work—a problem that became increasingly obvious as managed care came to dominate the coverage market."); *see also* Wooten, *supra* note 17, at 281 ("In the political history of pension reform, there was little discussion of employer-sponsored health plans.").

20. John H. Langbein & Bruce A. Wolk, Pension and Employee Benefit Law 892 (3d ed. 2000); *see also* Lorraine Schmall & Brenda Stephens, *ERISA Preemption: A Move Towards Defederalizing Claims for Patients' Rights*, 42 Brandeis L.J. 529, 538–40 (2004).

21. 29 U.S.C. § 1144(a).

22. Few topics have generated more interest from scholars and commentators in recent years than ERISA preemption. *See, e.g.*, Elizabeth Barnidge, *What Lies Ahead for ERISA's Preemption Doctrine After a Judicial Call to Action Is Issued in Aetna Health Inc. v. Davila*, 43 Hous. L. Rev. 125 (2006); Phyllis C. Borzi, *Distinguishing Between Coverage and Treatment Decisions Under ERISA Health Plans: What's Left of ERISA Preemption?*, 49 Buff. L. Rev. 1219 (2001); Phyllis C. Borzi, *Pegram v. Herdrich: A Victory for HMOs or the Beginning of the End for ERISA Preemption?*, 1 Yale J. Health Pol'y L. & Ethics 161 (2001); Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. Rev. 457 (2003); Linda P. McKenzie, *Eligibility, Treatment, or Something In-Between? Plaintiffs Get Creative to Get Past ERISA Preemption*, 23 J. Contemp. Health L. & Pol'y 272 (2007); Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 Fla. L. Rev. 1 (2001); Maureen McOwen, *Through the Eye of the Needle: How the New York City Health Care Security Act Will Escape ERISA Preemption*, 40 Colum. J.L. & Soc. Probs. 37 (2006); Rebecca A.D. O'Reilly, *Is ERISA Ready for a New Generation of State Health Care Reform? Preemption, Innovation, and Expanding Access to Health Care Coverage*, 8 U. Pa. J. Lab. & Emp. L. 387 (2006); Larry J. Pittman, *A Plain Meaning Interpretation of ERISA's Preemption and Saving Clauses: In Support of a State Law Preemption of Section 1132(a) of ERISA's Civil Enforcement Provisions*, 41 San Diego L. Rev. 593 (2004); Sharon Reece, *Puncturing the Funnel—Saving the "Any Willing Provider" Statutes from ERISA Preemption*, 27 U. Ark. Little Rock L. Rev. 407 (2005); Jeffrey G. Sherman, *Domestic Partnership and ERISA Preemption*, 76 Tul. L. Rev. 373 (2001); Alex Turner, *The Denial of Benefits to the Same-Sex Domestic Partners of State Employees: How Do Claims of Discrimination Fare Outside the Shadow of ERISA Preemption?*, 4 U. Pa. J. Lab. & Emp. L. 669 (2002); L. Darnell Weeden, *HMOs, ERISA's "Relate to" Preemption and a Patient's*

## II. RETHINKING ERISA AGENCY COST PROBLEMS

Inspired by agency theories that dominate the literature of economics as well as corporate law, we endeavor to develop a conception of EACPs that can be used to map agency analysis onto the realities of ERISA-governed health care. We begin from the premise that the risks attending any ERISA-governed employee benefit plan are the result of fundamental agency cost problems that are largely misunderstood and currently undertheorized. Using examples from the ERISA-governed retirement plan context, we argue that there are two distinct types of EACPs, and that an understanding of this distinction must inform any meaningful attempt to evaluate and/or reform our current system of health care financing and delivery.

### A. Viewing EACPs in Terms of Asset and Benefit Risk

An ERISA benefit plan is nothing more than the legal mechanism through which an employer's promise of benefits is formalized and effectuated. Indeed, an ERISA benefit plan is, in design and practice, a form of statutory quasi trust administered by the employer (or its designees) as a fiduciary for the employee.<sup>23</sup> Whatever the extent of ERISA's overlap with trust law, it is undeniable that an ERISA benefit plan creates (in economic terms) an agency relationship: the principal (i.e., the plan participant) relies on the agent (i.e., the plan fiduciary) to protect and advance the principal's interest.<sup>24</sup>

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*Right to an External Review of Medical Necessity Decisions and the Implications of Field and Conflict Preemption*, 5 DePaul J. Health Care L. 207 (2002).

23. ERISA mandates that "all assets of an employee benefit plan shall be held in trust by one or more trustees . . . [who, subject to limited exceptions,] shall have exclusive authority and discretion to manage and control the assets of the plan." 29 U.S.C. § 1103(a). According to the statute, "[T]he assets of a plan . . . [subject to limited exceptions] shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." *Id.* § 1103(c)(1). The statute groups those who oversee an ERISA trust under the rubric of "fiduciary" and provides an extremely broad definition of this term. *See id.* § 1002(21) (defining "fiduciary"). Indeed, any party who "has any discretionary authority or discretionary responsibility in the administration" of a plan is considered a fiduciary. *Id.* § 1002(21)(A)(iii). Moreover, the primary fiduciary duties under the statute are derived from the common law of trusts. The statute codifies the common law trust principle of a duty of loyalty by providing that "a fiduciary shall discharge his duties with respect to a plan . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . [and] defraying reasonable expenses of administering the plan." *Id.* § 1104(a)(1). The statute also codifies the common law trust principle of a duty of care by providing that "a fiduciary shall discharge his duties with respect to a plan . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use." *Id.* § 1104(a)(1)(B).

24. For purposes of this Article, we use the term "agency" as an economic or organizational notion, i.e., agency as a relationship where the agent voluntarily and formally acts on the principal's behalf to further the principal's interest, even if the principal lacks the strict authority to control the agent. This usage, of course, is distinct from the legal definition of agency, which is "the fiduciary relationship that arises when one person (a 'principal') manifests assent to another person (an 'agent') that the agent shall act on the

With the creation of this agency comes a common problem: how can a principal ensure the agent will serve the principal's interest rather than do things that benefit the agent at the expense of the principal?<sup>25</sup> No shortage of ink has been spilled on this subject (often called agency risk or the agency cost problem), particularly in the literature of economics and corporate law.<sup>26</sup> Far less, however, has been written about the role of agency risk in the trust setting.<sup>27</sup>

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principal's behalf and subject to the principal's control, and the agent manifests assent or otherwise consents so to act." Restatement (Third) of Agency § 1.01 (2006). The Restatement explicitly recognizes that it has adopted a narrow definition, noting that "terminology of agency is widely used in commercial settings and academic literature to characterize relationships that are not necessarily encompassed by the legal definition of agency." *Id.* § 1.01 cmt. b.; see also Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 Mo. L. Rev. 341, 371 (2001) (discussing the legal concept of agency with reference to an employer's purchasing of health insurance for employees).

25. There is an old story, originally told by American essayist Elbert Hubbard, concerning a principal, an agent named Rowan, and an opposing general named Garcia. According to the story, war had broken out, with the President in command of the government and (General) Garcia in command of the guerilla forces. The President had an idea for ending the war and needed to communicate urgently with Garcia. Garcia's location was unknown and he was thus not reachable by mail or phone. When the President asked his advisors how he could reach Garcia, he was told there was a man named Rowan who could deliver the President's message. The President summoned Rowan, gave him the written message, and told him to deliver it to Garcia. Rowan did not ask where Garcia was, how he was to get the letter to Garcia, or how long it would take. Rowan simply took the letter, traversed land and sea, camped in the hills, entered hostile territory, tracked down Garcia, and delivered the message to him. Hubbard's story celebrates an agent who asks no questions, makes no objections, requests no help, and endures great personal hardship, but nonetheless accomplishes his principal's daunting task. If all agents were like Rowan, there would be no principal-agent problem. But commentators have long acknowledged that agents like Rowan are, if not unique, then extremely rare. Those commentators include Hubbard himself. For agents other than Rowan, he observed, "Slipshod assistance, foolish inattention, dowdy indifference, and half-hearted work seem the rule; and no [principal] succeeds, unless by hook or crook or threat he forces or bribes other men to assist him." Elbert Hubbard, *A Message to Garcia: Being a Preachment 7-8* (East Aurora, N.Y., The Roycrofters 1899).

26. See, e.g., George S. Geis, *Business Outsourcing and the Agency Cost Problem*, 82 Notre Dame L. Rev. 955 (2007). For general background on agency theory including discussion of agency risk, see, for example, Kenneth J. Arrow, *The Economics of Agency, in Principals and Agents: The Structure of Business* 37 (John W. Pratt & Richard J. Zeckhauser eds., 1985); Kathleen M. Eisenhardt, *Agency Theory: An Assessment and Review*, 14 Acad. Mgmt. Rev. 57 (1989); Eugene F. Fama, *Agency Problems and the Theory of the Firm*, 88 J. Pol. Econ. 288 (1980); Sanford J. Grossman & Oliver D. Hart, *An Analysis of the Principal-Agent Problem*, 51 *Econometrica* 7 (1983).

27. In a recent work, Professor Robert H. Sitkoff cogently argued that agency theory can be used to explain fundamental problems that inhere in the donative trust setting. See Robert H. Sitkoff, *An Agency Costs Theory of Trust Law*, 89 Cornell L. Rev. 621, 623 (2004) (noting that "[a]gency cost theories of the firm dominate the modern literature of corporate law and economics" but that "the private express trust, an entity from which the corporation traces its roots, has been left largely untouched by agency cost analysis" (footnotes omitted)). The agency risks that inhere in the donative trust setting (where the default presumption is a neutral trustee) are far more acute in the world of ERISA-governed welfare plans. This is so because ERISA expressly permits the selection of a conflicted trustee. See Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive*

In drafting ERISA, Congress presumably hoped to protect against agency risk by adopting a modified version of preexisting trust law.<sup>28</sup> But the importation of trust law was far from complete; indeed, perhaps the most serious default presumption in trust law—that the fiduciary have no financial interest in the delivery of trust distributions—is utterly absent from the statute.<sup>29</sup> To the contrary, ERISA specifically permits the employer to employ or control the plan fiduciary.<sup>30</sup> To that, we will return shortly.

Generally speaking, agency risk threatens principals because it increases the likelihood that the principal's objectives will be achieved at a higher cost than necessary, or not at all. The beginning point in any contextual analysis of agency risk is to enumerate the subject principal's expectations for the agent, and then to consider the specific agency risk that may threaten the realization of each expectation.

In the ERISA setting, a principal's expectations can, for our purposes, be grouped into two categories. What we refer to as the "benefit expectation" is the expectation that promised benefits will be properly conferred to the employee. By contrast, what we refer to as the "asset expectation" is the expectation that the fiduciary will carefully protect and manage either (1) assets to which the participant has a direct entitlement or (2) assets that underlie a promise of benefits.<sup>31</sup> Which of these expectations arises

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*Benefit Rule*, 55 U. Chi. L. Rev. 1105, 1126 (1988) ("The statute leaves the plan sponsor to pick the fiduciary and, if the sponsor pleases, to do it from the ranks of management. Sponsors routinely exercise this authority."). The explicit scholarly recognition of agency cost problems in the ERISA setting is largely focused on problems of agency that attend the employer's purchase of insurance and initial selection of benefits. See, e.g., Agrawal, *supra* note 24, at 370–72; Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 Wake Forest L. Rev. 1037 (1996). Such issues are, of course, distinct from the agency cost problems associated with a conflicted fiduciary as plan operator and administrator.

28. John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 Colum. L. Rev. 1317, 1324 (2003) ("[W]hen confronting abuse in plan administration, Congress was able to adapt the long-familiar trust model as the regulatory regime."); see also *Varity Corp. v. Howe*, 516 U.S. 489, 496 (1996) (noting that the duties imposed by ERISA on plan fiduciaries "draw much of their content from the common law of trusts, the law that governed most benefit plans before ERISA's enactment" (citations omitted)); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989). The periodic reference to "administration risk" in the work of Professor Langbein unquestionably implicates notions of agency. Targeting a wholly different objective, however, Professor Langbein does not seek to overlay agency theory onto ERISA in such a way so as to build an accessible evaluative construct. This is evidenced by the very choice of the phrase "administration risk," which, while quite useful for other purposes, fails to reflect the various manifestations of ERISA agency cost problems (EACPs) that afflict different plan types and structures.

29. See Restatement (Second) of Trusts § 170(1) (1959). *But see id.* § 170(1) cmt. t (noting that self-dealing is authorized if permitted by the terms of the trust).

30. See *supra* note 27.

31. Commentators often describe all plans under ERISA as being either of the "defined benefit" or "defined contribution" variety. These terms are present in the statute. 29 U.S.C. § 1002(34) (2006) ("defined contribution"); *id.* § 1002(35) ("defined benefit"); see also U.S. Dep't of Labor, *supra* note 15 (explaining the difference between a defined benefit plan and

depends on the plan structure. For example, a 401(k) plan implicates the asset expectation; a traditional pension plan implicates both the asset and benefit expectations. Having defined the principal's asset and benefit expectations, we need now explore the corresponding risks that the principal's expectations will be frustrated.

### 1. Asset Risk

In a 401(k) plan, an employee is assigned an individual account within the plan to which money is contributed by the employee and/or the employer.<sup>32</sup> A participant's allocated assets are owned and controlled by the plan, subject to its duties to the employee,<sup>33</sup> until the moment they are withdrawn from the plan by a participant or beneficiary. Although some, if not most, plans provide participants with investment choices, the actual investment transactions are undertaken by plan fiduciaries. Indeed, any alternative arrangement would cause a 401(k) plan to lose its tax-preferred status under § 401 of the Internal Revenue Code.<sup>34</sup>

The principal's expectation is that the fiduciary will properly manage the funds allocated to the principal's account. The most prominent agency risk here is that the fiduciary will mishandle plan funds, either through outright theft or more likely by making imprudent investment decisions or ignoring a participant's instructions, resulting in a decrease in plan asset value. In modern America, the risk of outright theft, thankfully, is low, no doubt because theft is morally repugnant, easy to ascertain, and likely to result in criminal penalties for its practitioners. Fund mismanagement and/or self-dealing are the primary asset risks faced by employees participating in 401(k) plans or other individual account vehicles.

A traditional pension is also threatened by asset risk. Although such a pension is a promise of benefits legally unrelated to the performance of the assets that back that promise, from a pure agency perspective there is still an asset expectation, namely that the promisor will properly manage the assets backing the pension promise such that it will be able to pay a valid benefit sought by the principal. The risk is that the promisor will manage

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a defined contribution plan). While useful in describing to which party certain types of risk are allocated, this distinction is of limited value in analyzing and grouping the agency risks that arise under ERISA.

32. A 401(k) plan is one type of defined contribution plan. *See supra* note 15. Unlike a defined benefits retirement plan, a defined contribution retirement plan does *not* promise a specific amount of benefits. Instead, an employee who participates in a defined contribution plan is assigned an individual account within the plan to which money is contributed by the employee and/or his employer. 29 U.S.C. § 1102(34). For this reason, ERISA uses the terms "defined contribution plan" and "individual account plan" interchangeably. *Id.*

33. *See, e.g., supra* note 23.

34. *See, e.g.,* Rev. Rul. 89-52, 1989-1 C.B. 110, 111 ("While a qualified trust may permit a participant to elect how amounts attributable to the participant's account balance will be invested, it may not allow the participant to have the right to acquire, hold and dispose of amounts attributable to the participant's account balance at will." (citation omitted)).

the underlying assets so badly that there will be insufficient money remaining to pay benefits. Precisely that brand of asset risk was what in large part impelled the enactment of ERISA—several high-profile traditional pension plans lacked sufficient assets to meet their pension promises and defaulted, leaving retirees holding the bag.<sup>35</sup>

## 2. Benefit Risk

Unlike a 401(k) plan, a traditional pension plan is a promise of a particular benefit. Accordingly, the employee's expectation is twofold: (1) that the fiduciary will have the financial wherewithal to live up to the promise (as explained above) and (2) that the fiduciary will fairly *confer* promised benefits. Thus, in addition to the risk that theft or mismanagement of assets underlying the promise could make benefits financially unavailable, the traditional pensioner also faces the risk that, during the benefit conferral process, the agent will shirk his duties and advance his own interests—an agency hazard present regardless of the health of the assets backing the benefit promise. There are many ways for an agent to shirk conferring the promised benefit. Certainly one type of undesirable agent behavior is that the fiduciary is indolent or incompetent in conferring benefits, i.e., inaccurately calculating the pension amount. This behavior often occurs. But a more pernicious risk is one that arises because of the way ERISA permits benefit plans to be administered.

The decision whether to confer a benefit is zero-sum: the promisor keeps one dollar less for every dollar paid in benefits.<sup>36</sup> In contrast to traditional trust law, where the trustee is designedly impartial, ERISA permits plan fiduciaries to employ or control the party who makes benefit determinations.<sup>37</sup> Because every benefit decision is a zero-sum game with the agent on one side and the principal on the other, the obvious risk is that

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35. This type of benefit risk (i.e., that a fiduciary will not have the financial ability to live up to the benefit promise) is often referred to as "default risk." At the time ERISA was enacted, default risk was a severe problem in the context of traditional (i.e., defined benefit) retirement plans. Langbein, *supra* note 28, at 1322. This is not surprising "because [a defined benefit] plan promises today's worker to pay benefits far in the future." *Id.* Thus, before benefits are actually paid, "the plan can become insolvent, or it can renege in other ways on the pension promise." *Id.* Default risk was a substantial concern in 1974 because the pension system at that time was dominated by defined benefit plans. Wooten, *supra* note 17, at 278 ("As late as 1979, more than 80 percent of individuals who participated in a private retirement plan were in a defined-benefit plan," and such plans "held assets valued at roughly two and one-half times the value of assets held by . . . defined-contribution plans."). Today, default risk has all but been eliminated because of ERISA. *See* Langbein, *supra* note 28, at 1322.

36. This is true regardless of who is making the decision on benefits, i.e., even an impartial third party making the decision will either grant benefits (in which case the plan sponsor pays) or deny benefits (in which case the plan sponsor keeps the money). The plan participant's loss is the plan sponsor's gain. In contrast, asset decisions (except for self-dealing and theft) are not zero-sum. The asset decision maker does not gain a dollar for every dollar the participant's 401(k) declines in value.

37. *See supra* note 29 and accompanying text.

the agent will deny otherwise valid benefits to better itself.<sup>38</sup> We call this facet of benefits risk “zero-sum” agency risk.

Many disputes involving traditional pension plans have arisen because of such zero-sum agency risk. One such example reached the U.S. Supreme Court in the 2006 Term.<sup>39</sup> Although this case is the most recent example of zero-sum agency risk leading to pension litigation over the “benefit expectation,” it is by no means the first. For example, litigation has resulted when an employer reduces employees’ wages, terminates the employees, and then argues that the employees’ severance plan benefits should be calculated at the reduced rate.<sup>40</sup> Similarly, disputes regularly have arisen when an employer has sold a division to another firm and then argued that employees who continue to work for the acquiring firm are not entitled to benefits under the selling company’s severance plan.<sup>41</sup> Such conflict has persisted for many years.<sup>42</sup>

Zero-sum agency risk is enhanced greatly if the benefit conferral requires an exercise of discretion concerning the claimant’s “eligibility” for the sought benefit under the governing policy.<sup>43</sup> Accordingly, conflicted fiduciaries have an incentive to exercise creatively that discretion in ways that favor the fiduciary rather than the beneficiary. Although there are several ways to deal with this risk, as discussed in Part II.B of this Article, the only way to eliminate zero-sum agency risk is to prohibit fiduciaries from exercising any control over the party administering benefits.

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38. See *infra* Part III.A.

39. *Beck v. PACE Int’l Union*, 127 S. Ct. 2310, 2321 (2007) (unanimously holding that “merger is not a permissible method of terminating a single-employer defined-benefit pension plan”).

40. See, e.g., *Ahne v. Allis-Chalmers Corp.*, 640 F. Supp. 912, 914 (E.D. Wis. 1986).

41. Compare *Harris v. Pullman Standard, Inc.*, 809 F.2d 1495, 1496 (11th Cir. 1987), and *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1350 (9th Cir. 1984), with *Simmons v. Diamond Shamrock Chem. Co.*, 658 F. Supp. 1053, 1054 (E.D. Mo. 1987), *aff’d*, 844 F.2d 517 (8th Cir. 1988), and *Jung v. FMC Corp.*, 755 F.2d 708, 709 (9th Cir. 1985).

42. Almost twenty years ago, two prominent scholars described the cases cited in *supra* notes 40 and 41 as examples where “at the margin there can be doubt about how particular plan terms apply to particular circumstances.” Fischel & Langbein, *supra* note 27, at 1129.

43. An example from the traditional pension setting should illustrate this point. Litigation over a defined pension benefit rarely involves a claim that the fiduciary paid mathematically less than what was owed, i.e., that the fiduciary did not obey the formula governing the pension calculation. Fiduciaries are unlikely to violate clear rules governing benefit entitlement, because there will almost certainly be significant reputational consequences that result from such behavior. In general terms, this can be expressed as follows: agency risk still exists in a zero-sum game absent discretion, but it is far less dangerous because agents are more likely to face reputational risks from opportunistic behavior (as well as liability risks). When there is room for interpretation regarding how the agent should act, i.e., when the agent has discretion, behavior adverse to a given principal is less likely to negatively affect the agent’s reputation, because observers may attribute the agent’s decision to an unfavorable but unbiased interpretation of the rule. No such reputational protection exists for parties whose actions unquestionably violate clear rules. People may be willing to deal with wily operators, but few are willing to deal with out-and-out cheaters. This is true even if no government-imposed penalty (either statutory or at common law) for the rule breaking exists.

### B. ERISA's Disparate Regulation of Asset and Benefit Risk

ERISA contains a number of provisions designed to address asset risk, particularly in the retirement setting. ERISA created the Pension Benefit Guaranty Corporation (PBGC), a federal entity that guarantees traditional pensions should the company backing the pension default on its obligations.<sup>44</sup> The PBGC is the pension cousin of the well-known Federal Deposit Insurance Corporation (FDIC), which insures bank accounts.<sup>45</sup> ERISA also sets forth minimum funding requirements on companies offering defined benefit pensions to decrease the likelihood of default.<sup>46</sup>

As noted above, ERISA imposes upon fiduciaries the duties of loyalty and care imported from the common law of trusts.<sup>47</sup> In addition to codifying these common law fiduciary duties in general terms, ERISA also provides some specific examples of these duties in the plan management context. For example, the statute specifically provides that a plan fiduciary must “diversify[] the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.”<sup>48</sup> The statute also provides that a plan fiduciary must act “in accordance with the documents and instruments governing the plan” unless such documents are inconsistent with ERISA.<sup>49</sup> ERISA also strictly prohibits transactions and asset transfers between the fiduciary and the plan.<sup>50</sup> These duties and prohibitions directly address concerns of fiduciary theft and mismanagement.

ERISA has done considerably less to deal with benefit risk.<sup>51</sup> The statute does have some provisions intended to deal with this species of agency risk. For example, it imposes vesting requirements upon traditional pension plans, which address benefit risk by imposing nondiscretionary, *ex ante* standards upon fiduciaries that prevent the use of lengthy vesting periods and subsequent termination as a means of avoiding the payment of

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44. See Langbein, *supra* note 28, at 1323 (observing that “[a]ll defined benefit plans must pay a premium per covered participant into a fund administered by an ERISA-created government agency . . . which guarantees the payment of most benefits promised under defined benefit plans”).

45. The Federal Deposit Insurance Corporation (FDIC) is “[a]n independent agency of the federal government [that] was created in 1933 in response to the thousands of bank failures that occurred in the 1920s and early 1930s.” FDIC, Who Is the FDIC?, <http://www.fdic.gov/about/learn/symbol/index.html> (last visited Feb 8., 2008). The agency “insur[es] deposits in banks and thrift institutions for at least \$100,000,” and it “identif[ies], monitor[s] and address[es] risks to the deposit insurance funds.” *Id.* Accordingly, “no depositor has lost a single cent of insured funds as a result of a failure” since the corporation began to offer insurance in 1934. *Id.*

46. 29 U.S.C. §§ 1081–1086 (2006).

47. See *supra* note 23 and accompanying text.

48. 29 U.S.C. § 1104(a)(1)(C).

49. *Id.* § 1104(a)(1)(D).

50. *Id.* § 1106.

51. Minimum funding requirements and guaranty corporations do not alleviate benefit risk; nor have the enumerated fiduciary duties in ERISA, balanced as they are against the fact that ERISA permits *as a starting point* a nonneutral fiduciary, been practically applied in a way that meaningfully confronts benefit risk.



benefits.<sup>52</sup> The statute also empowers a participant or beneficiary of any ERISA-governed plan to initiate civil litigation “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”<sup>53</sup>

But these limits on benefit risk are overshadowed by ERISA’s statutory tolerance of conflicted fiduciaries. Indeed, ERISA’s failure to prohibit a conflicted fiduciary is the primary reason that benefit risk plagues ERISA plans. Other than those situations in which the fiduciary’s discretion is limited and *ex ante* rules can serve as a prophylactic, a participant is vulnerable to opportunistic behavior by fiduciaries. This problem requires careful attention because, as noted above, benefits determinations are zero-sum and frequently turn on the discretion of a conflicted fiduciary. As discussed in Part III of this Article, discretion is most frequently implicated (and thus a more frequent danger to the participant) in the health care context.

### III. THE ROLE OF EACPS IN OUR HEALTH CARE CRISIS

We have argued that fundamental agency cost problems inhere in any ERISA-governed employee benefits plan. Next, we contend that EACPs are responsible for a significant part of our current health care crisis. In Part III.A, we maintain that the agency cost problems that inhere in every ERISA-governed health plan are particularly acute and largely misunderstood. In Part III.B, we identify various features of ERISA that exacerbate EACPs. In Part III.C, we suggest that the failure to address meaningfully these agency cost problems has resulted in fundamental problems of coverage and care.

#### A. *The Misunderstood Problem of Health Care Benefit Risk*

EACPs in ERISA-governed health care are acute and misunderstood. Benefit risk in the health care setting is acute because benefit determinations often involve discretion,<sup>54</sup> fiduciaries have explicit discretion to make benefits determinations,<sup>55</sup> and a determination is a zero-sum game where fiduciaries lose by granting benefits. Benefit risk in the health care setting also is misunderstood because there is considerable

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52. *Id.* §§ 1051–1061.

53. *Id.* § 1132(a)(1)(B). Unlike most civil litigation authorized by ERISA, a lawsuit brought pursuant to 29 U.S.C. § 1132(a)(1)(B) may be filed in either federal or state court. *See id.* § 1132(e)(1) (noting that, “[e]xcept for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction,” but that “[s]tate courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraph[] (1)(B) . . . of this section”). However, the remedies available to a participant or beneficiary under 29 U.S.C. § 1132(a)(1)(B) are extremely limited. *See infra* notes 70–72 and accompanying text.

54. The problem is less acute in the retirement setting, where benefits risk exists but is not as pervasive because the conferral of benefits less frequently involves the same level of discretion. *See supra* note 43.

55. *See infra* Part III.C.

complexity in the ways in which health plans are funded and administered. There are three ways in which a health plan may be funded under ERISA. As explained below, zero-sum agency risk inheres in every ERISA health plan, regardless of which of these funding methods is employed.

### 1. Self-insured Plans

Under ERISA, an employer is permitted to establish a welfare plan, pursuant to which the employer assumes the cost of paying for all promised benefits.<sup>56</sup> In other words, the employer is not required to purchase third-party insurance.

ERISA does not require that employers who self-insure set aside segregated funds for such a plan.<sup>57</sup> Accordingly, one arrangement is pure self-funding, in which the employer pays 100% of the cost associated with providing benefits out of its general treasury. Under such an arrangement, the employer is directly and immediately sensitive to the zero-sum nature of benefit payments. In this circumstance, an employer may choose one of its own employees as plan administrator, in which case the zero-sum agency risk is obvious because the administrator's judgment is at some level biased in favor of the bottom line of the entity that pays him, either explicitly or through an unconscious desire not to "bite the hand that feeds him."<sup>58</sup>

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56. 29 U.S.C. § 1081(a)(1); *see also* Donald T. Bogan, *ERISA: Re-thinking Firestone in Light of Great-West—Implications for Standard of Review and the Right to a Jury Trial in Welfare Benefit Claims*, 37 J. Marshall L. Rev. 629, 633 n.21 (2004) (explaining that welfare plans, unlike pension plans, may be "funded through the establishment of a trust, or through the purchase of insurance, or plans can be unfunded").

57. Such plans are commonly called "unfunded plans." *See* Bogan, *supra* note 56, at 633 n.21.

58. Some commentators argue that health care benefits risk is limited because an employer, and hence its administrator employees, has a reputational incentive to award benefits so that the employer may keep and attract employees. *See, e.g.*, *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998) (noting that "it is a poor business decision to resist paying meritorious claims for benefits"). This argument at best lessens the agency risk, and the degree to which it does so is unclear. First, many employers offer no health plans at all, and yet still attract quality employees. Surely an employer who offered a health plan that provided, in practice, unexpectedly sparse benefits would still be able to attract quality labor that preferred some benefits over perhaps superior wages at an employer with no plan. Second, opportunistic manipulation of the benefit determination process need not result in routine benefit denial, or even denial at all; there are many ways in which agency risk may manifest itself that are subtle enough not to result in a reputationally costly perception of bias. Only obviously biased decisions are likely to damage the company's reputation. Moreover, significant reputational costs arise only to the extent that other workers are aware that biased denials (known to the victim) are occurring, and it is not clear how likely it is that this information would be made widely available to workers beyond those who suffered obviously biased treatment. Third, employers presumably face equal if not more pressure to keep down their cost of goods, because consumers can easily discriminate based on the price of the offered good or service. Thus, to the extent an employer needs to choose between (1) inflicting a difficult to ascertain "benefit manipulation cost" on its workers—who would be burdened with significant transaction costs if they wanted to change employment and who might be unable to communicate that cost to other current or prospective workers—and (2) bearing the cost of awarding benefits and then inflicting any increased cost of doing business on

Agency hazard also remains present if an unfunded plan retains a third party to administer benefits. If a third-party administrator's compensation is negatively tied to the amount of benefits awarded, as some are, then there is an obvious agency risk present. Even if a third-party administrator's fee is unrelated to the benefits awarded, however, the employer has an incentive to select administrators who keep its benefit costs down. For this reason, third-party administrators have an incentive to favor the employer in their determinations to increase the likelihood the employer continues to engage them.<sup>59</sup>

Another option for employers who wish to self-fund is to create a segregated trust for the payment of claims. Agency risk is present here for two reasons. First, the employer's promise to pay benefits is not limited to the amount of money in the trust; any excess benefit claims come out of the employer's treasury.<sup>60</sup> Second, and more importantly, the employer funds the trust, and thus, to the extent any self-favoring benefit manipulation results in the trust running a surplus, that lessens the future amount the employer needs to contribute. A benefits dollar opportunistically denied today is a dollar less that need be added to the pot at the next trust-funding interval.

Self-insurance only makes financial sense for employers who "have a pool of individual risks sufficiently large to minimize [their] insurance risk, reducing the value of purchasing third-party insurance."<sup>61</sup> Because self-

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consumers through higher prices for the sold good or service, employers would choose the former, because the risk of losing a consumer to a competitor's cheaper substitute good or service is greater than the risk of losing a worker or being unable to replace him.

59. Some observers have suggested that health care benefit risk is limited because benefit determinations are made by persons, not entities, and the determiner's personal interests may differ from the sponsoring employer. *See, e.g.,* *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999) (noting the difficulty for an entity to get employees to act exclusively in the company's interest). That a plan administrator's personal incentives may not be aligned perfectly with his employer's may serve as an outer limit on the administrator's exercise of discretion in favor of the employer, such that grossly immoral decisions would be avoided. Yet there is little reason to believe an administrator's personal incentives, to the extent that they diverge from his employer's, are likely to cut in favor of the employee, as the administrator secures no personal advantage for awarding benefits. At best, this argument shows that the administrator's divergent personal value system may operate to lessen the magnitude of agency risk faced by the beneficiary, not that there is no risk at all. Moreover, the more significant the overall cost of benefits is to the company's financial health, presumably the larger the overlap of incentive between the administrator and the employer, whose fortunes are entwined—and all parties agree that the cost of health benefits is significant to virtually every employer.

60. *See* Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 639 n.8 (2005) ("If the plan trust is unable to satisfy all of the plan beneficiaries' claims, the plan sponsor usually must either replenish the trust, if one exists, or pay the benefits directly out of its general treasury.").

61. Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 Yale J. Health Pol'y L. & Ethics 89, 106–07 (2005). *See generally* Gail A. Jensen, Kevin D. Cotter & Michael A. Morrissey, *State Insurance Regulation and Employers' Decisions to Self-Insure*, 62 J. Risk & Ins. 185 (1995). For a historical account of how the "savings" and "deemer" clauses came to be included in ERISA so as to address welfare plans, see Wooten, *supra* note 17, at 235–36, 256, 258–59.

insured plans are entirely immune from state regulation, however, there is a substantial noneconomic reason to self-insure.<sup>62</sup> Small employers have been able to offer health plans that qualify as self-insured under ERISA without exposing themselves to an unreasonable amount of financial risk by purchasing what is called stop-loss insurance. A stop-loss policy is simply an insurance policy that pays the employer for costs incurred above an agreed upon stop-loss point.<sup>63</sup> If an employer who has chosen to sponsor a self-insured plan with stop-loss insurance that is administered by a designee of the employer, the zero-sum agency risk is obvious as to all benefit decisions made prior to the time that the stop-loss minimum is reached.<sup>64</sup> For benefits above the stop-loss point, agency risk arises because the employer fears increased stop-loss premiums with each benefit award. If the stop-loss insurer administers the plan, the incentive is to globally manipulate the benefit process such that the benefits awards are unlikely to exceed the employer's minimum point.

## 2. Insured Plans

In cases where the plan fiduciary transfers both the administrative and insurance role to a third-party insurance company, the agency risk likely exceeds that of all other arrangements. The reason is that the third-party administrator/insurer is faced with the same zero-sum incentive as a self-insurer/administrator, and yet the third-party insurance company is more insulated from reputational damage than is the employer itself, owing to information asymmetry and the position of victimized beneficiaries. As the U.S. Court of Appeals for the Third Circuit has explained,

[W]hile in a perfect world, employees might pressure their companies to switch from self-dealing insurers, there are likely to be problems of imperfect information and information flow. Employees typically do not have access to information about claim-denying by insurance companies, and the relationship between employees and insurance companies is quite attenuated; so long as obviously meritorious claims are well-handled, it is unlikely that an insurance company's business will suffer because of its client's employees' dissatisfaction. Additionally, many claims for benefits are made after individuals have left active employment and are

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62. See, e.g., L. Darnell Weeden, *Tactical Self-Funded ERISA Employers Unnecessarily Threaten Employees' Right to an Independent Review of an HMO's Medical Necessity Determination with Preemption*, 77 St. John's L. Rev. 867, 884 (2003) (noting that ERISA preemption jurisprudence "may lead some employers to change to unfunded employee benefit plans to avoid ERISA's insurance saving clause").

63. Bureau of Labor Statistics, U.S. Dep't of Labor, *Definitions of Health Insurance Terms* 6 (n.d.), available at <http://stats.bls.gov/ncs/ebs/sp/healthterms.pdf> (providing definitions used by the Interdepartmental Committee on Employment-Based Health Insurance Surveys).

64. See, e.g., *Smathers v. Multi-Tool, Inc./Multi-Plastics, Inc.*, 298 F.3d 191, 199 (3d Cir. 2002) (holding that, where employer uses stop-loss insurance, there is a conflict because "the employer is directly funding a portion of the plan and is benefitted by denying the claims").

seeking pension or disability benefits. Details about the handling of those claims, whether responsible or irresponsible, are unlikely to seep into the collective knowledge of the still-active employees.<sup>65</sup>

Of course, the Third Circuit's observations apply with even more force to manifestations of agency risk far more subtle than opportunistic denying of claims, which we discuss below.

### B. ERISA's Failure to Address Health Care Benefit Risk

ERISA does not require that employers offer benefit plans; it merely imposes certain requirements upon an offered plan that vary with the plan type. The pertinent requirements for welfare plans are as follows: (1) the plan must be written and certain plan information disclosed to plan participants;<sup>66</sup> (2) the plan must be administered by a named fiduciary, designated by the employer;<sup>67</sup> (3) the fiduciary and any cofiduciaries must observe certain fiduciary duties and administer the plan "solely in the interest" of plan participants and beneficiaries;<sup>68</sup> and (4) benefit denials must be in writing and subject to internal review *by the fiduciary*.<sup>69</sup> The limited utility of these requirements should be apparent, because ERISA, as we have emphasized throughout, does not require that the welfare plan administrator be financially independent of the employer. Nor does ERISA impose financial or solvency requirements upon welfare plans or restrict the employer's (i.e., the plan sponsor's) choices regarding how to fund the plan.

ERISA does include remedies that are available to those harmed as a result of a violation of ERISA's substantive provisions, including a remedy for benefit denial.<sup>70</sup> But the Supreme Court has held ERISA's remedial provisions to be the "exclusive" remedies available to redress injuries arising from ERISA violations, and remedies such as traditional consequential or punitive damages—which are not named in ERISA's remedial provisions—cannot be implied.<sup>71</sup> Accordingly, the relief available

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65. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000).

66. 29 U.S.C. §§ 1021–1024, 1102 (2006).

67. *Id.* § 1102(a)(1)–(2).

68. *Id.* § 1104(a)(1).

69. The U.S. Code provides,

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

*Id.* § 1133.

70. *Id.* § 1132.

71. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) ("The deliberate care with which ERISA's civil enforcement remedies were drafted . . . argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive."); *Mass.*

to a plaintiff suing for an improper denial of welfare benefits is limited to receiving the denied benefit or the value thereof (with the possibility of attorneys' fees, awarded at the court's discretion). Put simply, ERISA's remedies undercompensate and underdeter.<sup>72</sup>

### C. *The Consequences for our Health Care System*

The health care market can be thought to have three categories of players: patient, provider, and payor. The patient receives medical services; the provider physically supplies them; and the payor pays for them. Prior to the passage of ERISA in the 1970s and steeply rising medical costs in the 1980s and 1990s, the traditional health insurance model was the "indemnity model." In the indemnity model, the patient chose a physician, the physician chose the appropriate medical services, and the payor (the insurer) paid the physician's "fee-for-service." This model, with little to no insurer involvement regarding the appropriate provision of services, has been largely displaced. Currently, insurers exercise a great deal of control over the type, amount, quality, and cost of the services provided. Inherent in such insurer control is a great deal of zero-sum agency risk. We discuss below the primary ways in which this agency risk has manifested itself.

#### 1. Agency Risk and Issues of Coverage

Insurers and self-insured plans now routinely include in their contracts the following provisions: (1) a clause that only "medically necessary" treatment is covered, (2) a clause excluding "experimental" treatments, and (3) a clause reserving the discretion to make such judgments to the insurer.<sup>73</sup> The process by which insurers make these determinations for a proposed treatment is known as "utilization review."<sup>74</sup>

The agency risk in utilization review is significant. Because utilization review is discretionary and often involves expert analysis as to whether a particular treatment is "medically necessary" or experimental, such adverse discretionary determinations in the utilization review setting are less likely to incur reputational costs than are flat denials of clearly covered services.<sup>75</sup>

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Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146 (1985) ("The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.").

72. The lack of such damages—which are generally available against self-serving fiduciaries in non-ERISA contexts—highlights why agency cost poses a more profound risk in the world of ERISA than outside of it. Insufficient deterrence encourages errant behavior.

73. See Jennifer Arlen & W. Bentley McLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. Rev. 1929, 1971–72 (2003); Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637, 1647 (1992).

74. Hall & Anderson, *supra* note 73, at 1652–53.

75. See *generally id.* Professors Mark A. Hall and Gerard F. Anderson assess whether insurers should be allowed "to control health care costs by denying payment for specific services based on the insurers' judgments of medical appropriateness," *id.* at 1641–42, and

Indeed, utilization review need not result in complete denial of the sought benefit; often denial of a specific sought treatment is coupled with the insurer's approval of an alternate, less costly treatment. If the patient, on account of his inability to self-pay for the desired treatment, accepts the alternative treatment, it is not difficult for the insurance company to boast of the high rate of "coverage" its policy affords—the patient, after all, received treatment. Moreover, if the patient accepts the alternative treatment and his condition does not improve or worsen, there is little litigation risk to the insurance company. ERISA both denies plaintiffs the right to collect traditional consequential or punitive damages in such circumstances and denies states the ability to supply that additional remedy.<sup>76</sup> Indeed, if the patient wishes to receive the denied treatment, his only option is to pursue an injunction to obtain that benefit. Such litigation is costly, time-consuming, and not amenable to contingent fee representation, making it very difficult for all but the wealthiest patients to challenge a payor's self-serving determinations.<sup>77</sup> And, again, even if such a patient declines the alternative, self-pays, and then seeks reimbursement, the insurance company is on the hook primarily for the cost of the treatment and, in rare circumstances, attorneys' fees.

## 2. Agency Risk and Issues of Care

Another EACP is that payors will set up payment systems that incentivize physicians to underprovide care.<sup>78</sup> Such systems have the

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propose that coverage disputes be resolved via contractually agreed, nonjudicial process, *id.* at 1683–89.

76. *E.g.*, *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1322–24 (5th Cir. 1992) (affirming the dismissal of a lawsuit for the wrongful death of an unborn child even though the employer denied hospitalization for the woman who, according to both her personal physician and an independent physician consulted by the employer, required complete bed rest and around-the-clock monitoring, where the fetus died while the woman was at home without medical care).

77. Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 *Seton Hall L. Rev.* 1055, 1068 (1996) (noting that patients often "find it too expensive or too difficult to pursue their objections through the costly and time-consuming judicial process").

78. Health plans "are largely free to try to shape physicians' clinical behavior by profiling their practice patterns, linking plan participation and referrals to economic performance, and offering financial rewards for clinical frugality." M. Gregg Bloche, *One Step Ahead of the Law: Market Pressures and the Evolution of Managed Care*, in *The Privatization of Health Care Reform: Legal and Regulatory Perspectives*, *supra* note 7, at 22, 25; *see also* Havighurst, *supra* note 7, at 13 (noting that "[h]ealth plans routinely select their subcontractors based on low cost, not demonstrated skill in treating patients, and compensate them in ways that can induce neglect or undertreatment"); David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 *U. Rich. L. Rev.* 155, 156 (1996) (describing the types of financial incentives to limit care, but then concluding that complete "opposition to financial incentives is ultimately misguided, [because] it gives insufficient weight to the benefits of financial incentives and to the broader context in which financial incentives are used" and recommending that "the government should place limits on the extent to which financial incentives can be used, [but] not prohibit the incentives entirely").

benefit of saving the insurer money and shifting the apparent blame to the treating physician, rather than the insurance company. This is analogous to an adverse utilization review as discussed above. It is well documented that “the practice style of physicians is influenced by the explicit and implicit financial incentives under which they operate.”<sup>79</sup> For example, one recent econometric study in the fee-for-service setting found that switching physician compensation from a fixed salary to profit sharing at a set of clinics owned by a hospital chain resulted in physicians increasing the number of patients that they saw.<sup>80</sup>

Another recent econometric study in the managed care setting confirmed that costs were reduced most when the incentives for physicians to cut costs were the greatest.<sup>81</sup> The most common structure of this type used by managed care organizations to incentivize physicians to cut costs is called “capitation.” In a capitation scheme, a physician receives from the payor a fixed amount of money for agreeing to treat a particular patient for a specified time interval. If the patient requires treatment in the specified period worth less than the capitation payment, the physician keeps the profit. If the patient requires treatment worth more than the capitation payment, the physician receives no additional money from the insurance company. The physician’s incentive is to maximize the number of patients and provide no more care than is paid for by the capitation payment.<sup>82</sup> In such circumstances, a patient might not even be aware that the physician is not providing care. The patient relies on the physician to tell her what care is needed; one manifestation of agency risk in this setting is that the physician simply does not mention treatment or care that is financially unattractive to a physician operating under a capitation scheme.

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79. David J. Cooper & James B. Rebitzer, *Managed Care and Physician Incentives: The Effects of Competition on the Cost and Quality of Care*, 5 Contributions to Econ. Analysis & Pol’y, No. 1, art. 16 (2006), at 4, available at <http://www.bepress.com/bejeap/contributions/vol5/iss1/art16> (discussing “recent econometric studies” that support this proposition). Of course, the governing legal rules will affect the ways in which payors choose to incentivize providers and, in turn, the resulting provider behavior. See generally Kathryn Zeiler, *Medical Malpractice and Contract Disclosure: An Equilibrium Model of the Effects of Legal Rules on Behavior in Health Care Markets* (Georgetown Univ. Law Ctr., Bus., Econ. & Regulatory Policy Working Paper No. 539224, 2004), available at <http://ssrn.com/abstract=539224> (developing a theoretical model of how specific legal rules affect ways in which managed care organizations decide to compensate physicians and the effect of such rules on physician treatment decisions).

80. See Cooper & Rebitzer, *supra* note 79, at 4 (discussing Jason R. Barro & Nancy Dean Beaulieu, *Selection and Improvement: Physician Responses to Financial Incentives* (Harvard NOM Research Paper Series No. 00-03, 2000), available at <http://papers.ssrn.com/paper.taf?abstract?id=258560>).

81. See *id.* (discussing Martin Gaynor, James B. Rebitzer & Lowell J. Taylor, *Physician Incentives in Health Maintenance Organizations*, 112 J. Pol. Econ. 915 (2004)).

82. T. Gosden et al., *Capitation, Salary, Fee-for-Service and Mixed Systems of Payment: Effects on the Behaviour of Primary Care Physicians*, at summary (2000), <http://www.cochrane.org/reviews/en/ab002215.html> (finding that “[t]here is some evidence to suggest that the method of payment of primary care physicians affects their behaviour” but noting that “[m]ore evaluations of the effect of payment systems on PCP behaviour are needed, especially in terms of the relative impact of salary versus capitation payments”).



Of course, payors may engage in additional practices to incentivize providers to cut costs. Some practices are formalized (e.g., providers may be penalized financially for specialist referrals or hospitalizations above preset limits or financially rewarded for coming in under such limits).<sup>83</sup> Other practices are more indirect. Much scholarship has been devoted to the significance of these incentives as well as proposed ways in which to address problems that result.<sup>84</sup>

#### IV. DEVELOPING A TAXONOMY OF REFORM OBJECTIVES

Numerous proposals to “fix” health care have been promoted by scholars, advocates, and legislators alike. In our view, any reform proposal must address EACPs, or numerous problems afflicting the current system will continue, and perhaps worsen. We argue below that any attempt to address agency risk necessarily falls into one of the following three broad categories: (1) proposals to improve the welfare plan bargaining process, (2) proposals to improve the terms of the bargain, and (3) proposals to make the fiduciary live up to the bargain. We categorize reform suggestions in this way because we believe these labels capture the *objective* of the reforms contained in the category. This grouping should facilitate the establishment of an empirical research agenda that can address the difficult questions whose answers must inform any considered attempt at systemic reform.

##### A. *Toward an Open Bargain*

ERISA does not require employers to offer welfare plans. Thus, existing welfare plans can be viewed as voluntary deals between the fiduciary and the plan participants. One could argue that the current system needs no change because it reflects a fair bargain struck between participants and fiduciaries—a bargain where the cost of agency risk is minimal<sup>85</sup> and willingly borne by the participant as part of the deal in return for lower

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83. In the 1990s, there was a public outcry when some insurers went so far as to insert gag clauses in their contract with physicians. Gag clauses prevent the physician from disclosing to the patient more expensive alternative treatments for certain conditions. For a discussion of such clauses, see Bethany J. Spielman, *After the Gag Episode: Physician Communication in Managed Care Organizations*, 22 *Seton Hall Legis. J.* 437, 467 (1998), and Nancy J. Picinic, Note, *Physicians, Bound & Gagged: Federal Attempts to Combat Managed Care's Use of Gag Clauses*, 21 *Seton Hall Legis. J.* 567 (1997).

84. See Cooper & Rebitzer, *supra* note 79 (arguing that increased competition between HMOs can mitigate the adverse effects of physician incentives); see also Mark A. Hall, *A Theory of Economic Informed Consent*, 31 *Ga. L. Rev.* 511, 518–21 (1997) (arguing for “global disclosure” of a cost-containment mechanism at the time of enrollment); Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 *New Eng. J. Med.* 2635, 2635 (2003) (discussing the fact that deficits “in adherence to recommended processes for basic care pose serious threats to the health of the American public”); Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 *Geo. L.J.* 1821, 1838–39 (1995).

85. The argument is that the cost is minimal because opportunistic behavior against one principal could severely damage the agent’s reputation with other prospective principals.

premiums or other consideration. But that argument presumes, among other things, that the bargaining process is fair.<sup>86</sup> Many reform proposals reject that notion and rest on the predicate belief that the current welfare plan bargaining process can be improved.

Scholarship and reforms targeted at the bargaining process often focus on disclosure, specifically more disclosure about the terms of the plan and the incentives underlying the provision of benefits.<sup>87</sup> The belief is that current plans are structured and operated as they are—namely, with a high likelihood of agency risk—because participants are uninformed about the substantive and operative specifics of the plan, particularly the incentives faced by fiduciaries and their designees.<sup>88</sup> The theory is that, once participants are armed with more accurate information about the plans (and thus the true likely cost of agency risk), they can bargain fairly and will demand lower premiums or other changes to the plan that favor beneficiaries.<sup>89</sup>

Unsurprisingly, one popular disclosure idea is that health plans must reveal to their participants or prospective participants the terms of their contracts with physicians. Thus, to the extent that a health plan payor uses physician contracts that have gag clauses, capitation arrangements, or other incentives for physicians to choose treatments that maximize profits at the possible expense of quality of care, participants can bargain (collectively) over the negative worth or acceptability of those plan features.

Disclosure solutions are not perfect. First, it is not clear that further disclosure or efforts to educate will be read or understood by plan participants. Unless read and understood, additional information will have little, if any, effect on the health care bargain struck. Second, even if further disclosure does, in fact, provide comprehensible information for the employee-participant, plans are largely contracts of adhesion. Better

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86. The view also presumes that all that matters is whether the bargaining process that resulted in the deal was fair and that outcomes are irrelevant. We do not opine on what, if any, principles of social justice should trump socially undesirable results that arise from a fair bargaining process.

87. See, e.g., Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform*, 5 *Yale J. Health Pol'y, L. & Ethics* 385 (2005) (encouraging policy makers to consider mandating disclosure of the contract terms between managed care organizations and physicians for the provision of services); Zeiler, *supra* note 79 (predicting that mandating the disclosure of contract terms between managed care organizations and physicians for the provision of services will result in higher rates of treatment and lower rates of lawsuits).

88. See, e.g., Kristin Madison, *Regulating Health Care Quality in an Information Age*, 40 *U.C. Davis L. Rev.* 1577, 1584 (2007) (“In short, absent regulation, information failures may hinder patients’ access to the quality of care they would otherwise demand and receive.”).

89. See McGraw, *supra* note 84, at 1824 (noting that “widespread use of [financial incentives] represents a sharp departure from the traditional notions of the physician as fiduciary to the patient” and proposing disclosure). See generally Mark A. Hall, *The Theory and Practice of Disclosing HMO Physician Incentives*, 65 *Law & Contemp. Probs.* 207 (2002). Alternatively, to the extent the participants are more informed and the plans stay the same, one could argue that nothing more needs to be done.

information need be actionable for it to change outcomes. To the extent that a plan is being provided by a third party, actual bargaining power regarding plan specifics resides with the employer, who, although no doubt subject to employee pressures (particularly so if the employees are unionized), nonetheless has divergent interests from the employees. Thus, any bargaining power the employees have is indirect and funneled through the employer, subject to agency risk on the part of the employer.<sup>90</sup> In the final analysis, the benefits to any particular disclosure rules will necessarily turn on complex empirical analysis.

### B. *Toward a Desirable Bargain*

A second avenue of reform focuses on improving the terms of the bargain for participants. This type of reform is attractive to observers who believe bargaining problems can never be fully fixed,<sup>91</sup> as well as those who believe that even if bargaining were perfectly fair, it might result in socially undesirable outcomes, with desirable outcomes more important than a fair process.<sup>92</sup>

#### 1. Mandatory Entitlements or Prohibitions

Government-imposed entitlements and prohibitions reflect the legislative judgment that all socially desirable health bargains need certain terms.<sup>93</sup>

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90. Plans offered directly by employers and negotiated by union representatives face a smaller bargaining agency risk (as the union's interests are more closely aligned with the employee's interests than the employer's interests are), and thus present situations in which further disclosure is more likely to benefit the employees. Plans offered directly by employers in nonunionized industries, even with substantive disclosures about plan terms, pose serious bargaining problems because it is too costly for any one employee to invest the time to assess the merits of the proposed plan and then force the employer to negotiate, either on an individual basis or with all employees.

91. See generally Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. Pa. L. Rev. 630, 633-34 (1979).

92. See generally Christine Jolls & Cass R. Sunstein, *Debiasing Through Law*, 35 J. Legal Stud. 199, 207 (2006) (observing that both heightened standards for product liability and bans on dangerous products are used to protect consumers who underestimate risk).

93. Certainly government-imposed rules that target agency risk can effectively reduce it because of the penalty (be it statutory or common law) that attaches to noncompliance with the risk-reducing rule, as we discuss below. But government rules also can have a deterrent effect on agency risk separate and apart from the financial deterrent associated with government penalties. Because of the more negative reputational consequences of breaking clear rules, the more comprehensive the list of entitlements and prohibitions, and the more clear the triggering conditions to the same are, the less likely it is that a fiduciary will engage in opportunistic behavior (either in manipulation of benefits or in prohibited conduct), whatever the government-imposed penalty for noncompliance. In addition to the fact that self-serving rule-breaking behavior has more significant reputational costs than self-serving interpretative behavior (as explained above), self-serving behavior that flouts government (rather than contract) rules bears additional risk for the agent. Specifically, the breaking of government rules is more likely to attract retributive government attention in the form of (1) legislative action to unfavorably change the damage rules (either increasing criminal or civil penalties) or (2) legislative action to change the substance or operation of liability rules

Mandatory entitlements reflect the government's determination that all bargains need include some minimum terms relating to specific medical care to which participants are entitled.<sup>94</sup> For example, in 1996 the federal government significantly curtailed the ability of group health insurers to impose preexisting condition exclusion.<sup>95</sup> This reflected the legislative view that it was simply unfair to exclude those with preexisting conditions from obtaining the tax and group advantages of participating in tax-favored employer health plans.<sup>96</sup> That same year, Congress also required that group plans cover minimum postpartum hospital stays for a mother and/or her newborn (forty-eight hours for vaginal delivery, ninety-six hours for Caesarean section).<sup>97</sup> This was a legislative response to insurers' attempt to economize by limiting postpartum hospital stays to a day or less.<sup>98</sup> Congress simply believed that limiting coverage to hospital stays below a

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(moving to strict liability, legislating a stricter form of judicial review, etc.). On the flip side, the less clear the government entitlement or prohibition, the less effective it will be in reputationally deterring agents from finding a way to behave strategically. The problem with using entitlements and prohibitions to deter agency risk (absent strong imposed penalties) is that establishing clear rules and triggering conditions for the mandated entitlement or prohibition benefits is difficult in the health care setting. Because medicine is more art than science and humans possess bounded rationality, neither the entire universe of future conditions nor the required response can be spelled out *ex ante* without relying on some level of circumstantial discretion. Were that not the case—were future conditions and the corresponding agent action subject to rigid description (such as, in the finance setting, proscribing courses of action for the agent depending on the price of a particular financial instrument)—then participants could without government intervention insert such clear rules in a contract. But few contracts have done so, even in cases where bargaining power is closer to equal. An *ex ante* entitlement or prohibition is limited in the extent to which it alone can reduce agency risk.

94. As applied to health care, see Russell B. Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 *Cornell L. Rev.* 1, 4, 9 (1999) (observing that "the legal academy has engaged in no real debate over the general efficacy of what is alternatively known as 'patient-protection' or 'mandated-benefits' legislation" and arguing that "government mandates are a useful tool in the arsenals of lawmakers who are concerned with ensuring that our society devotes the efficient level of resources to health care"). See generally Russell B. Korobkin, *Bounded Rationality, Standard Form Contracts, and Unconscionability*, 70 *U. Chi. L. Rev.* 1203 (2003) (arguing that consumers only consider a limited number of product attributes when making a purchasing decision and that the proper policy response to the inefficiency that results from this phenomenon is the greater use of mandatory contract terms). Mandating contract terms, of course, also addresses perceived unequal bargaining power. If certain parts of any deal are required by law, then unequal bargaining power can only accomplish victories for the more powerful party in areas for which the law has no protective requirement.

95. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 701(1)–(3), 110 Stat. 1936, 1939–40 (codified as amended in scattered sections of 29 and 42 U.S.C.).

96. See generally 142 Cong. Rec. H9785 (1996).

97. Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 711(a)(1), 110 Stat. 2935, 2936 (codified as amended in scattered sections of 29 and 42 U.S.C.).

98. See, e.g., Eugene Declercq & Diana Simmes, *The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, 75 *Milbank Q.* 175, 190–91 (1997).

certain minimum was unfair.<sup>99</sup> Mandatory entitlements target agency risk because they prevent fiduciaries from exploiting bargaining power to exclude explicitly attractive and basic plan terms (i.e., no coverage for preexisting conditions) and from interpreting a plan's terms not to include a reasonable construction of a covered benefit (i.e., where the plan covers pregnancy but interprets coverage to extend to only an unreasonably short postpartum stay).

Public (and judicial) complaints about undesirable fiduciary behavior also have led observers to propose reform measures targeting specific self-serving acts. Two examples of such regulation are antigag rules and antiretaliation requirements.<sup>100</sup> Participant-patients are not medical experts, and they rely upon their physicians to give them accurate medical advice regarding all treatment options. Participants expect and are entitled to clinical candor from their physicians. To the extent a fiduciary unduly limits a physician's ability to be candid and complete in rendering medical advice—either by a gag provision or threat of firing—that is a clear case of the fiduciary prioritizing its zero-sum interest ahead of the patient's. Such prohibitions against specific self-interested conduct squarely target agency risk.<sup>101</sup> The problem is that these prohibitions only deter the specific proscribed conduct. For example, fiduciaries need not resort to a crude gag provision to exert a coercive influence on a physician's candor; informal organizational pressure or the occasional withholding of discretionary performance bonuses from an uncooperative physician can do the trick. Antigag and antiretaliation rules do not deter whispered coercion.

## 2. Modifying Liability Standards

A different tack from focusing on specific acts the fiduciary must or must not perform is to adjust the rule used to determine in general when a fiduciary's conduct is blameworthy, namely, to adjust the liability standard applicable to the fiduciary. Perhaps the most popular proposal—both in terms of scholarly ink spilled and practitioners arguing it ad hoc before trial judges—is to hold the fiduciary vicariously liable for any malpractice committed by the physician. Vicarious liability is the notion that, when one party hires or controls another, the dominant party is liable for the controlled party's torts, even if there is no negligence on the part of the dominant party. Vicarious liability targets EACPs because it gives the fiduciary an incentive to influence the physician in a way that *reduces* the likelihood of negligent treatment. At a minimum, vicarious liability reduces the zero-sum agency risk posed to participants because it

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99. *See id.*

100. Antigag rules prohibit fiduciaries from contractually requiring treating physicians not to mention alternative treatments that are more expensive or otherwise disfavored by the plan. Antiretaliation rules prohibit fiduciaries from firing without cause physicians who exercise their medical judgment in ways contrary to the plan's interest.

101. Like mandatory benefits, prohibitions of specific conduct can supply a reputational deterrent (apart from any government-imposed penalties) if the prohibition is clear enough.

discourages the fiduciary from actively incentivizing the physician to take risks with the standard of care so as to decrease the amount of benefits paid out. Any monetary savings attributable to reduced benefits are counterweighed by an increase in liability exposure, to the extent any reduced provision of benefits increases the risk of a successful malpractice claim.<sup>102</sup>

### C. *Toward an Enforceable Bargain*

The last group of reform proposals focuses on mechanisms to ensure that the fiduciary lives up to the terms of the bargain. These proposals fall into three subcategories: (1) subjecting the fiduciary's behavior to review, (2) changing the standard of review, and (3) increasing the penalties associated with improper behavior.

#### 1. Subjecting the Fiduciary to Impartial Review

To the extent that the fiduciary is answerable to an external third party who either can require the fiduciary to take a certain action or impose a financial penalty on the fiduciary, external review is a potential mechanism for policing self-interested behavior on the part of the fiduciary. External review significantly diminishes agency risk because the agent's discretion for opportunistic behavior is circumscribed by the determinations of an impartial reviewer.

Litigation, of course, is nothing more than a very expensive, very time-consuming type of external review. But most proposed reforms involving litigation address the standard of review and the remedies available to litigants, not the character of the external review, should it occur. In contrast, one popular reform proposal (enacted in many states) recognizes the benefits of external review and proposes a particular character: namely impartial, third-party administrative review.<sup>103</sup> Administrative review is attractive because, to the extent it is timely and inexpensive, it need have less stringent penalties to deter strategic behavior. In other words, if a fiduciary knows a benefit denial will be reviewed by an impartial actor quickly and cheaply, there is little for the fiduciary to gain by wrongfully denying the benefit, even if the cost of a loss before the third-party administrator is merely the cost of the benefit. Conversely, administrative

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102. For example, some observers have argued that prospective utilization review materially reduces a physician's incentives to acquire relevant expertise and thus increases the risk that the physician will provide negligent care. See generally Jennifer Arlen & W. Bentley MacLeod, *Torts, Expertise, & Authority: Liability of Physicians and Managed Care Organizations*, 36 RAND J. Econ. 494 (2005) (arguing that managed care organizations (MCOs) should be held liable for physician torts because the MCOs' use of utilization review materially reduces physicians' incentives to acquire relevant expertise).

103. See, e.g., Ariz. Rev. Stat. Ann. § 20-2537 (2002); Fla. Stat. § 408.7056 (2002); N.Y. Ins. Law §§ 4910, 4914 (McKinney 2007). For a discussion of external review, see Leatrice Berman-Sandler, *Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability*, 13 Annals Health L. 233 (2004).

review's effectiveness may be limited if access to external review were expensive or time-consuming. In that case, the fiduciary has reason to engage in strategic behavior because it hopes such behavior will be too costly for participants to challenge.<sup>104</sup>

One way to lessen the effectiveness of administrative review in combating opportunistic agency risk is to permit fiduciaries to have extended internal review procedures that a beneficiary must satisfy before being eligible for external review.<sup>105</sup> Although having written internal review procedures and guidelines decreases the agency risk that benefit denials will be wrongfully made because the fiduciary does not wish to expend the effort to reviewing the merits of the claim (indolent denials being more likely the less process is in place), extended internal review as a precondition for external review may serve as a gauntlet for ill beneficiaries, thus decreasing the likelihood the external review process will ever commence. In terms of agency risk, the best combination may be optional (at the participant's choice) internal review—to discourage lazy denials—and matter-of-right external administrative review—to discourage strategic denials.

External review often is criticized on cost grounds, and it does increase costs (at a minimum because both benefits payors and the external review body have to maintain a review infrastructure), but it reduces the cost of

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104. Other limits on effectiveness include (1) not having a third-party reviewer who is genuinely impartial and (2) participants not being aware that administrative review is available or of how they may take advantage of it. Regarding the impartiality of the third-party reviewer, it is difficult to imagine how impartial third-party reviewers could exist absent government action, either through direct government action by creating external review departments within both federal and state health agencies, or indirect action by certifying qualified private entities seeking to supply a review function as impartial external reviewers. However, once impartial reviewers are created and knowable, it is not necessarily the case that external review itself be government mandated in all situations because if equal bargaining power exists, then external review could be negotiated or traded for other considerations. External review is an unlikely negotiating bargaining chip when there are difficulties in finding and agreeing upon genuinely neutral third-party reviewers. But, if impartial reviewers existed, then one can imagine scenarios where, if the self-insurer or third-party insurer had a track record of its determinations being upheld by external review, employees would prefer limited external review (for emergency or high-value cases) and additional other benefits over unconditional external review.

105. In 2001, the Department of Labor issued new regulations requiring that benefit claims and appeals be decided within a much shorter time frame if they are claims that require preauthorization before treatment can be given. *See* 29 C.F.R. § 2560.503-1 (2007). Some have argued that preauthorization requirements for certain nonexpensive treatments are less prevalent in health plans as a result of this regulatory change. *See, e.g.*, Phyllis C. Borzi et al., *Geo. Wash. Sch. of Pub. Health & Health Servs., How Care Is Managed: A Descriptive Study of Current and Future Trends in Care and Cost Management Practices Under Private Sector Employee Benefit Plans* 9 (2002), available at [http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/ASPE\\_full\\_report.032604.pdf](http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/ASPE_full_report.032604.pdf) (“Several of the employee benefit plan consultants noted that although the majority of employer health plans still have them, pre-authorization requirements for in-patient care and behavioral health services were not as prevalent as they had been in the past. Many saw this in part as a consequence of the new claims and appeals regulations issued by the U.S. Department of Labor under [ERISA].”).

agency risk. Strictly speaking, whether external review is cost justified hinges on how costly agency risk is to principals. In any event, even if external review is more costly than the agency risk it eliminates, which we doubt, the nation may be willing to incur a higher price for an outcome it perceives as socially desirable (i.e., impartial health benefits decisions).

The primary theoretical problem with external review as a cure for agency risk is that its effectiveness is limited to determinations an individual knows to be wrong, and thus can affect structural plan shortcomings caused by agency risk only indirectly. In other words, participants cannot contest conduct they do not know occurred. Although administrative review arguably could be used to recognize and correct patterns of self-serving conduct that manifested themselves in ways different from knowable, adverse benefit determinations, to expand the scope (and magnitude) of behavior subject to administrative review would likely make the process more costly and time-consuming—in other words, more like litigation. In that case, the advantages of administrative review would be lessened.

## 2. Changing the Standard of Review of the Fiduciary

Some scholars, working within the confines of ERISA, have proposed that agency risk be addressed by modifying the standard an external reviewer employs when reviewing a fiduciary's contested decision.<sup>106</sup> The less deferential the reviewer is to the fiduciary's preliminary determination, the less agency risk the fiduciary poses to the participant. In contrast, with a deferential standard of review, fiduciary determinations are less likely to be challenged, and also less likely to be won by those who do challenge.

Unsurprisingly, ever since the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch* ruled that a fiduciary's granting itself discretion to make benefits determinations would entitle it to deferential "arbitrary and capricious" review, tempered by the degree to which conflict of interest was present in the given case,<sup>107</sup> virtually every plan contains a grant of such discretion. Other scholars, notably Professor John Langbein, have assailed the Court's ruling that an ERISA fiduciary's discretion deserves deference given the inherent conflict created by ERISA's decision to permit fiduciaries to be plan administrators.<sup>108</sup> Lower courts have struggled to categorize the precise level of conflict present under different funding arrangements and then to apply the appropriate standard of review to each

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106. See generally Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care* (Brooklyn Law Sch. Legal Studies Working Paper Series No. 27, 2004), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=630482](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=630482). Generally this discussion relates to a court's standard of review, but it could just as easily govern the appropriate standard of review an administrative reviewer should take.

107. *Firestone Tire & Rubber Co. v. Bruch*, 498 U.S. 101, 115 (1989).

108. See generally 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 (2007).



level of conflict, with the review becoming less deferential as the conflict becomes more serious.<sup>109</sup> In our view, such is splitting the hair too thin. Zero-sum agency risk affects all plan funding arrangements, and the difference between the threat posed by alternative funding arrangements seems less than the difference between a conflicted fiduciary and an impartial one. Under that line of reasoning, the standard should mirror the “conflicted agent” standard from other areas of law: the agent should have to prove that its action was inherently fair.

### 3. Adjusting the Penalties for Improper Behavior

Perhaps the most contentious proposals involve increasing the penalties for improper fiduciary behavior. Increased penalties address agency risk because they force self-serving fiduciaries to internalize the costs of their conduct if liability is established. ERISA, as it stands, does not permit punitive or traditional consequential damages in connection with a denial of benefits. Supplying a more complete remedy to injured participants—as many have proposed—would directly address EACPs. We here briefly discuss the considerable influence the availability of traditional civil damages would have on conflicted fiduciaries.<sup>110</sup>

Even were conflicted agency risk entirely absent from the equation, traditional damages would deter careless health care denials, a considerable benefit. Of course, wrongful denials are tempting because such denials, in some instances, may permit a conflicted fiduciary to capture the time value of money against only the slim cost of paying attorneys’ fees if the denial is successfully contested.<sup>111</sup> In any event, the chance that an ill beneficiary may lack the resources or will to contest a denial—in which case a denial is pure profit—makes denials a financially attractive risk indeed. If the financial stakes are high enough, a fiduciary might be motivated to systematically deny benefits, as evidenced by the Unum/Provident debacle.<sup>112</sup> Such conduct seems a perfect fit for punitive damages. In the health care context, benefit denials can have a very high nonfinancial cost. Many participants cannot independently pay for treatment, so a denial of coverage equals a deprivation of treatment, which may result in serious

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109. See Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*, 58 Okla. L. Rev. 637, 652 n.71 (2005) (discussing standards of review across circuits).

110. Although certainly increasing fines that the secretary of labor could impose for ERISA violations would increase the deterrent effect, the value of such a deterrent would vary widely depending on whether the secretary was assertive. In contrast, the history of American law shows that private civil remedies are always pressed with vigor by private attorneys, particularly those compensated on a contingent basis. We thus confine our discussion here to the proposed expansion of private civil remedies.

111. See *Flint v. ABB, Inc.*, 337 F.3d 1326 (11th Cir. 2003) (holding that accrued interest is not recoverable for benefit denial). *But see Dobson v. Hartford Fin. Servs. Group, Inc.*, 389 F.3d 386 (2d Cir. 2004) (concluding that accrued interest may be recoverable and ordering remand).

112. See Langbein, *supra* note 108, at 1317–21.

injury or death for the participant. There are nonfinancial reasons to err on the side of deterrence. Of course, the decision to authorize any particular remedy must be driven by some measure of empirical data.<sup>113</sup>

## V. CONCLUSION: EACPS AND THE FUTURE OF HEALTH CARE

At the broadest level, there are only two ways to address EACPs: require administration by an impartial trustee or impose safeguards that protect against biased conduct. The framing questions, then, are as follows: Do the dominant proposals in the two major health care movements address EACPs? If so, do they confront EACPs by creating an impartial trustee, by creating effective safeguards, or some combination of the two? Proposals that do not admit of ready answers to these questions necessarily promise more than they will deliver.

### A. *The Defined Contribution Movement*

Let us return briefly to the pension setting. Recall that there are two types of pension plans: defined benefit and defined contribution.<sup>114</sup> The emerging consensus among both scholars and policy makers is that there has been a generational move away from the traditional defined benefit pension plans and toward defined contribution plans as the dominant mode of delivering pension benefits.<sup>115</sup> Some herald this transition as indicative of Americans' preference for an "ownership society" in which individuals have practical "ownership" and control of their retirement benefits and can invest according to their risk and consumption preferences, instead of relying on a paternalistic employer to supply them with a fixed benefit that is not tailored to their individual preferences. Whatever the truth of the claim that Americans prefer defined contribution to defined benefit retirement plans, or whether the transition from the latter to the former evidences some broad philosophical preference for "ownership," there is reason to believe that we are experiencing a movement toward defined contribution in the world of health care benefits.<sup>116</sup>

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113. Zeiler, *supra* note 87, at 388 (noting that "neither proponents nor opponents of [damage] caps have considered how caps might affect treatment choices made by physicians and managed care organizations").

114. *See supra* note 14–15.

115. *See, e.g.*, Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 *Yale L.J.* 451 (2004).

116. President George W. Bush is one vocal supporter of this movement. *See, e.g.*, White House, *Affordable, Accessible, and Flexible Health Coverage*, <http://www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html> (last visited Mar. 8, 2008); *see also* Borzi et al., *supra* note 105, at 14 ("According to the experts, many employers are considering offering their employees a restructured health plan that establishes overall limits on the employer's promise to finance health care for its employees. These plans [are] often called 'consumer-driven' or 'defined contribution' health plans . . ."); *id.* at 17 ("[M]ost employers seem to be looking to two principal mechanisms to manage their costs: . . . [including] moving away from more traditional models of employer-sponsored health plan coverage in favor of various defined contribution approaches.").

Defined contribution health care proposals rely in large part on the use of tax-deductible individual health savings accounts (analogous to a 401(k) account or individual retirement account in the pension setting) and high-deductible health insurance.<sup>117</sup> Participants use the money in their individual accounts to pay for minor, “everyday” medical costs; the health insurance kicks in for unexpectedly large expenditures. Costs incurred that exceed the balance of the health savings account but fall short of the deductible are paid for out-of-pocket by the individual. The purported benefits to such hybrid plans are twofold: first, they permit individuals to implement their preferred preferences between health savings and other uses of income; and, second, they avoid the claimed overconsumption hazard associated with insurance policies that require only nominal out-of-pocket expenditures for additional care.<sup>118</sup> Because people will be spending their own money for each use of medical services, the economic temptation to overconsume care will be largely squelched.

Many scholars and policy makers already have begun to debate the advantages and disadvantages of a move toward defined contribution employee benefit plans.<sup>119</sup> Regardless of the merits or flaws of defined

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117. For tax purposes, “high deductible” is defined as a minimum annual deductible of \$1000 or more for unmarried individuals and \$2000 for a family, and a maximum annual deductible of \$5000 and \$10,000 respectively. I.R.C. § 223(c)(2) (Supp. IV 2004). These limits are tied to inflation. *Id.* § 223(g).

118. When a patient has insurance, many commentators have pointed out that there exists an economic incentive for overconsumption of care, i.e., the moral hazard of overconsumption. The patient does not pay the bill for care; she merely receives the benefit. Thus, the argument goes, it makes economic sense for her to demand care without regard to cost, with the result being that she will demand much more care than she would if she were paying the cost of additional care herself.

We believe the magnitude of this risk is overstated. Obtaining care—even care paid for by another—is not costless to the patient. One must miss work or sacrifice leisure time to receive diagnosis and treatment, and many treatments have short-term negative physical utility. That is, neither medical procedures (nor even simple medication) are free of pain or without side effects. This is why many people opt for physical therapy—which is considerably cheaper than surgery—to address back problems before trying surgery, even if insurance pays for both.

Moreover, much care is not discretionary and thus far less susceptible to moral hazard. A diabetic does not consume insulin because someone else is paying for it. In contrast, the agency risk we have identified infects all benefit decisions made by a conflicted agent, whether the subject care is discretionary or nondiscretionary. Indeed, ERISA—by investing a fiduciary with the discretion to make benefit decisions and insulating it from liability for improper conduct—creates a pervasiveness and degree of agency risk tolerated in no other field of American law.

119. See, e.g., Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 Tul. L. Rev. 777 (2006); E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 Vand. L. Rev. 1207 (2006) (analyzing three kinds of litigation that are likely to arise when patients pay for their own care); see also Borzi et al., *supra* note 105, at 20 (“Some of the experts we interviewed observed that defined contribution health plans were primarily a means to shift costs to employees. These experts do not believe they serve as care management tools. They expressed concern that, as currently structured, defined contribution products put employees and their families at risk for a greater share of medical expenses without giving them the tools necessary to make better health care choices.”); Milt Freudenheim, *A New Health Plan*

contribution health plans, however, one fact is inescapable: their adoption will do little, if anything, to counter the threat of EACPs. To the extent that individuals will control a portion of their health expenditures, EACPs are admittedly small. But no credible advocate of these plans has suggested that individual health accounts entirely displace traditional insurance. That is because insurance supplies a risk-sharing function that individual accounts cannot. Few individuals can or would save enough to pay for catastrophic medical needs, like cancer treatment or organ transplants; only insurance is fit to provide security against those eventualities. Thus, proponents of hybrid plans envision a world where individuals will (in a subsidized way) assume the expense of low-cost, routine medical care, while the insurer will bear the expense of high-cost, nondiscretionary care beyond the power of even the most pessimistic individual account holder.

A hybrid plan positively may impact moral hazard and EACPs for low-cost medical treatments (particularly discretionary treatments). But it generates no constrictive force at all vis-à-vis the EACPs that menace the provision of benefits associated with major medical expenses that exceed the deductible. Unless such insurance is administered by a nonconflicted decision maker or with more safeguards than ERISA currently provides, EACPs will be no less likely to flourish than as under the current system and those disputes that result from EACPs will involve the particular issues that are of the highest stakes to the beneficiary.<sup>120</sup> No public predictions exist for the dollar volume of the sought care that would be above any particular deductible level—and thus subject to EACPs—but there is good reason to expect that a significant majority of the benefits conferred would be through the insurance component, not through expenditures from individual health savings accounts.<sup>121</sup> In our view, any sober discussion of the defined contribution movement need recognize and address that reality.

### B. *The Universal Coverage Movement*

Estimates peg America's uninsured at forty-seven million.<sup>122</sup> That an enormous number of people in America lack any health insurance has not

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*May Raise Expenses for Sickest Workers*, N.Y. Times, Dec. 5, 2001, at A1; Cato Inst., *The Ownership Society and Health Care*, [http://www.cato.org/special/ownership\\_society/healthcare.html](http://www.cato.org/special/ownership_society/healthcare.html) (last visited Feb. 8, 2008).

120. Indeed, one would guess that the type of care participants would most desire to insulate from EACPs would be life-saving or life-extending care. Such treatments are the most likely to be costly and would remain subject to EACPs under the hybrid approach.

121. This is true because the lion's share of medical spending in this country is for "big ticket items." Thomas Rice, *The Economics of Health Reconsidered* 82, 95–96 (1998). More than forty percent of health care expenditures each year are incurred by two percent of the U.S. population. *Id.*; see also Karen Davis, *Consumer-Directed Health Care: Will It Improve Health System Performance?*, 39 *Health Services Res.* 1219, 1223 (noting that ten percent of individuals account for sixty-nine percent of health care costs).

122. Nat'l Coalition on Health Care, *Health Insurance Coverage*, <http://www.nchc.org/facts/coverage.shtml> (last visited Feb. 11, 2008). Although some uninsured persons no doubt choose not to purchase insurance, the vast majority of the uninsured simply do not have access to affordable health insurance.

escaped the attention of reformers. Indeed, for many, this is the central flaw with the health care system in America, and a prescription for vastly reducing the number of uninsured (thus attaining universal or near universal coverage) is the cornerstone of many reform proposals.<sup>123</sup> Although such proposals vary considerably in form, any universal coverage proposal that does away with employer-based insurance<sup>124</sup> is entirely free of EACPs.<sup>125</sup> The converse is equally true: to the extent that a proposed reform retains employer-based insurance (and does not modify ERISA or create new federal law), EACPs will remain.

Proposals containing an employer-based coverage component come in two varieties: those that require Americans to purchase insurance offered by an employer, or those that give Americans the option of purchasing employer insurance or an alternative. While the first variety will hopefully have the merit of extending coverage to the employed uninsured, such proposals will also have the necessary demerit of continuing to subject millions of working Americans to EACPs. The second category of universal care proposals permits employed Americans to choose between employer-sponsored or government-sponsored insurance. One may wonder why, currently, Americans cannot simply choose nonemployer insurance, and the reason is twofold: the tax and group advantages of employer plans are significant.<sup>126</sup> The individual market for insurance is not equivalently tax favored and, laboring under adverse selection, does not offer rates or benefit packages comparable to those of group plans. Any plan for universal coverage that does not create a nonemployer insurance alternative that has the same tax and group advantages as an employer plan will leave employed Americans with no more choice than they have today.<sup>127</sup>

Choice is important for many reasons, but it is particularly important once EACPs are taken into account. If universal coverage reform creates a world in which employed individuals have a true, tax-indifferent choice between an employer-based ERISA plan and a non-ERISA group plan, transparent EACPs are far less problematic. Participants unhappy with the level of EACPs in an employer plan simply can switch to a non-ERISA

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123. Several prominent Democratic Party candidates profess either explicit membership or great interest in this movement. *See supra* note 3.

124. By employer-based coverage we mean coverage where the employer either is or financially controls the fiduciary.

125. Such plans may have non-EACPs. For example, a plan that relies upon subsidized private insurance supplied other than by an employer would have agency risk if the insurer doubled as the administrator, but such risk would be addressable by traditional tort law and state regulation. Other nonemployer systems may be almost entirely free of agency risk—single-payor plans, in which the government administers benefits through a central system and funds the program with general revenues and employer contributions, would theoretically be a system with an impartial trustee and thus have minimal agency risk.

126. Taxpayers, in essence, are subsidizing the plans—ERISA plans—that are most infected with agency risk.

127. One way to do this would be to eliminate the current tax exclusion. Another way would be to keep the tax exclusion, but permit it to apply for employer and employee contributions to nonemployer-based insurance.

plan, i.e., a plan that has impartial fiduciaries, adequate safeguards against agency risk, or both. Americans today employed in the private sector have no such option.

### C. *EACP-Fueled Observations*

Defined contribution proposals, as currently constituted, leave unaddressed EACPs whenever health care benefits exceed the patient's insurance deductible. As such, it is difficult to see how such plans could ever address these agency cost problems. In contrast, universal coverage proposals *can* address EACPs—by either doing away entirely with employer-based plans, or by providing employed Americans with tax-indifferent access to a non-ERISA group plan.<sup>128</sup> The latter may be especially appealing to those who favor choice and competition. Americans troubled with the level of agency risk in their employer plan can leave the plan; Americans willing to tolerate EACPs in their employer plan will be better positioned to bargain for lower premiums or more attractive benefits packages. Americans, in essence, will have more control over the degree of agency risk they are willing to live with and the exact price they are willing to pay for it. Who would not want that?

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128. Whether that access is accomplished by opening enrollment to the Federal Employee Health Benefit Program (as Hillary Clinton has suggested, *Hillary for President, American Health Choices Plan: Quality, Affordable Health Care for Every American 1* (n.d.), available at <http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf>), by creating regional insurance pools that will offer private group plans, or by expanding existing public programs will have important policy consequences unrelated to EACPs. The answer to such policy questions requires the weighing of empirical evidence and the making of politically informed policy choices that are beyond the intended scope of this Article.