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## The Collective Fiduciary

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Lauren R. Roth\*

# The Collective Fiduciary

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## I. INTRODUCTION

The fiduciary developed largely as a legal construct to allow an individual to perform a task for the benefit of one or a small number of individuals. Property was managed. Estates were distributed. Employees were hired.

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But can fiduciaries be made to serve public goals? I introduce the concept of the collective fiduciary to signify the shift taking place in private social welfare benefits towards collective goals and holding fiduciaries accountable for the welfare of many instead of one or a few individuals. A collective fiduciary is an organization that administers a social welfare program funded by the government, in whole or in part, either directly or through tax incentives, on behalf of a large number of beneficiaries and is bound by fiduciary duties imposed under common law or statute. Other scholars have focused on the individual whose fortunes or health is controlled by a fiduciary, making it difficult to collect information about fiduciary actions and obtain consistent, coherent decisions from fiduciaries who control access to private benefits. My argument here is that this is not a problem that can be fixed at the level of the individual fiduciary or individual beneficiary. Instead, by taking a collective approach, we can help individuals by ensuring that fiduciaries meet public targets for benefit distribution.

With the passage of the Patient Protection and Affordable Care Act (ACA),<sup>1</sup> millions have or will gain access to health insurance. Due to penalties for employers who do not offer the required coverage, many will enroll in new employer-sponsored health plans subject to the fiduciary regime codified under the Employee Retirement Income Security Act of 1974 (ERISA).<sup>2</sup> Private health insurance plans are largely subject to ERISA's mandates. However, ERISA contains few substantive provisions for health plans, which is why any discussion of reforming the fiduciary framework that governs private health plans must focus on ERISA.<sup>3</sup> Given that many tests, procedures, and expensive medications require preauthorization by a plan administrator with a fiduciary role, these fiduciaries can restrict access to the very benefits that many individuals think they are purchasing with health insurance.

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1. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (jointly "ACA").
  2. ERISA governs the enactment and maintenance of private employee benefit plans, such as pension plans and group health plans. Employers have full discretion to provide, or not provide, benefits and need not act in the best interests of employees when deciding what form of benefits to offer. However, once an employer decides to provide its employees with a benefit plan, ERISA's fiduciary duties play a central role. ERISA, in addition to corresponding Department of Labor and Internal Revenue Service regulations and federal case law, sets forth the rules that govern the relationships between these private parties. ERISA permits plan participants and their beneficiaries to bring lawsuits in federal court to challenge a denial of their claims to benefits or the manner in which the plan is run. ERISA § 502(a), 29 U.S.C. § 1132(a) (2012). ERISA prohibits litigation of these claims in state courts. ERISA § 514, 29 U.S.C. § 1144 (2012).
  3. See *infra* section II.C for a discussion of ERISA's broad preemption clause and how employers self-insure to fall within ERISA's orbit, instead of state insurance law.

Yet few of these fiduciaries—employees for a large health insurance company insuring or administering the plan—will ever meet or speak with the plan beneficiary for whom they are granting or denying coverage.

Consider the example of a participant in a group health plan subject to ERISA. The participant has cancer and seeks approval, through her doctor or hospital, for treatment. Her claim is denied by the insurance company administering her health plan because the treatment is not considered “medically necessary” for her condition. Both she and her doctor disagree with the fiduciary’s decision, however, so she takes the time and effort to figure out her plan’s appeals process and files a valid appeal of the denial of her benefit claim. The fiduciary denies her appeal. Leaving aside the ACA’s new external review procedures—which add another layer of appeals and are discussed further below—the participant then has final option of exerting more time, effort, and money—all while sick with a serious illness—to go to federal court and ask a judge to review the claim. The judge, however, will apply a highly deferential standard of review and ask—on the basis of the administrative record only—whether the fiduciary’s decision was arbitrary and capricious.

In the example, there is no collective accountability for the fiduciary. No third party has compared the claims of other, similarly situated participants decided by the same insurance company as a measure of internal validity for the decision. Likewise, no third party has investigated whether the insurance company is applying the same definition of care for the participant that other individuals with the same medical condition receive from competing insurance companies as a measure of external validity.

The movement under the ACA towards universal healthcare (although not all scholars believe that we have made such a movement with the statute<sup>4</sup>) requires us to focus on the relationships of trust

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4. Some scholars have argued that the ACA, by establishing universal access to health insurance, affirmed that healthcare is a universal right. *See, e.g.*, Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 *BUFF. L. REV.* 715, 716 (2011). Other scholars, however, argue that the ACA never intended to establish universal insurance participation and settled for dramatically increasing coverage instead because: (1) it does not cover legal immigrants who have been in the country for less than five years or illegal immigrants; (2) those for whom insurance premiums are unaffordable are not required to pay the penalty of the individual mandate; and (3) not everyone who can enroll will do so, choosing to pay the penalty instead. *See, e.g.*, Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 *HOUS. L. REV.* 1029, 1033–34 (2014). Note that this last point is irrelevant if we are focused on universal access to health insurance, or even to affordable health insurance, instead of universal insurance coverage. *See id.* at 1034–35 (“Rather than achieving actual universal coverage, the ACA’s central accomplishment is universal *insurability*. Even if substantial numbers of people remain uninsured, the ACA

between large organizations providing healthcare or access to healthcare and the populations they serve—abstracting up from the traditional one-on-one relationship between doctor and patient.<sup>5</sup> This implies that the fiduciary relationship has become a collective undertaking instead of a direct, personal relationship. I argue that this shift started in the pension context but has grown to greater significance in the healthcare world, because health and well-being are of greater salience than even finances. My concern, however, is first with the expansion of health insurance and the administration of health benefits instead of the direct provision of healthcare services. If patients are denied benefits, then they are effectively denied access to service providers—be they sole practitioners or growing corporations of doctors.

This Article examines the expansion of the role of the fiduciary as a result of growing demand for private welfare benefits in the United States. By failing to recognize the new role of the institutional fiduciary serving a large population of beneficiaries, the courts and Congress have declined to hold fiduciaries accountable for the collective responsibility they take on in a strong system of private welfare benefits. In a space where the government has been, until now, largely absent, both by choice and because of a lack of agreement on policy direction,<sup>6</sup> individual decisions by fiduciaries add up to the only large-scale policy existing for private benefits.<sup>7</sup>

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guarantees everyone the ability to obtain coverage at average community rates. It does so by prohibiting insurers from turning anyone down, or charging them more, for health-related reasons.”).

5. See generally Matthew, *supra* note 4.

6. The American welfare state depends heavily on employers to provide their employees with social welfare benefits (e.g., health insurance and pensions). A long emphasis on self-reliance and small government resulted in years of tax subsidies encouraging the connection of welfare benefits to work and a uniquely American path to social security. See JACOB S. HACKER, *THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SOCIAL BENEFITS IN THE UNITED STATES* (2002). Early research on the importance of public-private linkages in the welfare state showed that private welfare benefits are shaped and subsidized by the government through tools such as tax incentives. See generally CHRISTOPHER HOWARD, *THE WELFARE STATE NOBODY KNOWS: DEBUNKING MYTHS ABOUT U.S. SOCIAL POLICY* (2007) (arguing that researchers have ignored various policy tools, such as tax incentives, that make the welfare state larger than the literature suggests); Beth Stevens, *Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector*, in *THE POLITICS OF SOCIAL POLICY IN THE UNITED STATES* 123 (Margaret Weir, Ann Shola Orloff & Theda Skocpol eds., 1988) (discussing the appeal of family and employment policies over direct bureaucratic interventions).

7. Management consultant Peter Drucker called the growth of private pensions an “unseen revolution” and “an outstanding example of the efficacy of using the existing private, nongovernmental institutions of our ‘society of organizations’ for the formulation and achievement of social goals and the satisfaction of social needs.” HACKER, *supra* note 6, at 82. Political scientist Jacob Hacker, however,

Though I explore several possible solutions, my preferred proposal is a system where every fiduciary administering a health plan<sup>8</sup> is acknowledged by the fiduciary, the participants and beneficiaries, and those enforcing the applicable fiduciary duties to be a fiduciary for the collective—for a large population of insureds. Further, under this plan each decision on a claim for benefits is acknowledged by those parties to have broad implications for the collective given the power differential and inherent conflict of interest faced by representatives of large health insurers and administrators between funding benefits and retaining money for employers and insurance companies. I argue that fiduciary duties are only meaningful when denials of benefit claims are supervised and capped by government actors.

Part II of this Article provides background information on individual and collective fiduciaries, including the traditional fiduciary role—both the discretion that is at the heart of fiduciary power and the common law duties that seek to ensure that fiduciaries use the power to serve beneficiaries instead of themselves. I discuss the particular risks inherent where a fiduciary serves a large number of beneficiaries, an issue that altered the balance of power within traditional fiduciary relationships and resulted in a need for my collective fiduciary framework.

Part III explores the struggle under ERISA to hold private fiduciaries serving a public role in employees' benefits accountable under the individual fiduciary framework. During the decade-long struggle to pass the legislation, Congress sought to bring within the fiduciary framework all institutional actors involved in administering private pension funds. Yet the absence of sufficient government oversight of benefit decisions made by fiduciaries with conflicts of interest left beneficiaries with little of the trust in fiduciaries that was previously a requirement for these relationships to occur. The application of ERISA to more and more health insurance plans set the stage for fiduciaries to restrict meaningful access to health benefits as well.

I argue in Part IV that the ACA has further expanded the fiduciary role to the point that fiduciaries now act as gatekeepers to fundamental welfare benefits, tipping the public-private scale towards the former—requiring a new framework for fiduciary accountability. Increasing enrollment in health insurance plans as a result of con-

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sees danger when welfare policy control is located outside government and the path of welfare policy can be changed “through stealth.” *Id.* at 82–83 (“[T]he politics of private pensions is subterranean politics, only occasionally involving a broad circle of participants and resisting the scrutiny that public programs typically invite—even when sizable public resources and recognized national policy goals hang in the balance.”).

8. While my concept of the collective fiduciary is one that I think can and should be applied to other areas besides health law, I focus in this Article on that topic and save discussion of broader applicability for future research.

gressional efforts to incentivize near universal access to healthcare has broadened the scope of the problem and brought the government into prominence in a field that was previously left largely to private actors to administer. Changes to the fiduciary framework under ERISA are necessary.

In Part V, after exploring other options to increase accountability, I propose a new system of collective fiduciary liability for ERISA and the ACA. Under my framework, fiduciaries, participants and beneficiaries, and those who enforce ERISA's fiduciary duties acknowledge that the decisions fiduciaries make on individual benefit claims create policy and impact a much larger population. By force of statute, fiduciaries acknowledge their financial conflicts of interest, accept limits on their ability to deny benefit claims, and face increased scrutiny by courts without a deferential standard of review when judging their initial decisions.

Private fiduciaries can be made to serve public goals, but only if sufficient accountability is ensured. The expansion of health insurance under the ACA only adds to the need to remedy long-standing issues with the accountability of ERISA fiduciaries over fundamental welfare benefits provided in the United States.

## II. INDIVIDUAL AND COLLECTIVE FIDUCIARIES

To evaluate fiduciary status and duties as a mechanism for holding private actors accountable and protecting beneficiaries, whether under an individual or collective framework, it is necessary to first explore what it means to be a fiduciary. I first discuss powers and duties common to individual and collective fiduciaries, then explain the need for a distinction between the two categories. Although ERISA has codified common law fiduciary standards, the courts continue to inform our understanding of fiduciary powers and duties through interpretation and enforcement of this statute. The common law is therefore at the center of any discussion about who fiduciaries are and how they can and should behave. This Part traces the delicate balance back and forth between power and duty, discretion and restriction. Finally, I address special risks inherent to fiduciary relationships that involve large numbers of beneficiaries to emphasize the need to revise the existing system of accountability.

### A. Fiduciary Powers

A clear definition of the fiduciary role in American society is difficult to ascertain given the many different responsibilities and powers

that fiduciaries possess.<sup>9</sup> As Supreme Court Justice Murphy Frankfurter wrote:

[T]o say that a man is a fiduciary only begins analysis; it gives direction to further inquiry. To whom is he a fiduciary? What obligations does he owe as a fiduciary? In what respect has he failed to discharge these obligations? And what are the consequences of his deviation from duty?<sup>10</sup>

Thus, the heart of the fiduciary concept is the relationship between the fiduciary and the person who places his trust in that fiduciary (a beneficiary)<sup>11</sup> to accomplish a task. Generally, a fiduciary relationship forms when one party acts on behalf of another “while exercising *discretion* with respect to a *critical resource* belonging to the beneficiary.”<sup>12</sup> For example, fiduciary relationships arise because service providers—such as lawyers, doctors, or investment advisers—offer an expertise that is not common or easily obtained.<sup>13</sup> The parties to a fiduciary relationship set the initial terms and conditions under which the property or power will be shared by one with another. The law then enforces these terms or sets limits on what the terms may be.<sup>14</sup>

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9. The word “fiduciary” developed in nineteenth-century English courts to describe relationships of trust existing outside the formal legal meaning of that word as modern trust law developed to encompass specific agency relationships. See L. S. Sealy, *Fiduciary Relationships*, 1962 CAMBRIDGE L.J. 69, 70–71, 74–79 (seeking to narrow the typically broad definition of fiduciary relationships by classifying such relationships into four overlapping categories: (1) where a person has control of the property of another; (2) where a person is given a job by another; (3) where a person has limited or partial rights to property; and (4) where one person has undue influence over the other). Note the focus on the relationship between one individual and another, rather than institutional fiduciaries and multiple beneficiaries.

10. TAMAR FRANKEL, *FIDUCIARY LAW 2* (2011) (quoting *SEC v. Chenery Corp.*, 318 U.S. 80, 85–86 (1943)).

11. There are various terms used to refer to the person who places his trust in a fiduciary, such as a “principal” under agency law, a “beneficiary” under trust law, and a “participant” or “beneficiary” under ERISA. Professor Tamar Frankel coins the term “entrustor” for use in her articles and book that explore a unified concept of fiduciary law. I use the term “beneficiary” in this section since I discuss fiduciary law in general and the roots of ERISA in trust law. In discussions related to ERISA, I use the terms “participant” or “beneficiary.”

12. D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1402–04 (2002) (using the term “critical resource” to signify that many fiduciary relationships are not based on property but instead on another item “valued by the beneficiary,” such as confidential information).

13. These traditional relationships, including trustee/beneficiary, director/shareholder, and attorney/client, have been described as “formal,” while many “informal” relationships of trust have been defined as fiduciary without a clear explanation for when a relationship based on trust should rightly be called such. *Id.* at 1412.

14. FRANKEL, *supra* note 10, at 8 (providing as an example the entrustment of property, which may be considered a trust if the trustor reserves to himself a limited decision power, but may be classified as an agency if the trustor reserves to himself full control over the trustee’s decisions and performance of his services).

Attempting to provide concrete guidance, Tamar Frankel identifies three common characteristics of all fiduciary relationships: (1) “entrustment of property or power;” (2) trust of fiduciaries by those beneficiaries who provide them with property or power; and (3) risk to those beneficiaries.<sup>15</sup> This last element, which can also be called the “potential for opportunism,”<sup>16</sup> is the key to the creation of laws regulating fiduciary relationships because when the risk (or potential costs) of trusting fiduciaries becomes too high, these important relationships will not take place.<sup>17</sup> Laws are imposed to mitigate the risk involved with trusting another person and prevent harm to those who give their trust.

Some legal scholars who view fiduciary law as merely a species of contract law, however, seek to narrow the range of relations brought within the protective orbit of fiduciary law and the protections themselves. This might include a definition of fiduciary relationships that does not encompass broadly such relationships as those between doctor and patient or spouses.<sup>18</sup> Focusing only on financial relationships still provides a fiduciary with unwavering discretion to act through power delegated by the property owner.

As the discussion above illustrates, there is great debate over the proper definition of a fiduciary and the proper reach of fiduciary duties. When regulating different relationships of trust, lawmakers and courts choose who will fall into this fiduciary category. Lawmakers and courts also decide whether strict fiduciary protections are required or if the parties can be left to bargain amongst themselves. The extensive fiduciary regime of ERISA indicates the importance of the role of the fiduciary in our ostensibly private social welfare system. Congress decided to define “fiduciary” broadly and subject fiduciaries to stringent obligations because of the special vulnerability of

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15. *Id.* at 4 (explaining that, although the definitions of fiduciaries contain more detailed elements that distinguish one species of fiduciaries from another, these differences all derive from these three elements).

16. Smith, *supra* note 12, at 1444 (asserting that the “main focus in fiduciary duty cases is the potential for opportunism” on the part of the fiduciary, and explaining that “[w]hether the existence of a particular thing justifies the imposition of fiduciary duties . . . depends on whether that thing provides the fiduciary with the occasion to act opportunistically”).

17. Without an information asymmetry, there is no incentive to hire the fiduciary for his advice and services, but this very asymmetry requires regulation. Benjamin Cummings & Michael Finke, *The Economics of Fiduciary Investment Advice* (Sept. 1, 2010) (unpublished manuscript), *archived at* <http://perma.unl.edu/NB6Q-UEMF>.

18. Larry E. Ribstein, *Fencing Fiduciary Duties*, 91 B.U. L. REV. 899, 901 (2011) (explaining that his definition of a fiduciary as one who has “open-ended management power over property without corresponding economic rights” focuses on the particular type of entrustment that arises from a property owner’s delegation to a manager of open-ended management power over property by contract alone).

beneficiaries in this context. I therefore take as my starting point for ensuring sufficient accountability that an expansive definition of fiduciary is both appropriate and necessary, and that contract law provides insufficient protection for these relationships.

## B. Fiduciary Duties

Most discussions of fiduciary duties focus on the duty of loyalty and the duty of care.<sup>19</sup> Even if it is difficult at times to define precisely who is a fiduciary or what a fiduciary does, fiduciary obligations provide the reassurance necessary for these relationships of trust to occur. Private actors' behavior is limited by the fiduciary standards contained in a statute or set by common law, but standards necessarily sacrifice certainty in their application for flexibility to cover a variety of circumstances and prevent having to revisit a rule each time a new set of facts arises to which it is applied.<sup>20</sup> Much discretion, and therefore power, is placed in the hands of fiduciaries, as explained by legal theorist H. L. A. Hart:

It is a feature of the human predicament (and so of the legislative one) that we labour under two connected handicaps whenever we seek to regulate, unambiguously and in advance, some sphere of conduct by means of general standards to be used without further official direction on particular occasions. The first handicap is our relative ignorance of fact; the second is our relative indeterminacy of aim.<sup>21</sup>

The duty of loyalty requires that fiduciaries act solely in the interest of beneficiaries.<sup>22</sup> The duty requires that fiduciaries avoid self-interested behavior when "exercising *discretion* with respect to the beneficiary's *critical resources*."<sup>23</sup> The duty of loyalty also requires that the fiduciary adhere to instructions provided by the beneficiary,

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19. See Smith, *supra* note 12, at 1409–10 (asserting that fiduciaries are expected to be more careful about self-interested behavior than a party merely engaged in a contractual relationship with another because the fiduciary relationship is not limited by the four corners of the contract).

20. H. L. A. HART, *THE CONCEPT OF LAW* 124–28 (1961).

21. *Id.* at 125.

22. See RESTATEMENT (SECOND) OF AGENCY § 394 (1958) ("Unless otherwise agreed, an agent is subject to a duty not to act or to agree to act during the period of his agency for persons whose interests conflict with those of the principal in matters in which the agent is employed."); Ribstein, *supra* note 18, at 208–10 (asserting that this is the only true fiduciary duty and other related "non-fiduciary" duties, such as the duty of care, are implied in contract); Smith, *supra* note 12, at 1406–07, 1409 (arguing that fiduciary duty refers only to the duty of loyalty because "the duty of care is 'not distinctively fiduciary'"). Regardless of how one may define the concept of fiduciary duty using legal history, Congress defined fiduciary duty to include the duty of care under ERISA.

23. Smith, *supra* note 12, at 1402 (explaining that self-interested behavior constitutes a wrong when the fiduciary does or has something that is inconsistent with the beneficiary's interest in the critical resource).

act in good faith, and account to the beneficiary (disclose information).<sup>24</sup>

Disloyalty typically occurs when there is a conflict between the fiduciary's interests and the beneficiary's interests, but a conflict may also involve representing multiple beneficiaries with conflicting interests. Disloyalty can occur in three scenarios. First, the fiduciary may use his position (without the beneficiary's consent) to direct business opportunities to himself (self-dealing). For example, the fiduciary could pass himself off as the owner of the trust property and use it as collateral to purchase additional property. Second, the fiduciary might transact for the beneficiary with his or the court's consent but gain such consent due to inadequate disclosure. For example, the fiduciary may invest the beneficiary's assets with the beneficiary's consent but not tell the beneficiary that the company he is investing in is owned by the fiduciary's brother. Third, the fiduciary could transact with a third party in a way that implicates the beneficiary's interests, such as misappropriating an opportunity and pursuing "secret profits."<sup>25</sup> For example, imagine a buyer of real estate purchase a house from a seller through the seller's real estate agent. The agent, a fiduciary, may know that the price offered is above the seller's minimum sales price but choose to pocket the difference without informing the seller.<sup>26</sup>

Since delegating discretion to a fiduciary necessarily involves ceding control, the difficulty with penalizing breaches of the duty of loyalty is discovering them. A poor outcome (such as a negative return on investment) does not necessarily mean that the fiduciary has engaged in a self-interested act (such as misappropriating all or part of the value of property entrusted to the fiduciary). While the beneficiary can observe the outcome, because the outcome is based both on the fiduciary's act and chance, it is difficult to tell whether the fiduciary's act or chance caused the poor outcome.<sup>27</sup> In addition, the more effort the beneficiary must expend in monitoring a fiduciary to prevent a breach of this duty, the less reason there is for the existence of the

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24. FRANKEL, *supra* note 10, at 108, 122, 129. Although these duties are related to the duty of loyalty, they are frequently cited as distinct duties.

25. Robert Cooter & Bradley J. Freedman, *An Economic Model of the Fiduciary's Duty of Loyalty*, 10 TEL AVIV U. STUD. L. 297, 297-306 (1990) (explaining further that the duty of loyalty can be understood as a special set of rules designed to deter such behavior).

26. Deborah A. DeMott, *Disloyal Agents*, 58 ALA. L. REV. 1049, 1053 (2007) (stating that however the agency relationships among the parties may have been structured—the agent represented the seller, buyer and seller, or just the buyer—the conduct was disloyal).

27. Cooter & Freedman, *supra* note 25, at 300-01 (using a model to explain that "[t]he interaction of conduct and chance prevents the principal from inferring the agent's act with certainty" and, as a result, "the principal must guess whether the agent's act was other-regarding or self-regarding").

fiduciary relationship at all since the costs may begin to exceed the benefits.

Penalties for breach of the fiduciary duty of loyalty under common law seek to rectify this situation. The duty of loyalty carries remedies taken from the law of contracts, torts, restitution, and unjust enrichment.<sup>28</sup> If the only remedy were disgorgement of ill-gotten gains, given imperfect enforcement, there would still be a large incentive for the fiduciary to breach his duty. More is needed to deter improper conduct.<sup>29</sup> The aggrieved party need only demonstrate that the fiduciary's actions were a substantial factor in a loss to the beneficiary—a low threshold. Once this burden is met, the beneficiary may be entitled to punitive damages in addition to requiring the fiduciary to disgorge any gains received through improper use of the beneficiary's property (even if the beneficiary was not harmed at all by the breach).<sup>30</sup> The deterrent value of these remedies demonstrates the importance at law of preventing breaches of the fiduciary duty of loyalty.<sup>31</sup> The prohibitions on self-interested behavior by fiduciaries do not seek to prevent all self-dealing, however. Rather, they promote advance disclosure to the beneficiary so that he can make an informed decision on whether to consent to the transaction.<sup>32</sup> The fiduciary's ability to obtain advance consent and his ability to terminate the relationship soften the harshness of remedies for breach of the duty of loyalty.<sup>33</sup> The high cost of penalties for fiduciary breaches has not de-

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28. DeMott, *supra* note 26, at 1049.

29. Cooter & Freedman, *supra* note 25, at 304 (explaining that if the plaintiff, or principal, has the burden of detecting and proving the agent's breach of duty, the probability of a sanction will be low, which would cause the expected sanction to be less than the gain from wrongdoing). The lack of sufficient remedies for ERISA benefit claims has been criticized for exactly this reason.

30. DeMott, *supra* note 26, at 1056.

31. Remedies for incorrectly decided benefit claims under ERISA, however, are limited. See Katherine T. Vukadin, *Hope or Hype?: Why the Affordable Care Act's New External Review Rules for Denied ERISA Healthcare Claims Need More Reform*, 60 BUFF. L. REV. 1201, 1219 (2012) (citing *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456 (3d Cir. 2003) (Becker, J., concurring) (“[V]irtually all state law remedies are preempted [by ERISA] but very few federal substitutes are provided.”)).

32. Robert H. Sitkoff, *The Economic Structure of Fiduciary Law*, 91 B.U. L. REV. 1039, 1043 (2011) (“The aim [of procedural and substantive safeguards designed to enforce the duty of loyalty] is to induce the fiduciary either to refrain from self-dealing or to disclose the material facts of the transaction and how the fiduciary's conflict might compromise the fiduciary's judgment . . .”).

33. DeMott, *supra* note 26, at 1052–53. But see Donald C. Langevoort, *Psychological Perspectives on the Fiduciary Business*, 91 B.U. L. REV. 995, 1003 n.30 (2011) (discussing how disclosure may give fiduciaries “greater moral wiggle room” and result in greater acceptance of their advice among beneficiaries). Even when aware of a conflict of interest, beneficiaries rarely have full information about how that conflict has affected a fiduciary's advice, frequently discounting possible bias or at least exhibiting an increased tendency to accept the advice based on the

tered many from entering the field—providing fiduciary services has become a big business with big profits. As a result, there is frequently a culture at companies that serve as fiduciaries that motivates greed and self-dealing instead of ethical behavior.<sup>34</sup>

The second major fiduciary duty, the duty of care, requires fiduciaries to act “with prudence, attention, and proficiency” in providing their services.<sup>35</sup> Fiduciaries must have or obtain the information required to competently perform their tasks and act on such information after engaging in a reasonable deliberative process.<sup>36</sup> The performance of a fiduciary with specialized training and skills is measured by the standard of what a “reasonable or prudent person” with those skills would have done in the same circumstances.<sup>37</sup> This standard does not hold fiduciaries liable for mistakes or unfavorable outcomes but instead for failing to complete their duties in a professional manner.<sup>38</sup>

Measuring performance, however, is difficult. Even courts must rely on other experts to judge fiduciaries’ performance.<sup>39</sup> As with the duty of loyalty, it is difficult to determine whether the fiduciary has

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existing relationship of trust. Although an experiment by Bryan Church and Xi (Jason) Kuang, see Bryan K. Church & Xi (Jason) Kuang, *Conflicts of Interest, Disclosure, and (Costly) Sanctions: Experimental Evidence*, 38 J. LEGAL STUD. 505 (2009), finds that disclosure and the threat of sanctions in the financial adviser/advisee context resulted in less biased advice by the adviser and better evaluation of that advice by advisee, their experiment models sanctions as costly for the beneficiaries but certain to result in punishment where the fiduciary engages in bad behavior. The experiment also assumes the advisee has complete freedom regarding whether to invest or not and that the relationship is a one-time interaction—an unrealistic scenario because pension plan participants, for example, do not choose the plan’s financial adviser(s), and most adviser/advisee relationships involve repeated interaction. Langevoort, *supra* note 33, at 1003 n.30.

34. Langevoort, *supra* note 33, at 995 (“It is thus worth thinking hard about what the favored traits are in the fiduciary business and how they interact with—and easily frustrate—the law’s efforts to insist on fiduciary responsibility from those who are, in heart and soul, salespeople.”).
35. FRANKEL, *supra* note 10, at 169. Like Ribstein and Smith, William A. Gregory argues that the duty of care is not a fiduciary duty at all but instead a negligence concept that has been conflated with the fiduciary duty of loyalty by courts and legal scholars. See William A. Gregory, *The Fiduciary Duty of Care: A Perversion of Words*, 38 AKRON L. REV. 181, 183 (2005) (“To describe negligent acts as being breaches of fiduciary duty is misleading, because a breach of fiduciary duty ‘connotes disloyalty or infidelity. Mere incompetence is not enough.’”). Gregory’s point is that only duties that are unique to the fiduciary role are fiduciary duties. Instead, he argues that the duty of care always falls under tort law. *Id.* at 188.
36. Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1062 (1991) (“Successful management of an asset requires judgment, and the fiduciary’s duty of care applies to the process of making this judgment.”).
37. Sitkoff, *supra* note 32, at 1044.
38. FRANKEL, *supra* note 10, at 170–74.
39. *Id.*

used “reasonable” effort based on outcome since, in the absence of disloyalty, a poor outcome can result from either poor effort or chance.<sup>40</sup> Courts typically evaluate the “process” used by the fiduciary to fulfill his role.<sup>41</sup> Unscrupulous intent is not required to find a breach of this duty.<sup>42</sup>

My focus in this Article is on the duty of loyalty because it is more likely to result in systematic erroneous denials of benefit claims. Improper decisions on benefit claims due to breaches of the duty of care should result in both false positives (granting claims that should have been denied) and false negatives (denying claims that should have been granted). These errors should cancel out and not produce overall bias against participants and beneficiaries or a subset of participants and beneficiaries, such as the poor or racial minorities who are perhaps less likely to appeal incorrect decisions (though we lack data on the numbers and types of claims denied and subsequently appealed).<sup>43</sup>

### C. The Expanding Fiduciary Role

Traditionally, fiduciary relationships occurred between one fiduciary and one or a small number of beneficiaries.<sup>44</sup> Thus, the rules designed to hold fiduciaries accountable developed in this context and did not contemplate the rise of less personal and direct relationships

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40. Cooter & Freedman, *supra* note 36, at 1056–57; see Arthur B. Laby, *Resolving Conflicts of Duty in Fiduciary Relationships*, 54 AM. U. L. REV. 75, 119 (2004) (“Whether the trustee is prudent in the doing of an act depends upon the circumstances as they reasonably appear to him at the time when he does the act and not at some subsequent time when his conduct is called in question.” (quoting RESTATEMENT (SECOND) OF TRUSTS § 174 cmt. b (1959))).

41. Laby, *supra* note 40, at 117.

42. *Id.* at 109. Professor Arthur Laby argues that the negative duty of loyalty trumps the positive duty of care. This emphasizes the importance of trust in the relationship between fiduciary and beneficiary rather than the quality of services provided. One example of how the two duties can conflict in the ERISA context was faced by Enron directors who also served as administrators of the company’s ERISA plans that invested in company stock. The court found that the plaintiffs stated a claim for breach of the fiduciary duty of loyalty to ERISA plan participants even though any disclosure of the company’s precarious financial condition by the directors would arguably have violated their fiduciary duty of care to the company. *Id.* at 141–45.

43. When I mention “improper,” “erroneous,” or “incorrect” decisions by fiduciaries of benefit claims, I include not just clear errors but all decisions that are part of a concerted effort to ensure that all close calls or decisions based on ambiguous or vague plan terms are decided in the administrator’s or employer’s favor. If bias as a result of a financial conflict of interest were not at play, I would expect to find that half of such claims are granted and half are denied. Given my focus on collective fairness and justice, I consider these decisions improper, erroneous, and incorrect.

44. See Sealy, *supra* note 9 (discussing traditional and modern fiduciary relationships in the context of relationships between A and B).

between institutional fiduciaries and large numbers of beneficiaries that exist today.

Yet the rise of the modern corporation with its larger workforce and the parallel move of workers from the farm to the city resulted in fiduciaries performing tasks for an ever-growing number of beneficiaries. It also resulted in the growth of institutional fiduciaries, providing services to both corporations and hundreds or thousands or beneficiaries.

The growth of modern employee benefits contributed substantially to the expanding role of the fiduciary. As private pension plans became increasingly attractive to industrial workers left without the family support of an agrarian society (and to businesses seeking to push older, less productive workers out of the workforce), employers outsourced plan design and maintenance—including investment advice.<sup>45</sup>

However, common law restraints on fiduciaries were a poor fit for these new, institutional fiduciary/mass beneficiary relationships that developed to provide a valued safety net to workers. Early on, pension benefits were considered a gratuity, and even as the courts began to recognize pension rights fiduciaries successfully found ways to opt out of liability—not to mention the many individuals and entities involved in pension plan administration who were not considered fiduciaries at all.<sup>46</sup> Scandals arose surrounding improper management of pension funds and broken promises to workers.<sup>47</sup>

Typically, as the number of beneficiaries increases, the total amount of property (e.g., money) that the fiduciary is responsible for increases. As is often the case, with more money comes more power for the fiduciary. Among other responsibilities, fiduciaries select service providers to help manage assets, such as lawyers and investment advisers. These third parties compete to please the fiduciaries that hire them—not the beneficiaries who own the assets or rights to the

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45. Plans consulted actuaries, lawyers, and investment managers who remained loyal to the employers that hired them. These consultants largely customized pension plans to suit the needs of employers rather than employees. See STEVEN A. SASS, *THE PROMISE OF PRIVATE PENSIONS: THE FIRST HUNDRED YEARS 156–78* (1997) (quoting pension consultants that argue “[a]ny course of action which leads to a stronger company, better able to weather occasional financial reverses, and to meet competition, may enhance the security of the employees as a whole . . .”).

46. See, e.g., Lauren R. Roth, *A Failure to Supervise: How the Bureaucracy and the Courts Abandoned Their Intended Roles Under ERISA*, 34 *PACE L. REV.* 216, 220–33 (2014) (reviewing courts’ treatment of pension promises prior to ERISA).

47. See SASS, *supra* note 45, at 192 (discussing investigations during the 1950s into mismanagement of pension funds by labor union officials). This disjuncture between common law fiduciary duties and the needs of workers eventually resulted in the passage of ERISA, which included an expanded definition of who was considered a fiduciary.

assets. Two consequences are: (1) externally, it becomes difficult for those doing business with a fiduciary to distinguish whether he manages the assets or owns the assets and (2) internally, each beneficiary's control over the fiduciary is weakened because of the small share of his ownership.<sup>48</sup> The first consequence leads to greater temptation to breach the duty of loyalty, as discussed above, and an increased ability to do so given his apparent ownership of the assets managed. My focus, however, is the distinct difficulty in controlling the fiduciary internally as the number of beneficiaries increases.

Acting as a fiduciary to a large number of beneficiaries is a public-service role even when performed by supposedly private actors. In a 1995 article, Frankel defines "public fiduciaries" as those engaged in "commercial relationships, that is, mass-produced, non-personal relationships with numerous public [beneficiaries]" and "private fiduciaries" as only those in relationships with few beneficiaries.<sup>49</sup> She identifies two categories of public fiduciaries: (1) fiduciaries who manage large pools of assets for efficiency (e.g., pension fund managers) and (2) fiduciaries to entities owned by many beneficiaries (e.g., directors of public corporations).<sup>50</sup> The first category, which I focus on in this section, is typically regulated by law as private fiduciaries. I define public fiduciaries to include only government actors (e.g., congressmen or employees of government agencies) and not fiduciaries to mass amounts of beneficiaries to tease out the differences between private parties supplying services to the mass public and government actors doing the same. Frankel's terminology, however, indicates the easy comparison between her public fiduciaries and government actors and the extent of the powers held by fiduciaries in relationships with many beneficiaries.<sup>51</sup>

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48. FRANKEL, *supra* note 10, at 11 (explaining that these consequences are the reason that fiduciaries that serve numerous beneficiaries in a standardized manner acquire power that is greater than the power of fiduciaries that serve individuals, even if the individual beneficiaries are very wealthy).

49. Tamar Frankel, *Fiduciary Duties as Default Rules*, 74 OR. L. REV. 1209, 1251–52 (1995).

50. *Id.* at 1252 n.117.

51. The Founding Fathers were acquainted with fiduciary law. See David L. Ponet & Ethan J. Leib, *Fiduciary Law's Lessons for Deliberative Democracy*, 91 B.U. L. REV. 1249, 1254 n.34 (2011) (providing a list of writings by the Founding Fathers in which they discuss fiduciary law and the government's role in preserving property rights). They therefore set forth the terms governing public fiduciaries' performance of their duties just as the parties to a private fiduciary relationship agree on basic terms to govern their relationship. FRANKEL, *supra* note 10, at 281–82. At the federal Constitutional Convention in 1787, many delegates espoused "ideals of fiduciary government," drawing on concepts already contained within state constitutions. Robert G. Natelson, *The Constitution and the Public Trust*, 52 BUFF. L. REV. 1077, 1084 n.19 (2004) [hereinafter Natelson, *Public Trust*] (citing THE FEDERALIST NO. 49 (James Madison)). This comparison of public officials and private fiduciaries is known as the public trust doctrine. See *id.*

Frankel recognizes that fiduciaries who provide services to a large number of beneficiaries have significant power because the beneficiaries are “rationally passive,” meaning that the cost for an individual beneficiary to monitor a fiduciary exceeds the small benefit to the beneficiary that results because of his small share of ownership.<sup>52</sup> A fiduciary managing property for many beneficiaries cannot be subject to the direction of each beneficiary on a daily basis—that would make managing the property impractical and defeat the purpose of centralizing management to increase efficiency. With a large number of beneficiaries, it is more likely that each has a small financial interest and will not rationally expend the large amount of time, effort, and money necessary to monitor or remove the fiduciary for the entire group and will instead “free ride” on the effort of any active investors.<sup>53</sup> “A fiduciary managing \$500 million for one [beneficiary] has far less power than a fiduciary managing the same amount for 50,000 [beneficiaries].”<sup>54</sup> Fiduciaries controlling the property of a large number of beneficiaries also have more power to affect the economy and financial order of our society. If beneficiaries feel powerless to control bad behavior among fiduciaries—if, for example, strong legal standards do not restrict fiduciary malfeasance—they may withdraw from the system entirely.<sup>55</sup> Frankel argues that the more beneficiaries, the more strict regulation of fiduciaries and remedies for breaches of these rules should be.<sup>56</sup>

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at 1087; Robert G. Natelson, *The Government as Fiduciary: A Practical Demonstration from the Reign of Trajan*, 35 U. RICH. L. REV. 191, 192 (2001) (“We are the trustees and agents of our fellow citizens.” (quoting Grover Cleveland)). The public trust doctrine, as set forth by Robert G. Natelson but nowhere formally required of elected officials, includes: (1) a duty to follow instructions, such as those outlined in the Constitution; (2) a duty of reasonable care; (3) a duty of loyalty; (4) a duty of impartiality, which requires that public officials not favor one group of citizens over another; and (5) a duty to account for their actions, including remedying harm (although this is limited in the case of public officials). Natelson, *Public Trust*, *supra* note 51, at 1088, 1091. The parallels between the duties owed by a private fiduciary, as discussed above, and the duties owed by a public fiduciary are clear.

52. Frankel, *supra* note 49, at 1252–53.

53. *Id.* at 1256; *see generally* MANCUR OLSON, *THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS* (1971)

54. Frankel, *supra* note 49, at 1257. One interesting point about the rational passivity of beneficiaries participating in these mass fiduciary relationships is that the larger the number of beneficiaries gets, the less incentive each individual beneficiary has to monitor the fiduciary or to attempt to influence the relationship. Ironically, the larger the number of those with health insurance, the less power each insured has with respect to his or her benefit claims (assuming the number of players providing insurance does not increase proportionately).

55. *Id.* at 1259–60.

56. Tamar Frankel, *Fiduciary Law in the Twenty-First Century*, 91 B.U. L. REV. 1289, 1297 (2011). There is an inverse relationship between private and public fiduciary power, however, once Congress decides to regulate a particular field.

With respect to the nature of the mass fiduciary role, not only are these mass fiduciaries more difficult to control than fiduciaries involved in more typical agency relationships because of the need to centralize management and gain distance from individual beneficiaries, but exit from the relationship is also more difficult.<sup>57</sup> On this first point, institutional fiduciaries are now hired to serve large numbers of beneficiaries precisely because they can streamline administration and save costs. The cost-saving motivation of necessity prioritizes efficiency over personal contact and a focus on the overall needs of the plan instead of the needs of individual beneficiaries. On the second point, where the employer or health insurance company sponsoring or administering a health insurance plan selects the fiduciaries and the decision is not up for a vote or individual input, exit involves switching employers or health insurance plans—a decision with other costs and drawbacks. Finally, the last reason the nature of the mass fiduciary relationship results in greater power for fiduciaries is that they design the package of services they provide themselves instead of the more customized agency relationships of fiduciary law.<sup>58</sup> Since beneficiaries traditionally entered into relationships with fiduciaries to accomplish their own goals, they outlined the basic details of the relationship. Now, however, fiduciaries do more than decide how to accomplish the tasks set forth by the beneficiaries—they design the parameters of the relationships themselves.

In addition to the general risk to all beneficiaries where a fiduciary has greatly increased power, there is also a risk to beneficiaries that the fiduciary will prefer the interests of some beneficiaries over others. The fiduciary has many different principals to respond to—and it is often an impossible task to give all the beneficiaries, who will often have conflicting goals and desired strategies, what they want. As a result, under trust law, fiduciaries have a duty of impartiality when dealing with various beneficiaries of a pool of assets managed by the fiduciary.<sup>59</sup> This duty falls within the duty of loyalty discussed

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An increase in private power comes at the expense of public control, and Congress ceded significant control over health insurance to private actors. The excesses of private fiduciary power in a time of limited regulation, as we have seen recently, frequently result in increased government control in response. See FRANKEL, *supra* note 10, at 285. For example, the well-known corporate governance failures in the Enron scandal resulted in the passage of the Sarbanes-Oxley Act in 2002. Therefore, the pendulum may swing back in the future, and Congress can retake some of the power over social welfare benefits. See *id.* at 286.

57. See Frankel, *supra* note 49, at 1253–54 (“Even if public fiduciaries are expected to act as agents, they cannot be subject to the control or unlimited power of removal by their principals.”).

58. *Id.*

59. Although the duty of impartiality traditionally referred to the fiduciary’s duty to consider both life and remainder interests in trust property, see John H. Langbein, *Why Did Trust Law Become Statute Law in the United States?*, 58 ALA.

above.<sup>60</sup> At its most basic level, any payment from the pool of assets harms the interest of the other beneficiaries by reducing the pool of assets, and the fiduciary must decide who has the right to payment in different circumstances.<sup>61</sup>

Building on Frankel's argument that a fiduciary to a large number of beneficiaries has more power and takes on a public role and the traditional duty of impartiality, I argue that there is a need for a new framework that distinguishes the responsibilities of fiduciaries based on the number of beneficiaries they serve. The modern, institutional nature of fiduciaries in these mass beneficiary relationships and the resulting distance between fiduciary and beneficiary only heightens the need for a new framework that ensures collective accountability to all beneficiaries (and to the public since the services of the fiduciary are subsidized by tax exclusions and deductions).

### III. THE FAILURE TO HOLD THE EXPANDING FIDUCIARY ACCOUNTABLE UNDER ERISA

ERISA formalized nearly a century of public-private relationships by systematically regulating pension promises made by employers to employees for the first time.<sup>62</sup> ERISA was designed to protect workers from the insecurities of a private pension system while simultaneously encouraging the growth of that private system.<sup>63</sup> After all, protecting employee expectations of receiving pensions would be

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L. REV. 1069, 1075 (2007), the duty is equally applicable for trusts that manage assets owned by large numbers of beneficiaries. RESTATEMENT (THIRD) OF TRUSTS § 79 (2003) ("A trustee has a duty to administer the trust in a manner that is impartial with respect to the various beneficiaries of the trust . . .").

60. DeMott, *supra* note 26, at 1054; Daniel Fischel & John H. Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. CHI. L. REV. 1105, 1109 (1988). ERISA ignores impartiality and instead emphasizes that fiduciaries must act in the best interest of participants—implicitly assuming that those participants share common interests. The Revenue Act of 1921 first introduced the exclusive benefit rule, or the idea that an employer creating a pension plan had to set up a trust for the exclusive benefit of employees, into the American private pension system. ERISA continues this same rule. *Id.* at 1109. Fischel and Langbein, however, show that it is foolish to assume all pension plan participants, for example, have common interests. They detail typical conflicts, such as that between older and younger workers over the extent to which employers should provide compensation in the form of pension benefits at all and the conflict between active employees and retirees. ERISA's exclusive benefit rule does not sufficiently explain how to balance these competing interests, and over a decade after the passage of ERISA, Fischel and Langbein argued for the incorporation of the trust law duty of impartiality into pension law. *Id.* at 1120–21, 1159–60.

61. Fischel & Langbein, *supra* note 60, at 1128–29.

62. JENNIFER KLEIN, *FOR ALL THESE RIGHTS: BUSINESS, LABOR, AND THE SHAPING OF AMERICA'S PUBLIC-PRIVATE WELFARE STATE* (2003); Stevens, *supra* note 6.

63. HACKER, *supra* note 6.

meaningless if employers stopped offering pension plans because of onerous regulations.<sup>64</sup>

What many outside the field do not know is that ERISA also governs group health plans. While including little in the statute specific to health plans, Congress included a broad preemption clause within ERISA that made state insurance laws inapplicable to ERISA plans. More and more employers now self-insure to fall within ERISA's favorable boundaries.<sup>65</sup>

Every day, ERISA fiduciaries make decisions about whether to grant one participant's claim for benefits or change one rule about how one benefit plan will be administered. ERISA sanctions their right to make these decisions. In the aggregate, these decisions make policy. The issue that remains many decades later is accountability—who determines whether these private actors are behaving as desired; how compliance is measured, meaning what the standards are to which they are supposed to adhere and how deviation is determined; and what the consequences are if the private actors fail to behave as desired. In this Part, I show that the application of these accountability principles to ERISA does not result in sufficient accountability to the many participants and beneficiaries in ERISA plans and therefore requires a new framework.

#### A. Holding Private Actors Accountable: The Role of Congress

If bureaucratic structure and oversight is heavily debated when Congress delegates to government actors, then structuring delegations to private actors deserves at least as much attention.<sup>66</sup> My goal here is not to debate the wisdom of delegation in general or in the case of ERISA specifically,<sup>67</sup> but instead to focus on the importance of legis-

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64. "Based on the sheer number of lives touched, the passage of ERISA is arguably the third 'big bang' of the American welfare state" after Social Security and Medicare/Medicaid. HOWARD, *supra* note 6, at 77. By 1974, nearly 31 million Americans were covered by a private pension plan, and today, roughly one-half of private workers participate in an employer-sponsored retirement plan. Irena Dushi & Howard M. Iams, *Pension Plan Participation Among Married Couples*, 73 SOC. SEC. BULL. 45, 45-52 (2013); JOHN W. THOMPSON, BUREAU OF LAB. STAT., DEFINED BENEFIT PLANS AT THE DAWN OF ERISA 1 (Mar. 30, 2005), *archived at* <http://perma.unl.edu/BQC5-9R7C>.

65. *See infra* section II.C.

66. In this section, I discuss congressional delegation to private fiduciaries and not the agency relationship between fiduciaries and beneficiaries. The parallels of the two agency relationships are clear, however.

67. *See generally* THEODORE J. LOWI, THE END OF LIBERALISM: THE SECOND REPUBLIC OF THE UNITED STATES (1979).

lative and judicial tools to control private fiduciaries used by Congress to achieve public goals.<sup>68</sup>

Delegation involves risks:

The opportunism that generates agency losses is a ubiquitous feature of the human experience. It crops up whenever workers are hired, committees are appointed, property is rented, or money is loaned. The message that we are all feckless agents of a Divine Principal is at the very heart of Judeo-Christian theology.<sup>69</sup>

In addition to outright theft or self-dealing, delegation can result in shirking and slippage. While an agent pays the cost for hard work in time (if not money), the reward goes mainly to the principal. An agent may therefore “shirk”—or exert less effort—to complete the delegated task, resulting in slippage—or the gap between what the principal wants done and how the agent completes the task. Because monitoring involves costs, a principal must weigh the benefits of monitoring (reduced shirking and slippage) against these costs.<sup>70</sup> Some amount of slippage is inevitable at each point of delegation and oversight (e.g., when citizens delegate to government, when the legislature delegates to the bureaucracy or private actors, or when the courts or Congress hold hearings regarding complaints about the agent’s behavior).<sup>71</sup>

Government faces the same basic principal-agent problem when delegating to private actors. But government delegation to private actors instead of the bureaucracy presents unique difficulties for policy implementation.<sup>72</sup> Beyond the classic notion that firms are motivated by maximizing profits making it difficult to align their goals with those of Congress, the voluntary nature of the relationship between principal and agent in this case affects Congress’s ability to control its agents.<sup>73</sup> The literature is now moving toward an exploration of how Congress can control private actors (or at least hold them accountable)

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68. See Terry M. Moe, *The Politics of Bureaucratic Structure*, in *CAN THE GOVERNMENT GOVERN?* 267 (John Chubb & Paul Peterson eds., 1989).

69. D. RODERICK KIEWIET & MATHEW D. McCUBBINS, *THE LOGIC OF DELEGATION: CONGRESSIONAL PARTIES AND THE APPROPRIATIONS PROCESS* 5 (1991).

70. Terry M. Moe, *The New Economics of Organization*, 28 *AM. J. POL. SCI.* 739, 750–51 (1984).

71. Terry M. Moe, *Political Institutions: The Neglected Side of the Story*, 6 *J.L. ECON. & ORG.* 213, 231 (1990).

72. See Gillian E. Metzger, *Privatization as Delegation*, 103 *COLUM. L. REV.* 1367, 1462 (2003) (“A central characteristic of much government privatization is that private delegates are granted powers not simply for their own advantage, but rather to enable them to act—and more specifically, to interact with third parties—on the government’s behalf.”). These private actors have additional power based on the importance of the services they provide and the imprimatur of the government. *Id.* at 1463–64.

73. Jessica F. Green, Presentation at the Viterbo III Seminar on Global Administrative Law, *Delegation to Private Actors: A Study of the Clean Development Mechanism* (June 15–16, 2007).

when it decides to delegate to them. Accountability is “the most difficult issue when governance is provided by private actors.”<sup>74</sup>

The first step when exploring a method of holding private actors with delegated powers accountable is to define accountability. Jerry Mashaw supplies a framework:

[W]e should be able to specify at least six important things: *who* is liable or accountable *to whom*; *what* they are liable to be called to account for; *through what processes* accountability is to be assured; *by what standards* the putatively accountable behavior is to be judged; and, what the potential *effects* are of finding that those standards have been breached.<sup>75</sup>

I provide Mashaw’s framework here because it is both general enough to apply to all delegations to private actors and comprehensive enough to evaluate existing and proposed fiduciary regimes used as accountability mechanisms (including under ERISA).

When the policy space is very complex, as with health insurance regulation, grants of power are necessarily broad and provide private actors with great discretion. “Certain public problems . . . lend themselves to neither specific behavioral commands nor measurable outcomes.”<sup>76</sup> Congress typically sacrifices control to realize the benefits of bureaucratic expertise, and the same may be said for delegation to private actors. Facing a lack of access to information possessed by private actors, this delegation is at times an expedient and necessary strategy. Congress has used the strategy of delegation in areas of complex legislation and difficult political compromise for many years. In fact, leaving significant discretion to the private sector instead of burdening it with cumbersome regulation is frequently part of the political compromise.

The common law has been handling complex delegation issues under the classic principal-agent scenario for many years. Fiduciary law addresses the problems that arise when an agent enters into a fiduciary relationship with a principal—when the relationship triggers a higher level of protection because of the special vulnerability of the principal in the relationship. A conflict of interest exists here because the agent is tasked with ignoring his own interests in favor of those of another.<sup>77</sup> It is necessary to address, then, whether common

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74. Walter Mattli & Tim Büthe, *Global Private Governance: Lessons from a National Model of Setting Standards in Accounting*, 68 L. & CONTEMP. PROBS. 225, 227 (2005) (internal quotation marks omitted).

75. Jerry L. Mashaw, *Accountability and Institutional Design: Some Thoughts on the Grammar of Governance*, in PUBLIC ACCOUNTABILITY: DESIGNS, DILEMMAS AND EXPERIENCES 115, 118 (Michael W. Dowdle ed., 2006); see Jody Freeman & Martha Minow, *Introduction: Reframing the Outsourcing Debates*, in GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY 1 (Jody Freeman & Martha Minow eds., 2009).

76. Kenneth A. Bamberger, *Regulation as Delegation: Private Firms, Decisionmaking, and Accountability in the Administrative State*, 56 DUKE L.J. 377, 389 (2006).

77. Metzger, *supra* note 72, at 1463.

law or codified fiduciary standards are a sufficient means of holding private actors accountable.<sup>78</sup>

Regardless of whether fiduciary standards have ensured sufficient accountability in the ERISA context—and I find that they have not—I argue that the ACA has created a new opportunity to increase accountability under ERISA as it continues to expand the fiduciary role in health insurance and healthcare. I address Congress’ role because its passage of ERISA is the foundation of the issues I discuss below regarding whether each of the solutions I propose require further congressional action, and if so, what action.

### **B. Expanding the Definition of “Fiduciary”**

The main accomplishment of ERISA’s fiduciary provisions is that it expands the number and types of people and institutions defined as fiduciaries and subject to the strictures of fiduciary duties. ERISA requires every covered plan to “provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.”<sup>79</sup> In addition, ERISA states:

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.<sup>80</sup>

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78. ERISA is an example where Congress delegated substantial authority to private actors in a complex policy space and utilized fiduciary standards developed by courts under the common law to hold actors accountable. It is not the only example where fiduciary standards are used to hold private actors accountable. For example, the foster care system holds foster parents accountable for meeting their fiduciary duties under state common law. ERISA, however, has the benefit of greater transparency for research purposes since it was a significant federal statute where common law fiduciary standards were codified (showing intent to use fiduciary duties as part of an accountability regime) and copious legislative history exists. There are also several decades of evidence showing the effects of ERISA’s design, including federal case law.

79. ERISA § 402(a)(1), 29 U.S.C. § 1102(a)(1) (2012). The main difference between the House and Senate bills on fiduciary standards related to the definition of “fiduciary.” The House definition included not only those who managed plan assets but also anyone who had discretionary authority over plan administration. The conference committee staffers recommended the broader House definition, and the conferees agreed on June 18, 1974. *See* JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 257–58 (2005).

80. ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A) (2012). ERISA’s test of who is a fiduciary is a “functional” one—the work done for a plan by the person determines whether he or she is a fiduciary rather than the title or lack of title assigned to

Fiduciaries are subject to ERISA's fiduciary duties, which provide that:

[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) 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 in the conduct of an enterprise of a like character and with like aims; (C) by diversifying 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; and (D) in accordance with the documents and instruments governing the plan . . . .<sup>81</sup>

ERISA's broad definition of fiduciary allows for the "fractionalization of trusteeship."<sup>82</sup> While the commonly accepted definition of "trustee" is "the person holding property in trust," reflecting the notion of one person or entity managing the trust, ERISA's more complex definition allows management of the trust to be dispersed to numerous individuals and entities, recognizing that today the administration of benefit plans is typically split among and within institutions. With the vast sums of money involved in large pension and health plans, they frequently outsource management to: the actuaries, consultants, or insurance companies who design the plan; several financial services companies who manage the investment of plan funds; a bank who safeguards the funds; third-party administrators who decide claims and make payments; and lawyers, accountants, and actuaries who handle other daily administrative needs of the plan.<sup>83</sup>

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the party. An example given by the Department of Labor is illustrative. A plan may employ a person as a "benefit supervisor." If that benefit supervisor only calculates how large of a benefit to pay a participant based on the formulas set forth in plan documents and a superior has final authorization to confirm the benefit, then the benefit supervisor is not a fiduciary. If the person with the title "benefit supervisor" instead has final approval to determine the benefit amount of a participant when there is a disagreement as to how much the participant is entitled to under the plan documents, then the person is a fiduciary. 29 C.F.R. § 2509.75–8, D–3 Q (2008); see *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993) ("ERISA, however, defines 'fiduciary' not in terms of formal trusteeship, but in *functional* terms of control and authority over the plan."). Persons who merely perform administrative functions for the pension plan and have no discretion regarding management of the plan are not fiduciaries. 29 C.F.R. § 2509.75–8, D–2 Q ("[A] person who performs purely ministerial functions such as the types described above for an employee benefit plan [which include determining eligibility to participate in the plan, calculating benefits, and making recommendations to others regarding plan administration] within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary . . . .").

81. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1974).

82. JOHN H. LANGBEIN, SUSAN STABILE & BRUCE WOLK, *PENSION AND EMPLOYEE BENEFITS LAW* 516 (4th ed. 2006).

83. *Id.* at 516–17.

To enforce ERISA's fiduciary provisions, Congress authorized both criminal and civil penalties. The statute provides for civil action by plan participants and beneficiaries or the Secretary of Labor.<sup>84</sup> This private litigation remedy is designed to protect beneficiaries' rights through a review of fiduciary actions in the federal courts.

The most basic question to address when discussing ERISA's expansive fiduciary rules is why they were enacted at all. Stricter minimum vesting standards (i.e., rules regarding the time it takes for pension participants to qualify irrevocably for their benefits and not risk forfeiting those benefits upon job loss) and funding standards for pensions were needed because they did not previously exist—the government had allowed employers and employees to make their own pension bargains without setting any minimum terms. Judges had used states' common law of trusts, however, to enforce fiduciary obligations against trustees for many years. ERISA required that all plans be in the form of trusts but need not have preempted state trust law's application to benefit plans. So why was codification of the fiduciary rules necessary at all?<sup>85</sup> And how, if at all, did ERISA change those fiduciary rules based in trust law?<sup>86</sup>

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84. ERISA creates a private right of action as follows:

A civil action may be brought (1) by a participant or beneficiary . . . (B) 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 . . . (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan.

ERISA § 502(a), 29 U.S.C. § 1132(a) (2014).

85. There has long been a debate among legal scholars regarding whether the common law should be codified in all areas of the law. See Mark D. Rosen, *What Has Happened to the Common Law?—Recent American Codifications, and Their Impact on Judicial Practice and the Law's Subsequent Development*, 1994 WIS. L. REV. 1119, 1127 (“Codification refers to the legislative pronouncement of previously fluid judge-made law in an organized and authoritative form.”). Although the debate was at its height from the 1830s to the early 1900s, with those against codification carrying the day, significant codification occurred starting in the middle of the twentieth century. See *id.*; see also Gunther A. Weiss, *The Enchantment of Codification in the Common-Law World*, 25 YALE J. INT'L L. 435 (2000) (exploring how codification affects common law systems). Opponents of codification have traditionally argued that the common law adds needed “flexibility” that allows the law to adapt to changing facts and times, while proponents assert that unelected judges should not be making law. Rosen, *supra* note 85, at 1122–23.
86. Congress incorporated fiduciary standards from trust law into ERISA, which is why agencies and courts look to trust law for answers when ERISA is silent or ambiguous. John H. Langbein, *The Secret Life of the Trust: The Trust as an Instrument of Commerce*, 107 YALE L.J. 165, 168 (1997); see *Varity Corp. v. Howe*, 516 U.S. 489, 496 (1996) (“In doing so, we recognize that these fiduciary duties 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

In answer to the first question, codification was necessary because trust law was originally designed to respond to interfamilial gifts to a small number of people managed by neutral trustees. Codification was therefore necessary not to set in place an entirely new legal regime, but instead to adapt trust law to the employee benefit context.<sup>87</sup> In answer to the second question, ERISA expanded the fiduciary duties of trust law and made them mandatory for a larger number of people and institutions involved in the administration of a pension plan—refusing to let fiduciaries opt out of the expansive new duties for plan administrators.<sup>88</sup> Codification of common law fiduciary duties and attempted adaptation to the institutional fiduciary/mass beneficiary context was the first step towards a collective framework of accountability—and Congress was willing to take it.

ERISA codified the duties of loyalty and prudence from trust law but otherwise did not write existing trust law into the statute wholesale.<sup>89</sup> Instead, Congress intentionally relied on the courts to look to trust law to fill in its “skeletal” outline and adapt trust law to the

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Tire & Rubber v. Bruch, 489 U.S. 101, 110 (1989) (“ERISA’s legislative history confirms that the Act’s fiduciary responsibility provisions ‘codif[y] and mak[e] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts.’ Given this language and history, we have held that courts are to develop a ‘federal common law of rights and obligations under ERISA-regulated plans.’” (citations omitted)).

87. ERISA architect Senator Jacob Javits noted that trust law developed to deal with relationships involving a small number of beneficiaries and argued that “there is a very serious problem arising from the fact that at common law the definition of ‘trustee’ is quite narrow in scope, while in pension and welfare trust administration, the number of persons who handle and exercise control of the funds is much broader.” Javits stated that at common law:

These trusts usually involve but a single settler and, at most, a relatively small, well defined class of beneficiaries . . . . Clearly, this body of traditional trust law, vast as it is, must be applied quite differently to employee benefit plans which are the product of collective bargaining and may cover thousands of employees of many different employers.

S. 3589—Introduction to Employee Benefits Protection Act—Administration Bill to Amend the Welfare and Pension Plans Disclosure Act, 91st Cong., Cong. Rec. 7278–79 (Mar. 13, 1970) [hereinafter S. 3589].

88. Senator Jacob Javits stated that trust law permitted exculpatory clauses that helped fiduciaries avoid responsibility for breaching their duties, and this did not provide the security needed for pension plan participants. *Id.* at 7285–86. Ignoring the likelihood that savvy trustees could take advantage of those creating trusts, trust law historically permitted exculpatory clauses in trust formation documents that exempted trustees from liability for anything other than egregious conduct. *Collins v. Storer Broad. Co.*, 120 S.E.2d 764, 769 (Ga. 1961).
89. 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, 1319 (2003) (arguing that “the reach of trust-law principles in ERISA is far deeper and more controlling” than the courts often recognize but that ERISA adapted trust law to the employee benefit context).

employee benefits context.<sup>90</sup> Unable to compromise on thorny political issues, Congress punted to the courts to make resolving these issues unnecessary. Refusing to spell out each detail of the legal framework that would govern employee benefit plans also gave Congress flexibility when regulating a complex field that few understood and whose response to such regulations fewer could predict.<sup>91</sup> Adopting much of the trust-law framework saved Congress the time of having to generate and agree on a new regime while also providing the legitimacy associated with a well-established body of law.<sup>92</sup>

Changes to existing trust law were necessary to solve a few problems with the strict application of trust law to employee benefit plans and expand the definition of fiduciary.<sup>93</sup> A tougher problem with the application of state trust law to large-scale benefit plans was the conflict of interest between employers and employees, plan sponsors and participants. Although all fiduciary relationships involve some conflict of interest because a fiduciary must act for the interests of beneficiaries even where they directly oppose the fiduciary's interests, the fiduciary typically has not contributed any of the assets in the trust from his own pocket, nor is he paying to administer the trust. This is the issue that makes Congress's delegation risky and—according to some—requires that the government administer all pension and health funds. Congress decided that alterations to common law fiduciary protections at the time of codification could reduce the risk sufficiently to make delegation to these conflicted fiduciaries advisable, particularly since Congress had to balance the need to protect beneficiaries already participating in pension plans with the goal of encouraging the maintenance and growth of private pensions by employers.<sup>94</sup>

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90. *Id.* at 1325–26.

91. *Id.* at 1329.

92. *Id.* at 1328.

93. *See* *Varity Corp. v. Howe*, 516 U.S. 489, 496–97 (1996) (“We also recognize, however, that trust law does not tell the entire story. After all, ERISA’s standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection. . . . Consequently, we believe that the law of trusts often will inform, but will not necessarily determine the outcome of, an effort to interpret ERISA’s fiduciary duties. In some instances, trust law will offer only a starting point, after which courts must go on to ask whether, or to what extent, the language of the statute, its structure, or its purposes require departing from common-law trust requirements. And, in doing so, courts may have to take account of competing congressional purposes, such as Congress’ desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.” (citations omitted)).

94. ERISA’s drafters sought to prevent fiduciary disloyalty and poor management because pension plan sponsors frequently created and administered plans for

ERISA departs from trust law by allowing executives of the employer to serve as fiduciaries, even though trustees were traditionally professionals without any inherent conflicts of interest and employer representatives face inherent conflicts.<sup>95</sup> The plan may also be administered by one or more third parties hired by the employer to run the plan, resulting in another conflict of interest: a third party has an interest in pleasing the plan sponsor in order to retain the contract to administer the plan, but less interest in pleasing the participants who have no say in the selection of the plan administrator.<sup>96</sup> Congress recognized that allowing the plan sponsor to retain control over plan administration was necessary to encourage plan formation by helping an employer keep costs down through its hiring or retention of lower-cost parties to help administer the funds.

But Congress believed that mandatory fiduciary obligations would prevent employers from acting in their own interest and force them all—everyone involved in running the pension plans—to act in the interests of plan participants.

ERISA's fiduciary regime, which governs benefit denial cases, is also profoundly paternalistic. Precisely because ERISA subjects every employee benefit plan to ERISA's duties of loyalty, prudent administration, and "full and fair" internal review of benefit denials, we can be certain that Congress preferred these protective principles of ERISA fiduciary law [to freedom of contract].<sup>97</sup>

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their own benefit instead of participants'. Employers created benefit plans to shelter money from taxes or to invest in employer securities. Sponsors rarely had rank-and-file employees' well-being as their sole focus. Sponsors traditionally had the ability to control plan documents and make investments that served their business interests. For example, they could amend plans at any time to cut or eliminate benefits, and they frequently invested pension funds in real estate the company wanted to purchase or in loans to the company that carried low interest rates. Since sponsors were not required to disclose the plan's investments, forcing disclosure of "prohibited transactions" required timely and costly litigation by plan participants who were often uninformed and certainly less powerful than those running the plans. See SASS, *supra* note 45, at 205–07.

95. 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, 1326–27 (2007); see also ERISA § 408(c)(3), 29 U.S.C. § 1108(c)(3) (2012) ("Nothing in section 1106 of this title shall be construed to prohibit any fiduciary from . . . (3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.").

96. Langbein, *supra* note 95, at 1326.

97. *Id.* at 1329–30. Langbein takes issue with cases decided by Judge Posner that fail to acknowledge the inherent conflict of interest held by most ERISA plan administrators and instead argue that the relationship between administrator and participants is similar to that of any contractual parties standing on opposite sides of the table. Instead, Langbein asserts that ERISA's fiduciary protections do not permit the type of self-interested behavior allowed among contractual parties and instead protect participants from the clear conflict of interest of plan administrators who work directly or indirectly for the plan sponsor. *Id.*

Congress thus explicitly incorporated fiduciary standards into ERISA to hold those who administer private employee benefit plans accountable, but it did so under a framework focused on the individual rights of participants and beneficiaries under the terms of a particular benefit plan. There was no mention of a universal right to pensions or health insurance or consistent treatment of workers across employers.

### C. A Failure of Legal Accountability

As has been amply covered by scholars previously, efforts to force accountability under ERISA's provisions have been stymied by the courts to a large extent.<sup>98</sup> Courts have inappropriately compared private fiduciaries facing a clear conflict of interest between providing benefits and containing costs for employers and insurance companies to government bureaucrats making decisions about whether to grant social welfare benefits. The result has been lax review of fiduciary decision-making under an arbitrary and capricious standard of review and nearly unbridled discretion for these powerful figures in our public-private social welfare system. As Brendan Maher wrote:

ERISA's remedial system exemplifies the preference of many litigation reformers. It is a (1) mandatory, (2) no-damages, (3) private scheme of dispute resolution, subject only to (4) modest agency regulation, (5) feeble judicial oversight, and (6) no juries. . . . The irony is that ERISA, at the time of its passage, was hailed as a landmark protective statute.<sup>99</sup>

Prior to the passage of ERISA, courts first treated pensions as gratuities granted by generous employers—not money that workers had earned through deferred wages for long years of service.<sup>100</sup> Even as courts came to accept a theory of pension promises to employees as contracts, employees had a difficult time claiming their benefits.<sup>101</sup>

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98. See, e.g., James A. Wooten, *A Reflection on ERISA Claims Administration and the Exhaustion Requirement*, 6 DREXEL L. REV. 573, 575–76 (2014) (“In the sphere of claims administration, however, the governing rules—including the exhaustion requirement, deferential judicial review of claims denials, and the limitation of judicial review to the record developed as part of the plan’s claims process—create a regime that leaves participants and beneficiaries extremely vulnerable. . . . Here, then, is a set of rules that seems very ill adapted to the expectations and capacities of the people benefit plans exist to serve.”); Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 16 (1992) (discussing how legislative history shows Congress preempted state laws on benefit claims that were too strict and did not permit equitable remedies).

99. See Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 661–62 (2014) (discussing how instead of meeting ERISA’s goal of easy access to courts and broad remedies, the courts limited remedies and preemption left no other avenue for plan participants).

100. See Roth, *supra* note 46, at 221–25 (“Beginning in the late nineteenth century and lasting until the middle of the twentieth century, courts viewed pensions as gratuities (i.e., gifts) to be altered or withdrawn freely by employers.”).

101. *Id.* at 225–33 (“Most judges believed that they had no choice but to favor employers and strictly construe the terms of the pension plans that they drafted.”).

This historical view of pensions influenced ERISA common law in spite of congressional goals.

After ERISA, the federal courts charged with helping to hold fiduciaries accountable largely abdicated that role. They created a deferential standard of review for fiduciary decisions on benefit claims—overturning only arbitrary and capricious decisions instead of ensuring that claims were decided correctly. This allowed private actors the same discretion typically accorded to an agency decision maker.<sup>102</sup>

Courts also required that claimants exhaust a benefit plan's internal review procedures before pursuing their claims in court, although legislative history indicates that Congress wanted to create multiple avenues for claimants to seek redress and not erect additional barriers to relief.<sup>103</sup> Extra grievance procedures seem, therefore, not to have helped claimants successfully pursue their benefits but instead have kept claimants from meaningful review of their claims.

Yet few outside the discipline realize how dramatically the courts altered our healthcare landscape under ERISA as well.<sup>104</sup> This lenient standard of review applies to health plans subject to ERISA's strictures, and employers largely self-insure to gain access to this deferential standard of review through ERISA's preemption clause.<sup>105</sup>

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102. *Id.* at 257–62 (discussing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and its progeny).

103. *Id.* at 262–66 (“The current law pays little attention to ERISA’s central purpose of safeguarding benefit expectations. Indeed, it often seems perversely designed to thwart benefit expectations, for no better reason than judicial force of habit.” (quoting Conison, *supra* note 98, at 3)). *But see* Wooten, *supra* note 98, at 578–79 (discussing how former congressional staffers who helped draft ERISA, Bob Nagle and Frank Cummings, explained at a recent conference that they “had in mind an exhaustion requirement” at the time of the statute’s passage because of similar procedures used in labor law at the time).

104. *See* Maher, *supra* note 99, at 653 (explaining that ERISA’s remedies for benefit claims were far more restrictive than those available under state law likely because of “legal realism” since “[j]udicial extra-statutory concerns about the cost of health care, the lack of a suitable alternative to employment-based health insurance, and a profound skepticism toward the utility of remedy in general were significant, if not dominant, variables in reading ERISA as the judiciary has done”).

105. ERISA’s preemption clause allowed employers to avoid state regulation of healthcare and deny benefits to an increasing number of participants. WOOTEN, *supra* note 79, at 281. The clause declares that ERISA “supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan” with an exception for any law that “regulates insurance, banking, or securities.” 29 U.S.C. § 1144(a), (b)(2)(A) (2012). The “deemer clause” then prevents the application of these state insurance, banking, and securities laws to employee benefit plans. In the case of health plans, the deemer clause provides that an employee benefit plan will not be “deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance” for the purpose of state insurance laws. 29 U.S.C. § 1144(b)(2)(B); *see* WOOTEN, *supra* note 79, at 281.

Under ERISA, Congress sought to ensure that employees' expectations would be met and their rights secured.

Many additional employers turned to self-insurance as healthcare costs rose in the 1980s in order to fall under ERISA's preemption clause and lax standard of review for review of benefit determinations. The use of utilization review by third-party administrators (and through these third parties, employers) brought insurers into the doctor-patient relationship and determinations of appropriate healthcare treatments. The plans increasingly required pre-approval of costly tests and procedures. Self-insured employers did not increase their liability significantly because they used "stop-loss" policies to hedge against liability from benefit claims that exceeded a particular dollar threshold.<sup>106</sup>

Employers increasingly denied benefit claims through utilization review, while plan participants faced an uphill battle when appealing denials in court. At worst, the plan would have to pay the claim and attorney's fees after a lawsuit because courts also interpreted ERISA's remedies narrowly.<sup>107</sup> Scandals over bad faith denials of benefit claims were exposed slowly and called into question the involvement of ERISA fiduciaries in healthcare decisions.<sup>108</sup>

In *Pegram v. Herdich*,<sup>109</sup> the Supreme Court held that treatment decisions made by physicians employed by Health Maintenance Organizations (HMOs) are not even fiduciary acts under ERISA. Since HMOs are designed to contain health expenses by rationing medical care, the Court found that a provision giving physicians a financial incentive to deny treatment was not a fiduciary act.<sup>110</sup> While *Herdich* does not point to any particular treatment decision and thus argues purely that the conflict of interest inherent in the plan design is a violation of ERISA's fiduciary duties (an argument unlikely to succeed since ERISA fiduciaries commonly operate under a financial conflict of interest), the Court shows great deference to plan administrators who make "mixed eligibility and treatment decisions."<sup>111</sup>

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106. WOOTEN, *supra* note 79, at 281–83.

107. *Id.*

108. See Langbein, *supra* note 95, at 1317–21 (discussing the scandal over the Unum/Provident Corporation's long-term policy of denying valid disability benefit claims to increase profits).

109. 530 U.S. 211 (2000).

110. *Id.* at 221 ("Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so), any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk.").

111. *Id.* at 226; see *id.* at 229 ("The eligibility decision and the treatment decision were inextricably mixed, as they are in countless medical administrative decisions every day.").

I argue in this Article that the courts went astray in their review of fiduciary decisions under ERISA because they ignored changes in the fiduciary role as individual fiduciaries became institutional fiduciaries and individual beneficiaries became large numbers of beneficiaries. Basing decisions on traditional trust law as the relationship between fiduciary and beneficiary grew more attenuated was even more dangerous as the fiduciary relationship became less about property rights and more about access to healthcare.

#### IV. HOW THE ACA CONTINUES TO EXPAND THE FIDUCIARY ROLE

Although the ACA has generated dramatic controversy and many claim that it has gone too far in advancing a right to health insurance, any purported right to health insurance or healthcare is in its infancy. Just as private pensions were first treated by the courts as mere gratuities offered by generous employers, the provision of private health insurance is subject to so many conditions and qualifications as to make any “right” of little value without additional regulation.

Some scholars find that the ACA creates a statutory right to healthcare—a right that may or may not be “durable” depending on the implementation of the statute<sup>112</sup>—but they largely ignore the way in which the implementation of another protective statute with respect to social welfare benefits continues to dramatically restrict access to healthcare. The ACA does nothing to impede the discretion of ERISA fiduciaries who act as gatekeepers to benefits provided under many private group health insurance plans. Increased access is only meaningful if the role of fiduciaries as guardians of broad social welfare rights is acknowledged and they are properly supervised in recognition of their current conflicts of interest as representatives of businesses that seek to limit those rights for financial gain.

##### A. A Right to Healthcare

The Supreme Court’s analysis of the ACA has all the hallmarks of early jurisprudence on pension rights—a discussion of economics and costs with little mention of engineering a larger societal safety net or even protecting individuals. In *National Federation of Independent*

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112. Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 441 (2013) (arguing that only time will reveal whether the ACA is a superstatute and the right to healthcare therefore durable or—more likely in her view—a quasi-superstatute that struggles upon implementation); see Wendy K. Mariner, *Health Insurance Is Dead; Long Live Health Insurance*, 40 AM. J.L. & MED. 195, 214 (2014) (“The ACA is intended to provide near-universal health insurance coverage for the purpose of enabling Americans to obtain needed medical care. In this respect, health insurance performs a governance function by financing and distributing healthcare.”).

*Businesses v. Sebelius (NFIB)*,<sup>113</sup> the debate surrounding the ACA is framed as one regarding constitutionally acceptable methods of encouraging increased participation in our public-private health insurance system—not of a universal right to healthcare or even to health insurance.<sup>114</sup> In fact, while Congress dramatically increased the number of individuals eligible for affordable health insurance,<sup>115</sup> many are excluded from the new opportunities for health insurance provided by the statute—including prisoners and illegal immigrants.<sup>116</sup> Others will choose to pay the tax penalty rather than purchase insurance.<sup>117</sup> Thus, if a right exists, it is only meant to be enjoyed by large segments of society and is not a universal right, according to both Congress and the Supreme Court.

Chief Justice Roberts argues instead that the policy issue under the ACA's individual mandate is one of cost shifting since hospitals are required to pay for the care of the uninsured and then pass the costs onto insurance companies and from there to covered individuals through insurance premiums.<sup>118</sup> In her concurrence, however, Justice Ginsburg recognizes that the uninsured are typically denied impor-

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113. 132 S. Ct. 2566 (2012).

114. *Id.* at 2580 (“The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care.”); see Michael J. Graetz & Jerry L. Mashaw, *Constitutional Uncertainty and the Design of Social Insurance: Reflections on the Obamacare Case*, 7 HARV. L. & POL’Y REV. 343 (2013) (“The ACA case, then, is best understood as a legal attack on the means, but not the goals, of the health care legislation, even though, as we shall show, by inhibiting potentially achievable means for expanding social insurance, the Court may also have undermined the goals of expanding and modernizing our nation’s social-insurance protections.”); see also Mariner, *supra* note 112, at 201 (“The goal of making healthcare available to all (or virtually all) could only be financed through modern health insurance methods. Thus, the ACA cemented a broader social function for health insurance, employing it to serve the goal of access to affordable healthcare for all.”).

115. *NFIB*, 132 S. Ct. at 2585 (“In the Affordable Care Act, Congress addressed the problem of those who cannot obtain insurance coverage because of preexisting conditions or other health issues. It did so through the Act’s ‘guaranteed-issue’ and ‘community-rating’ provisions. These provisions together prohibit insurance companies from denying coverage to those with such conditions or charging unhealthy individuals higher premiums than healthy individuals.”).

116. 26 U.S.C. § 5000A(d) (2010).

117. *NFIB*, 132 S. Ct. at 2594, 2597 (noting the Congressional Budget Office estimated that four million people per year will choose to pay the penalty and forego insurance coverage, and that those who pay no income tax will not be subject to the penalty).

118. *Id.* at 2585 (“Congress estimated that the cost of uncompensated care raises family health insurance premiums, on average, by over \$1,000 per year.”); see Mariner, *supra* note 112, at 199 (arguing that “Americans treat healthcare like a necessity and a public good” instead of a typical insurance product because of this legal duty to treat patients in hospital emergency rooms).

tant primary care.<sup>119</sup> In this way, Ginsburg reminds us that the statute should be interpreted to help accomplish its broader social policy goals.

The Court does its best to view the ACA as a technical statute that makes modest changes to our present health insurance system instead of a dramatic reengineering of social welfare benefits. It seems to warn Congress to exercise caution in this area. In striking down the requirement that states expand Medicaid to cover those earning 133% of the poverty level or lose all Medicaid funding, Chief Justice Roberts asserts that the provision “accomplishes a shift in kind, not merely degree.”<sup>120</sup> As he states, under the provision, Medicaid “is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.”<sup>121</sup> Given that Congress can presumably enact such a national plan, though (and thought it had done so under the ACA), Justice Ginsburg in her concurrence questions whether “Congress must take the repeal/reenact [Medicaid] route” instead of merely amending the current statute.<sup>122</sup> By forcing a repeal to change Medicaid in the manner contemplated, Roberts prioritizes form over substance and undermines a right to healthcare.

Regardless of the avoidance of any discussion by Congress or the Supreme Court of a right to health insurance or healthcare, all agree that the goal and impact of the ACA is to dramatically expand the number of participants in the public and private health insurance systems. The larger the population with health insurance, the more likely that it will come to be viewed as a universal (or near universal right).<sup>123</sup> Wendy Mariner argues this point in her recent article and states that under the ACA, health insurance is equivalent to social

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119. *Id.* at 2611–12 (Ginsburg, J., concurring) (“The failure of individuals to acquire insurance has other deleterious effects on the health-care market. Because those without insurance generally lack access to preventative care, they do not receive treatment for conditions—like hypertension and diabetes—that can be successfully and affordably treated if diagnosed early on.”); see Mariner, *supra* note 112, at 200 (explaining that inclusion of preventive care in health insurance policies separates them from other forms of insurance where indemnity from predictable and regular expenses is not sought and would not be worth the cost because preventive health expenses help prevent larger future costs).

120. *NFIB*, 132 S. Ct. at 2605–06 (majority opinion).

121. *Id.* at 2606.

122. *Id.* at 2629 (Ginsburg, J., concurring) (“A ritualistic requirement that Congress repeal and reenact spending legislation in order to enlarge the population served by a federally funded program would advance no constitutional principle and would scarcely serve the interests of federalism.”).

123. Mariner, *supra* note 112, at 202 (“As more people are able to obtain health insurance, whether public or private, the idea of having health insurance becomes routine and expected. Because insurance is a means of spreading costs, the expectation of health insurance suggests that the cost of healthcare is a shared responsibility—at least to the extent of the benefits it covers.”).

insurance instead of a more typical insurance product.<sup>124</sup> Almost all Americans need healthcare, and almost all use it regularly.<sup>125</sup> Americans pay for the vast majority of their health expenses with direct payments from their health insurance companies to service providers, using insurance to purchase a product instead of seek reimbursement for losses. In this way, private benefits function like public benefits.<sup>126</sup> As Mariner states, “Intangible states of being, like going places and getting well, are not products that can be bought.”<sup>127</sup>

Mariner argues that this has two primary repercussions for the ACA. The first is how the law regulating health insurance plans needs to change. She assumes that legislation and regulation will increase and force health plans to comply with the new policy of near-universal access, even at the expense of the insurers’ own goals.<sup>128</sup> While a noble concept, this is simply not what happened in the aftermath of ERISA and there is no guarantee that the connection between access to health insurance and ERISA plans will result in increased regulation of ERISA-covered plans.

The other issue that using private insurance to meet the public goal of near-universal access leaves for ACA implementation is what benefits will be offered.<sup>129</sup> As Mariner admits, however, “Given the breadth of required coverage, the decisions most important to patients—exactly what treatment will and will not be paid for within the general categories—remain with the insurer.”<sup>130</sup> This is precisely the reason that fiduciaries hold so much power over access to healthcare and a new framework of accountability is needed that takes into account near-universal access and the resulting quasi-public nature of all health insurance.

My question stands as to whether the expansion of insurance is meaningful given the murky role of fiduciaries in a public-private system of ever-increasing size. As private actors stand guard over access

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124. *Id.* at 195–96 (“Health insurance is now so integrated into the healthcare system that we can no longer have one without the other.”).

125. *Id.* at 198 (noting that in 2009 only 1% of adults had never seen a healthcare provider and 82.5% had done so within the previous year).

126. *Id.* at 197 (citing the fact Americans used public and private health insurance to pay for 85.7% of health expenses to bolster this argument).

127. *Id.* at 198.

128. *Id.* at 204 (“[W]hen insurance is used to finance a goal like access to healthcare, the insurance contract or ‘product’ itself must be designed to achieve that goal, instead of other goals the insurer may prefer. . . . This means that legislation and regulations will increasingly shape the boundaries of health insurance coverage and pricing.”).

129. *Id.* at 206–09 (discussing the Essential Health Benefits required of health plans under the ACA).

130. *Id.* at 209.

to this right (whether present or future), the readiness of fiduciaries to serve the collective and protect this right is in doubt.<sup>131</sup>

## B. Fiduciary Gatekeepers for Healthcare

ERISA and its fiduciary mandates do not cover the health plans of all employees with employer-sponsored health insurance. Plans offered to employees and their dependents by religious organizations (church plans) and governments at all levels are excluded, as are government-run benefit plans such as Medicare and Medicaid.<sup>132</sup> A 2006 survey by the U.S. Census Bureau found that 82%, or 132.8 million of 161.7 million Americans with employer-sponsored health plans were participants or dependents in plans covered by ERISA.<sup>133</sup> Roughly 55% of those in plans covered by ERISA are subject to self-insured plans that are not covered by any state regulation as a result of ERISA's preemption clause.<sup>134</sup>

According to the Congressional Budget Office's April 2014 projections, six million nonelderly Americans will have gained insurance coverage through enrollment in the new federal and state exchanges by the end of 2014 as a result of the ACA (with fewer than half a million losing employment-based coverage).<sup>135</sup> By 2016, the projections increase to twenty-four million gaining coverage through the exchanges while seven million lose employment-based coverage (most of whom are presumably among those gaining coverage through the exchanges).<sup>136</sup> Regardless of any official right to healthcare or lack thereof, millions are gaining health insurance and, through this insurance, access to preventive healthcare instead of having to rely on emergency rooms.

Scholars conclude that the ACA will shift the provision of healthcare in several important ways that impact fiduciary law and ERISA. First, it "will shift influence over physicians' medical decisions towards group-based decision-making, and away from considerations that focus solely on an individual patient."<sup>137</sup> The use of "quality mea-

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131. Matthew, *supra* note 4, at 723 ("Expanding the role of fiduciary law in health policy will, I assert, determine the extent to which the government's reform will, in fact, 'still work for the people.'").

132. William Pierron & Paul Fronstin, *ERISA Pre-Emption: Implications for Health Reform and Coverage*, ISSUE BRIEF, (Emp. Benefit Research Inst., D.C.), Feb. 2008, at 1, 9, *archived at* <http://perma.unl.edu/BW5N-CB7R>.

133. *Id.* at 9, 11 (noting that the 132.8 million number may be slightly high because it includes church plan members who were difficult to identify and exclude).

134. *Id.* at 11.

135. CONG. BUDGET OFFICE, *INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT—CBO'S APRIL 2014 BASELINE*, at 3 tbl.2 (2014), *archived at* <http://perma.unl.edu/8VLR-2W5L>.

136. *Id.*

137. Matthew, *supra* note 4, at 743.

tures,” “clinical practice guidelines,” and new medical centers focused on care proven across large swaths of the population will accelerate this trend.<sup>138</sup> Second, organizations—rather than individual physicians—will now “control costs, quality, and access to health care.”<sup>139</sup> “[B]ecause the ACA reflects a socio-political shift towards focusing on the health of populations rather than only on the health of individual patients, fiduciary law must speak to the public health concerns of populations, not just individual patients.”<sup>140</sup>

The shifting focus to the health of larger populations instead of individuals is the latest manifestation of the problem presented by mass fiduciaries with insufficient accountability. Just as in the case of pension plan fiduciaries representing a diverse group of participants who value differently the tradeoff between current wages and future pensions, health plan fiduciaries represent a diverse population with differing health concerns and priorities. As Matthew states:

The question of who can represent the patient understates the reality that the patient is an aggregated population. This population is comprised of the employed and the unemployed; citizens and aliens; adults and children; the wealthy, the poor, and those in between; the young and the elderly; the very healthy and the very ill; and those of different racial, cultural, and religious backgrounds. In other words, the patients who consume health care are a collective principal population with divergent and sometimes competing interests.<sup>141</sup>

Perhaps the main reason for those who view the ACA as purely an exercise of cost shifting and containment to develop a better framework for mass fiduciary relationships in health law is because of the impact health care has on the economy and on society in other ways. From a financial perspective, 17.9% of GDP in this country was spent

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138. *See id.* (predicting that the ACA will reward use of “quality measures” and “clinical practice guidelines,” and “establish[] new centers to research, disseminate, and train practitioners to use innovative methodologies, technologies, and best practices that have been proven effective over time with diverse patient populations”).

139. *Id.* at 743. Note, however, that to a large extent this was already occurring under health insurance plans covered by ERISA.

140. *Id.* at 744; *see id.* at 769 (“Significantly, patients and their physician agents are increasingly less likely to be engaged in the one-on-one agency relationship that has provided the prototypical agency model. Today, the patient in the fiduciary medicine model must be seen as a member of a group of principals that distantly controls many different providers through various agency and sub-agency arrangements that includes payers, managed care organizations, hospitals, insurers, health plans, long-term care facilities, home health agencies, pharmaceutical firms and physicians. MCOs create networks to serve aggregated groups of patients who seek services through employers or other aggregating institutions. Employers go into the market to obtain insurance products on behalf of groups of employees.”). Although Matthew discusses the doctor-patient fiduciary relationship, these words are equally applicable to ERISA fiduciary law.

141. *Id.* at 769–70.

on healthcare in 2012.<sup>142</sup> While many consider that to be an unhealthy amount of expenditure that crowds out other sectors of the economy, a large percentage of our economy is currently reliant on health spending. If the beneficiaries of health insurance lose faith in fiduciaries as a result of improper accountability and conflicts of interest, an important economic sector may decline and certainly more money will be spent on regulation as the complaints become a groundswell of outrage. Preemptive fixes are likely to be far less expensive.

So, how do we fix the problems in our current fiduciary regime governing access to healthcare through private health insurance?<sup>143</sup> All of the solutions I propose in the next Part seek to fix the accountability framework through ERISA. National regulation of private health plans to date has occurred through ERISA. Rather than starting from scratch, it is more expedient to fix what is broken. Finally, the historic connection between the employment relationship and access to health insurance is what makes ERISA the proper place to locate expanded fiduciary duties for an expanded healthcare system, even as

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142. *Health Expenditure, Total (% of GDP)*, WORLD BANK, <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> (last visited Jan. 16, 2016), *archived at* <http://perma.unl.edu/EQJ4-WLS5>; see Victor R. Fuchs, *Why Do Other Rich Nations Spend so Much Less on Healthcare?*, THE ATLANTIC (July 23, 2014), <http://www.theatlantic.com/business/archive/2014/07/why-do-other-rich-nations-spend-so-much-less-on-healthcare/374576/>, *archived at* <http://perma.unl.edu/PS8Q-6KVS>.

143. Matthew, focusing on the healthcare itself instead of the access to such care, proposes a “fiduciary medicine model” as a framework for the implementation of the ACA. Matthew, *supra* note 4, at 718. One aspect of Matthew’s model is to make “all major participants in the health care industry” subject to fiduciary duties already existing in this field. *Id.* “[T]he fiduciary medicine model might reach beyond physicians and individual patients to require skill, competency, loyalty, and good faith from hospitals, home health agencies, pharmaceutical companies, nursing homes, employers, and a host of other agents.” *Id.* at 720.

In summary, the fiduciary medicine model is based on these four fundamental principles: first, agency is the primary fiduciary relationship that characterizes the treatment relationship between medical providers and their patients, thus agency law is the body of rules that should govern these relationships. Second, while the law of agency governs most medical treatment relationships, the law of trusts governs those health care relationships that dispose of property, such as the role of health plan administrators who collect premiums and pay claims. Third, fiduciary law provides the substantive and procedural legal rules needed to align the diverse interests of patients who enroll, subscribe, or are beneficiaries under contracts with integrated health care organizations. Fourth, when the state and federal governments manage health care markets as payers, regulators, educators, and researchers, the state owes fiduciary duties of loyalty, good faith, and due care to its citizens. Regulation based upon these seemingly straightforward four principles will hold providers and payers accountable to the underlying intent and objectives they have already articulated for themselves.

*Id.* at 785.

more individuals gain access to health insurance outside of employment.<sup>144</sup>

## V. A FRAMEWORK FOR THE COLLECTIVE FIDUCIARY

As more individuals and entities are brought within ERISA's fiduciary ambit as a result of ACA penalties for employers who do not offer health insurance, accountability will be difficult to come by unless changes are made. Under the ACA, "[P]rivate health insurance serves a function similar to that of worker compensation insurance, unemployment insurance, Social Security, and Medicare; that is to say, it ensures that those in need of assistance have access to a source of funding for that aid."<sup>145</sup> If private actors are to serve a public goal and forgo conflicting self-interest, a better system of accountability is needed. ERISA-covered health plans remain the main source of health insurance for the non-elderly. It is only through this lens that public goals can unite an insurance system cobbled together from public and private plans.

Scholars more often explore the issue of collective accountability through the lens of corporate law.<sup>146</sup> As Darian Ibrahim writes:

An individual focus does not allow a director to hide behind her fellow directors' compliance, but instead deems her singular breach of sufficient gravity to jeopardize the board's functioning and warrant legal sanctions. A collective focus, on the other hand, will serve to insulate any one director's wrongdoing provided the remaining directors complied with their fiduciary duties.<sup>147</sup>

Ibrahim's focus is on whether to hold the individual or a larger body accountable, not about the number of people to whom they are ac-

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144. See Maher, *supra* note 99, at 656 ("Because many more people were covered by employment-sponsored insurance rather than individual insurance, as a practical matter, ERISA has been much more significant in defining health insurance remedies than has state law."). Although Matthew identifies agency law as the appropriate basis for fiduciary obligations in healthcare, I find her arguments for the distinction of trust law and agency law in this case to be without any true effect in application. See Matthew, *supra* note 4, at 745–46 ("Agency principles delineate the full range of fiduciary relationships among providers, payers, administrators, health plans, employers, and insurers, and patients in the health care market . . ."). What she dubs property-based rights to health benefits under trust law can, and frequently do, prevent access to healthcare and impede the relationship of physician and patient.

145. Mariner, *supra* note 112, at 201.

146. See Darian M. Ibrahim, *Individual or Collective Liability for Corporate Directors?*, 93 IOWA L. REV. 929 (2008) ("More broadly, the unexplored question within fiduciary duty law is this: how are outcomes affected when, although all directors vote the same way, some do so in compliance with their fiduciary duties while others do not? Should director liability be assessed individually or collectively?"); Frankel, *supra* note 49, at 1254 (discussing how the market functions to regulate relationships involving corporate "public" fiduciaries even without default fiduciary duties—although she finds that regulation to be insufficient).

147. Ibrahim, *supra* note 146, at 933.

countable. Yet, in either case, a choice of a collective framework has important implications for an enforcement regime. In the context of health insurance and ERISA fiduciaries, this results in not only the similar question of who should be held accountable—the larger entities administering benefit plans or the individual fiduciaries who make the benefit determinations—but also what they should be held accountable for—incorrectly denying individual benefit claims or denying too many claims or comparable claims in the aggregate. It is the latter question that I think is of greater concern because only by focusing on this question can the end goal of near-universal access to healthcare be achieved.<sup>148</sup>

In the past, Congress and the courts provided little oversight of ERISA fiduciaries in part because of the need to persuade employers to provide employees with health insurance where there were no public programs to fill the gap and the market for individual insurance was weak.<sup>149</sup> With the growth of the exchanges under the ACA, this viable alternative means that government actors need to be less afraid that employers will stop offering health insurance to their employees and can stop bending over backwards to leave conflicted fiduciaries with open discretion when making benefit determinations.

The challenge then for any proposed revision to ERISA's fiduciary framework is to balance responsibility to the individual whose benefits are in question with responsibility to the larger populations that are the focus of the ACA and efforts to reform healthcare in this country. As Brendan Maher and Peter Stris explain in an article on the need for structural reform of ERISA, "It is difficult to overstate the magnitude of expectation uncertainty associated with the promise of 'medically necessary' care. To put it mildly, it dwarfs the expectation uncertainty present in all other benefit promises."<sup>150</sup> And decision

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148. On the first question of who should be held accountable, Ibrahim notes that courts support an individual focus on fiduciary breaches for the duty of loyalty and a more collective approach for breaches of the duty of care, and he argues in favor of such a duty-specific approach. See Ibrahim, *supra* note 146, at 933–34 ("This Article favors a duty-specific answer to the individual/collective question on both descriptive and normative grounds. First, it shows that courts generally have focused on the board as a whole in duty of care cases, and on directors as individuals in duty of loyalty cases. Second, this Article argues that courts have been correct in drawing this duty-based distinction because it strikes the proper balance between the board's authority and its accountability in each case.").

149. See Maher, *supra* note 99, at 666 ("When assessing questions about the contour of the ERISA benefit denial remedy, judges would have been hard pressed to ignore the consequences of interpreting the remedy expansively. If employers were deterred from offering insurance because of the cost and uncertainty associated with generous remedies—for example, runaway damage awards for pain and suffering—then quite literally many millions of Americans would have become unable to obtain health insurance.").

150. Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 462 (2010).

makers can reasonably disagree about whether to provide benefits because there are consequences associated with providing costly treatments with limited health consequences.<sup>151</sup>

In this Part, I explore three possible changes to ERISA's fiduciary decision-making framework: (1) enhanced external review beyond that required by the ACA; (2) altering federal ERISA common law to reduce the discretion accorded to fiduciary decisions on benefit claims; and (3) caps on benefit claim denials set by government actors and enforced on appeal. I find that only the last proposal meets the need for collective consistency and fairness demanded by the ACA's goal of near-universal access to healthcare.

### A. A Proposal for an Enhanced External Review Process

Prior to the ACA, forty-three states had laws providing for an external review process for benefit decisions made by administrators of health insurance plans. Some states, however, limited access to particular types of plans (such as HMOs) or claims (denial of benefits because of disagreement of what was "medically necessary"). Filing fees and quick filing deadlines discouraged many from taking advantage of this remedy. In addition, many states allowed insurance companies to select an Independent Review Organization (IRO) from a list, thus potentially decreasing the neutrality of the decision makers.<sup>152</sup> And any advantage beneficiaries gained was mollified by the need to jump through yet another hoop to receive their rightful access to benefits.

Expanding on the Supreme Court's decision in *Rush v. Prudential HMO, Inc. v. Moran*,<sup>153</sup> which declared that an Illinois statute requiring independent review of conflicts between HMOs and physicians regarding appropriate treatment was not preempted under ERISA, the ACA requires health plans and insurance issuers to comply with any established state external review process or to implement an external review process that complies with new regulations if the applicable state law does not establish such a process or the plan self-insures and is not subject to state insurance law.<sup>154</sup> Participants in plans that

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151. *Id.* at 462–64; see Vukadin, *supra* note 31, at 1202 (noting that in addition to disagreements about what treatments are medically necessary or experimental, up to 20% of health benefit claims are decided incorrectly).

152. Wade S. Hauser, Note, *Does Iowa's Health Care External Reviews Process Replace Common-Law Rights?*, 99 IOWA L. REV. 1401, 1405–08 (2014) (exploring Iowa's amended external reviews process after the ACA and judging it to be a cumulative remedy for insureds instead of an exclusive remedy that barred subsequent access to the courts).

153. 536 U.S. 355 (2002).

154. 42 U.S.C. § 300gg-19(b) (2012) (requiring an external review process that "at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners"). In a technical release issued in June 2011, the Department of La-

self-insure and are therefore subject to the new federal external review process gained a new remedy.<sup>155</sup> Guidance from the Department of Health and Human Services (HHS), however, allows plans to meet the requirement of compliance with a federal external review process by following the state statute or contracting with a private Independent Review Organization instead.<sup>156</sup>

It is questionable whether the new external review requirement under the ACA is beneficial to plan participants, however, because it adds yet another layer of review that participants can only access after exhausting internal claims procedures within the insurance company or administrator of the plan.<sup>157</sup> Both plan sponsors and insurance companies benefit from the new appeals process because claimants drop out with each level of appeal—leaving fewer to file claims in court.<sup>158</sup> Many participants drop out of the process before ever appealing their denied benefit claims, and adding to the appeal burden will not help.<sup>159</sup> ERISA’s legislative history indicates that Congress wanted beneficiaries to have easy access to courts and did not wish to add extra steps to claims procedures.<sup>160</sup> Perhaps learning from past mistakes on this point, courts have been reluctant to rule in favor of health plans that have tried to force their participants to use

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bor reiterated the requirement that every state must have a state-regulated external review process that meets the sixteen minimum consumer protection standards outlined in the release. U.S. DEP’T OF LAB., TECHNICAL RELEASE NO. 2011-02, GUIDANCE ON EXTERNAL REVIEW FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP AND INDIVIDUAL HEALTH COVERAGE, AND GUIDANCE FOR STATES ON STATE EXTERNAL REVIEW PROCESSES 2 (2011) [hereinafter TECHNICAL RELEASE 2011-02]; see Maher, *supra* note 99, at 691–92 (“The Supreme Court, however, has made clear that, as a general matter, external review is outside conflict preemption. The ACA codifies that thinking; indeed, the Model Act used by the ACA as a referent envisions external reviewers supplying no *Firestone* deference to internal reviews.”).

155. Insurers and plans—including self-funded plans subject to ERISA—in states whose external review processes do not meet federal requirements must participate in a federally-administered external review process managed by the Office of Personnel Management or through an accredited IRO. TECHNICAL RELEASE 2011-02, *supra* note 154, at 7–8; see Hauser, *supra* note 152, at 1410.
156. TECHNICAL RELEASE 2011-02, *supra* note 154, at 7–8.
157. Vukadin, *supra* note 31, at 1203–04 (“As a practical matter, is a further level of review—usually available only after exhaustion of internal levels of review—the kind of reform that will make a difference to most plan participants?”).
158. *Id.* at 1204 (describing the additional “winnowing” effect of a new external review process on top of the fact that “all but a few plan participants fail to complete the arduous appeal process available to them even before this new, external level of review”).
159. *See id.* at 1205.
160. *See* Wooten, *supra* note 98, at 587 (“Moreover, the legislative history of ERISA also reveals a trend in congressional decision-making away from requiring participants and beneficiaries to jump through a hoop before going to court.”).

the external review process instead of making it an optional method of relief.<sup>161</sup>

The rules as currently written do nothing more than place another obstacle in the path of participants seeking access to their benefits. External review boards cannot grant damages<sup>162</sup> or otherwise compensate appellees for the time and effort spent to exhaust their options through the internal review process—within which there are typically two rounds of appeals—and pursue another appeal through the external review process. Because fiduciaries know that even participants with valid claims drop off at each level of appeal, an extra hurdle increases their incentive to deny valid claims since fewer will be appealed in court and costs to fight at each level of appeal are discounted by the percentage who never appeal or drop off at each level of appeal. This clearly does not bring collective accountability.

My proposal would be to (1) make all benefit claim denials above a certain dollar threshold subject to a mandatory external review process and (2) ensure that there are no ties between the fiduciaries and the independent decision makers completing the external review. On the first point, fiduciaries might make different decisions if they knew that all of those decisions would be subject to a meaningful review. By requiring all benefit claim denials above a certain *de minimis* threshold to be reviewed externally, the impetus for supervising fiduciary decisions would not need to come from plan participants who are often uninformed about the procedure for appeals or sick and unable to fully engage in an appeals process. Recognizing that this proposal is costly, plans could be authorized to eliminate all internal review procedures in favor of this one, automatic external level of review. The dollar threshold could also be adjusted upwards to find an appeals process with a reasonable cost.

On the second point, the only way that external review processes have any value is if we can eliminate the conflicts of interest that plague the current internal review procedures. Health plans that choose to contract with IROs are required to contract with three IROs and rotate assignments among them. These IROs, however, have had difficulties keeping up with demand, and according to Department of Labor guidance plans can avoid enforcement actions by demonstrating

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161. See, e.g., *Bailey v. Chevron Corp. Omnibus Healthcare Plan*, No. SACV 13-1366-JLS (ANx), 2014 WL 2219216, \*2 (C.D. Cal. May 7, 2014) (finding that although plans may be required to implement an external review process, this does not mean that they can require their plan participants to use the external review process before resorting to litigation); *Goldman v. BCBSM Found.*, 841 F. Supp. 2d 1021, 1026 (E.D. Mich. 2012) (holding that, given the language of the plan's benefit guide, the plan participant was only required to exhaust the internal review process and was not required to seek external review by state regulators before seeking judicial remedies).

162. Maher, *supra* note 99, at 671.

that they are taking other steps to ensure that their external review process was independent and without bias.<sup>163</sup>

Asking any group to police themselves is obviously fraught with problems, particularly where that group has a financial incentive for bad behavior such as incorrectly denying valid claims or even merely questionable ones. If the fiduciaries themselves select the decision makers, as the ACA and many states allow, there is no hope for a truly fair hearing of the benefit claim. Even if fiduciaries do not select the decision makers and they are instead randomly assigned, the fact that the fiduciaries are repeat players and may have a good working relationship with the decision makers introduces bias and makes this solution less desirable. In addition, the focus with this proposal is still on the individual beneficiary and the individual claim, not on ensuring consistency or overall fairness.

## B. A Proposal to Alter Federal ERISA Common Law

Many scholars have argued that the federal courts were wrong in their early ERISA cases governing benefit claims. They argue that courts should not have (1) required that claimants exhaust internal review procedures before seeking redress in the courts, (2) applied a deferential “arbitrary and capricious” standard of review to fiduciary decisions, or (3) limited their review to the administrative record of that one claimant.

First, nowhere did Congress indicate that claimants were required to exhaust internal review procedures prior to appealing the denial of a benefits claim to the courts.<sup>164</sup> Focusing on efficiency and cost concerns, the courts required participants to jump through this extra hoop by appealing to the fiduciary who has already denied the exact claim previously.<sup>165</sup>

Second, in *Firestone Tire & Rubber Co. v. Bruch*,<sup>166</sup> the Supreme Court held that the standard of review for benefit claims—where the plan documents reserved the fiduciary’s right to use discretion to decide benefit claims—is the same arbitrary and capricious standard

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163. TECHNICAL RELEASE 2011-02, *supra* note 154, at 8–9.

164. ERISA § 503, 29 U.S.C. § 1133 (2012) (“[E]very employee benefit plan shall . . . (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.”). *But see* Wooten, *supra* note 98, at 578–79 (noting recent comments by congressional staffers involved with drafting ERISA that they did intend for claimants to exhaust internal review procedures before seeking judicial redress).

165. *See* Roth, *supra* note 46, at 263–65 (“Courts relied on Congress’ supposed concern with efficient resolution of ERISA claims—favoring efficiency over correcting flawed decisions.”).

166. 489 U.S. 101 (1989).

that decision makers in government agencies are reviewed under.<sup>167</sup> Judges then cannot overturn a fiduciary's decision on a benefit claim unless it is arbitrary and capricious, even if the judge thinks the decision is wrong. The power of judges over ERISA benefit claims has been largely abrogated then, as all well-drafted benefit plans now include such a reservation of rights for the fiduciary.

Third, and most relevant to my discussion of the need for a collective framework, courts have limited their review of benefit claims to the claimant's administrative record. Therefore, even sick plan participants fighting for important medical treatments cannot obtain discovery or use evidence outside of the administrative record presented by the fiduciary to challenge the decision.<sup>168</sup> This is the case in the vast majority of ERISA claims, with the exception of a few cases where clear conflicts of interest beyond the standard cost-containment motivation are shown.

This last point means that statistical evidence showing that a fiduciary denies a disproportionate number of claims or unevenly rejects claims for a particular type of participant or beneficiary is not welcome in the courts. In fact, the courts would have no way of knowing what a disproportionate number of claim denials is because they do not require the fiduciary to produce evidence of how many similar claims are denied (within the company or across similar companies). There is not even a simple, anecdotal comparison made between an individual benefit claim before the court and other claims made to that fiduciary. There is no collective accountability in this process.

Congress could step in to alter federal common law in this area and make the process easier on individual claimants. The fact remains, however, that for over forty years, Congress has not done so. The odds that Congress will revisit this issue in exactly this way after many calls for it to do so went unheeded are low. Perhaps this is because it is hard to rally Congress behind the idea of intervening on a small scale, in a way that only impacts the comparatively few individual claimants who appear before the courts. In addition, without looking to issues of collective benefit outcomes, the decisions in these cases are unlikely to be overturned because there is great difficulty in determining a "correct" decision on an individual level when looking at ambiguous plan terms. My last proposal, however, takes the problems that resulted in calls to alter federal ERISA common law and places them within the collective fiduciary framework forming after the ACA—per-

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167. *Id.* at 109.

168. Mark D. DeBofsky, *What Process Is Due in the Adjudication of ERISA Claims?*, 40 J. MARSHALL L. REV. 811, 812 (2007) (noting that courts have not analyzed whether claimants have any due process rights in the adjudication of their benefit claims).

haps making it more likely that Congress will be moved to act now or in the future.

### C. A Proposal for Statistical Limits on Benefit Denials

I argue here that what is needed to ensure that fiduciaries protect, not hinder, access to healthcare is to focus on aggregate benefit decisions and aggregate accountability.<sup>169</sup> All the procedural safeguards and fantastical beliefs that fiduciaries can wear two different hats do not change the fact that private fiduciaries face a conflict of interest under ERISA and the ACA. They are supposed to act for the exclusive benefit of plan participants and beneficiaries but face pressure to contain costs to advance the goals of for-profit institutions.

I propose that legislation be enacted to allow HHS to set caps on the percentage of benefit claims (based on dollar value) that fiduciaries can deny. This will ensure that government actors tailor the work of fiduciaries to meet public goals. After all, private entities are profiting from what is now a social insurance program—from a system that many other countries have made entirely public. The government should demand some accountability.

For now, participant grievances would still be addressed through ERISA's current appeals processes, however. Focusing on the current appeals procedures, as onerous as they may be, allows insurance companies and administrators to maintain control, authority, and efficiency over the majority of benefit claims that are clearly spelled out under the terms of the policy. Obviously, the harm in this is that some participants whose claims are wrongfully denied initially based on the new aggregate data collected will decide not to appeal, whether consciously or because they do not fully understand their rights. Yet a more fair appeals process will likely result in more appeals in the long term.

HHS would decide how to set caps based on data reported by health insurers and administrators on all claims decided internally. HHS would be authorized to determine the proper data set used to calculate average claims denials. For example, there may be regional variations in benefit decisions initially until the government can work towards a more uniform healthcare system. More importantly, the question will arise whether the denial of a claim for a breast cancer

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169. It is of course difficult to have a collective fiduciary framework if not everyone has equal access to health insurance and healthcare. See Emily Whelan Parento & Lawrence Gostin, *Better Health, but Less Justice: Widening Health Disparities After National Federation of Independent Business v. Sebelius*, 27 NOTRE DAME J.L. ETHICS & PUB. POL'Y 481 (2013) (discussing disparities in access to healthcare and in health more broadly based on which states are opting out of the Medicaid expansion under the ACA).

treatment should be compared to denials for all breast cancer patients or for all adult cancer patients.

Finally, because we are now focused on systemic issues of inequality within our healthcare system, data should also be collected from institutional fiduciaries on the gender and racial background of participants whose initial claims are denied and the percentage who do not appeal that denial.<sup>170</sup> The cap on benefit denials would require that fiduciaries stay under the cap for both male and female insureds and among different races. Inequality in claims denials between those categories would be required to stay within a certain margin of error as well. So, an institution could not stay under the aggregate cap while denying many more benefit claims for blacks than for whites. Special notices can be sent to those whose claims are denied to make it easier for them to understand the new rights accorded to them if they appeal.<sup>171</sup>

Fiduciaries who exceed the HHS caps will be subject to large penalties that continue to accumulate while they are noncompliant. Penalties should be a percentage of profits rather than a multiple of the claim value to ensure that fiduciaries cannot continue to deny small dollar value claims that add up to big bucks in the aggregate without recompense. Proper deterrence requires larger sanctions.<sup>172</sup>

Assuming that a benefit claim is denied and appealed to the courts, I would include a requirement that federal courts hearing benefit claims review only the question of statistical compliance with the HHS claim denial caps de novo to ensure compliance. The insurance company or administrator would be required to supply the court with the relevant data on its benefit claim denials broken down by gender and race as well as the relevant caps set by HHS. If the insurer or administrator is within a certain distance of the HHS cap, federal judges would be required to decide the entire substance of the benefit claim de novo—with no deference accorded to the fiduciary's earlier decision on appeal.<sup>173</sup>

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170. See Vukadin, *supra* note 31, at 1208 (“The regulations do not, however, require any particular processes or safeguards to ensure that decision making is consistent—the means of accomplishing consistent decision making are left to payors.”).

171. See *id.* at 1206 (noting the need to “increase consumer participation” with notices designed to inform participants and beneficiaries of their rights and about the appeals process).

172. See *id.* at 1220 (“Thus, even when a claim is improperly and repeatedly denied, a participant who sues in federal court and wins still only receives the value of the benefit. The payor’s improper and repeated denials are not separately punished at all.”).

173. This buffer zone near the HHS cap in which federal judges are required to give benefit determinations extra scrutiny also helps allay concerns that shifting statistics could result in inequality between claimants who file similar appeals at

Not only is this more likely to contain benefit denials on appeal, but judges would finally be forced to address the merits of at least a very small portion of ERISA benefit claims. Some government actor would be forced to look into whether benefit denials are correct at least once in a while. Up to this point, even that much has not happened.<sup>174</sup> My proposal reduces not only the discretion accorded to fiduciaries but also the discretion left to federal judges under ERISA.<sup>175</sup>

This proposal ensures that our system of fiduciary accountability moves towards a focus on a larger population and ensuring equality of healthcare access; it also maintains efficiency by allowing fiduciaries to make initial benefit determinations and follow current appeals procedures in place (which winnow down the number of appeals). Fiduciaries even maintain the deference typically accorded by federal judges where they stay under the cap for denials of benefit appeals set by HHS and under the buffer zone.

Of course my proposal is imperfect. It does not alter the fact that most claimants never appeal their benefit denials at all—let alone to a federal court. Yet the more carefully appeals are monitored and the more fair they appear, the more likely participants are to appeal their claims. Although many argue (and I have argued in the past) that an arbitrary and capricious standard of review is inappropriate in the case of an ERISA benefit claim, these arguments have been unsuccessful for four decades, and it is clearly time to consider more dramatic steps to protect beneficiaries, particularly in the healthcare context where the stakes are so high and additional protection is needed to prevent irreparable harm. By protecting collective goals, we protect individual claimants.

## VI. CONCLUSION

ERISA came to fruition because the risks associated with pension loss were too much for workers to bear, and the public took notice.<sup>176</sup>

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different times, when the changing statistics could result in different decisions in their cases.

174. Vukadin, *supra* note 31, at 1205 (“Furthermore, the external review rules do not address another major failing of the ERISA claims process, namely that there is no direct, negative, and substantial consequence of payors’ incorrect denial of legitimate healthcare claims.”). Vukadin proposes interest and penalties on any benefit claims overturned during the external review process to deter claims from being decided incorrectly initially. *Id.*

175. See Maher, *supra* note 99, at 678 (“A fair presumption is that the foregoing extra-statutory concerns—diminished relative to ERISA, but not weakened so much as to fade into insignificance—will influence judicial interpretation of the ACA, both with respect to the content of the law itself and the degree to which judges will be willing to interpret it to prevent states from pursuing policies that thwart or undo litigation reform.”).

176. Employees lost all or a portion of their expected pensions when: (1) plan managers “misuse[d] or [stole] assets” (agency risk); (2) the employees quit or were fired

After ERISA, employers systematically shifted those risks back to workers. Employers avoided default and forfeiture risks by shifting their defined benefit pension plans to defined contribution plans. When pension costs went up because employers had to maintain a higher level of funding and many employees no longer forfeited their benefits, employers reacted by paying small sums (if any) into tax-deferred plans with no commitment to continue paying past the termination of employment.

What has happened with group health plans subject to ERISA is the same basic process. As healthcare costs rose, employers sought cost-containment measures and fiduciaries began to ration healthcare in ways that plan participants and beneficiaries do not fully understand until their claims are denied. As the ACA uses non-ERISA plans to increase health insurance coverage to near-universal levels, ERISA plans must be made to fit this larger goal. Where fiduciaries can systematically deny benefit claims to limit plan expenses, those with employer-sponsored health insurance lack full access to their health insurance. To make public and private health insurance programs work together to achieve public goals, consistent and coherent fiduciary accountability is key.

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from employment (forfeiture risk); or (3) an employer failed to properly fund the benefit plan and faced hardship itself (default risk). WOOTEN, *supra* note 79, at 3.